Shetland Islands Council

MINUTE - PUBLIC

Meeting	Integration Joint Board
Date, Time and Place	25 August 2015 at 11.00 a.m. Council Chamber, Town Hall, Lerwick, Shetland
Present [Members]	Voting Members G Cleaver B Fox K Massey C Smith *[Chair]* C Waddington *[Vice-Chair]* M Williamson Non-voting Members S Beer, Carers Representative S Bokor-Ingram, Chief Officer S Bowie, Senior Clinician – GP S Gens, SIC Staff Representative H Massie, Patient/Service User Representative M Nicolson, SIC Chief Social Work Officer I Sandilands, NHS Staff Representative E Watson, NHS Chief Nurse Community and ACF K Williamson, NHS Chief Financial Officer
In attendance [Observers/Advisers]	C Ferguson, Director of Corporate Services SIC J Riise, Executive Manager – Governance and Law SIC S Duncan, Financial Accountant SIC C Anderson, Senior Communications Officer L Gair, Committee Officer SIC *[note taker]*
Apologies	Voting Members None Non-voting Members C Hughson, Voluntary Sector Representative J Unsworth, Observers/Advisers R Roberts, Chief Executive NHS

Chairperson	Mr C Smith, Chair of the Integration Joint Board, presided.
Declarations of	None.

Interest	
03/15	**Confirm minutes of meeting held on 29 July 2015**
	The Board approved the minutes of the meeting held on 29 July 2015 on the motion of Mr Cleaver seconded by Mrs Williamson.
04/15	**Establishing the IJB Audit Committee**
Report No. CRP-14-15-F	The Board considered a report which presented proposals to establish the IJB Audit Committee. The Director of Corporate Services introduced the report and explained that the establishment of an IJB Audit Committee would ensure that good governance arrangements are in place. An Audit Committee is seen as a key component to good governance arrangements by the Integrated Resources Advisory Group. She referred members to the proposed terms of reference and to the appointments required. In addition, the Director of Corporate Services drew attention to the Scott-Moncrieff NHS Shetland Internal Audit report which was a Review of Governance, Risk Management and Project Management for the Integrated Board attached for information. She went on to explain that confirmation of the External Auditor will be advised in due course and it was expected to be Audit Scotland. In response to a question from Mrs Williamson, the Executive Manager – Governance and Law advised that given the distinct roles of Health Board and IJB Audit Committees, there would be no barrier to her being appointed as a member of the IJB Audit Committee. The Vice-Chair referred to paragraph 3.7 of Appendix 1 and queried the reference “other persons shall attend meetings...” and asked if IJB members had a right to attend if they choose. The Director of Corporate Services explained that the statement did not preclude IJB members from attending but ensures that the Chair is aware of their attendance. She went on to explain the different roles of members, and depending on the business to be considered by the IJB Audit Committee it may be inappropriate for IJB members to attend. She said that there needs to be a way of assessing that in order that individuals are not put in an inappropriate position, therefore it is important that the Chair has discretion on who else attends. The Executive Manager – Governance and Law concurred with the Director’s comments and explained a situation where any of the parties of the IJB may provide information that the Audit Committee may require to question in an investigative mode and that would be inappropriate for the parties to be involved. He said that it was advisable to leave this to the discretion of the Chair. In response to a question regarding the appropriateness of the IJB self auditing, the Director of Corporate Services said that it was entirely appropriate for public bodies to be in charge of the audit and regulation of its own affairs and it is an expectation that the IJB will do so.

	The Chair moved that the IJB approve recommendations 1-5 contained in the report, seconded by Mr Massey. In calling for nominations, the Chair said that he wished to decline the opportunity to sit on the Audit Committee in light of his role as Chair of the IJB. Mr C Smith nominated Mr Cleaver and Mr Fox, seconded by the Ms Waddington. Mr Cleaver and Mr Fox confirmed their acceptance of the role as Member of the Audit Committee. Mr Massey nominated Mrs Williamson, seconded by Ms Waddington. Mrs Williamson confirmed her acceptance of the role as Member of the Audit Committee. Mrs Williamson, nominated Mr Massey, seconded by Mr Fox. Mr Massey confirmed his acceptance of the role as Member of the Audit Committee. For the role of Chair of the IJB Audit Committee, Mrs Williamson declined the nomination by Mr Fox. Mr Fox declined the nomination from Mrs Williamson. Mr Fox nominated Mr Massey, who advised that he would be willing to accept, but highlighted to members that his current term of office would end in June 2016 but his successor would be eligible to replace him as a Member. Mr Cleaver seconded. For the role of Vice-Chair, Mr Fox nominated Mr Cleaver, seconded by Mr Smith. Mr Cleaver confirmed his acceptance of the role as Vice-Chair of the Audit Committee.
Decision	The Integration Joint Board RESOLVED to: 1. Formally appoint the Executive Manager Audit, Risk and Improvement as the Chief Internal Auditor for the IJB; 2. Approve the IJB Audit Committee Terms of Reference attached at Appendix 1 to the report; 3. Appoint four members of the IJB Audit Committee from among the voting members of the IJB as set out in the Terms of Reference, namely, Mr Cleaver, Mr Fox, Mr Massey and Mrs Williamson; 4. Appoint the Chair and Vice-chair of the IJB Audit Committee as set out in the Terms of Reference, namely, Mr Massey and Mr Cleaver respectively; and 5. Note that an IJB Audit Plan will be prepared and presented at a future meeting of the IJB for approval.
05/15	**Clinical Care and Professional Governance**
Report No. CRP-19-15-F	The Board considered a report which presented proposals to establish a Joint Clinical, Care and Professional Governance Committee. The Director of Corporate Services introduced the report and

	advised that under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the IJB are required to have a Clinical Care and Professional Governance Committee (CCPGC) which will strengthen the formal governance arrangements. She drew attention to the diagram attached as an appendix that illustrates that there is a structure in place for the CCPGC to report to the NHS, IJB and the SIC on the specific duties and responsibilities relating to each. The Director of Corporate Services referred to the draft Terms of Reference and the proposed Membership and said that, given this would be a joint committee from all three agencies, the proposals required their approval, starting now with IJB. The Director of Corporate Services added that this IJB was the first to attempt a joint CCPG Committee and she hoped that it would be adopted and that a cohesive approach would mean that nothing would be missed which was important when working with the most vulnerable people in the community. Dr Bowie expressed concern regarding the membership and held the view that this was light on GP clinical participation. The Director of Corporate Services said that the membership reflects what is currently required by the Health Board's Clinical Governance Committee which is underpinned by wider clinical forums therefore this Committee would not be the only place clinical representation is provided. Dr Bowie explained that new BMA changes would be coming through in respect of general practice in 2017 that will lead to GPs becoming clinical leads in localities. She said that the membership is fine whilst the Medical Director is a GP but this could be lost if the representative is from the hospital or a different medical group. The Director of Community Health and Social Care commented that Dr Bowie made a good point and that GPs have a central role in localities. He said that the Medical Director collates views and concerns and puts forward papers on behalf of nursing and pharmacy teams and covers the full range of fields. He said however that it was important to ensure that these views are being collated but that would not be expected at Committee level and that the leading role would come from the Medical Director. Dr Bowie added that GPs have a role in the local committee and the area committee as well as in the community care centres where they see governance in action giving GPs a lot of expertise in this area and particularly GPs who are also trainers. It was suggested that the BMA changes be considered now rather than be required to change these arrangements again in 2017. The Director of Corporate Services said that the formal

	arrangements at paragraph 2.2.2 lists those normally expected to attend and this is consistent with the current Clinical Care Governance Committee of the NHS. She advised that the Health Board, last week, approved changes to the standing orders in regard to the Clinical and Care Governance Committee. Should the IJB wish to make a change to the list it would be presented to the Health Board as well. This recommendation could be made but the Health Board will need to consider how GP representation is sought. In response to a question from Mr Massie on paragraph 2.2.1 regarding patient forum representatives, Mr Massey explained that for lay representatives an invite is put to the Patient Focussed Public Involvement (PFPI) to attend. Ms Beer referred to paragraphs 2.2.1 and 2.2.2 and in particular to the reference to "other Members..." and "officers" and asked if there was a suggestion of a greater right for either to attend. The Director of Corporate Services said that there is a distinction carried forward from the Health Board Clinical Care and Governance Committee that some representatives are expected to attend and there is a separate list of those that may attend. In response to a question regarding who the representation on the Patient Forum would be and what part they would play, the Director of Corporate Services explained that this was a term in the NHS Clinical Governance Committee that is causing confusion. She explained that the role was about getting wider stakeholder input. Mr Massey advised that the Patient Forum would be made up from the Public Partnership Forum (PPF) and PFPI. He said that it was important to have lay representatives on the CCPGC to understand patient experience and opinion. Mr Massey referred to Dr Bowie's earlier point about GP representation on this Committee and said that he agreed. He explained that there have always been questions as to whether or not the representation of the Medical Director, on behalf of the Area Clinical Forum, goes far enough. He proposed that the IJB take a recommendation to the Health Board that GPs have a separate representative on the CCPGC. At the request of a member, the Director of Corporate Services said that it was absolutely appropriate for the IJB to make recommendations to the Health Board. Mrs Williamson said that the IJB was aware that clinicians have difficulty attending meetings as representatives from localities and asked if it was possible for the GP to be represented by someone in the Localities Team. The Chair advised that non-voting Members can put forward substitutes with prior notice to the Chair. Mr Fox agreed with Dr Bowie and Mr Massie and said that as matters move forward GP representation needed to be addressed.

	Mr C Smith moved that the Board approve the recommendations contained in the report with the addition of a sixth paragraph to take on board Mrs Bowie's point, supported by Mr Bokor-Ingram, Mr Massey and Mr Fox.
Decision	The Integration Joint Board RESOLVED to approve: 1. Approve the proposals for a Joint CCPGC and recommend the proposals to the Council and the Health Board for approval; 2. Approve the DRAFT Terms of Reference for the CCPGC at Appendix 1 and recommend the DRAFT Terms of Reference for approval by the Council and the Health Board; 3. Agree that the CCPGC once constituted will have delegated authority from the IJB to finalise the detail with regard to the operation of the clinical, care and professional governance framework and update the Terms of Reference accordingly; 4. Agree the appointment of the members of the new Joint Committee in accordance with the membership set out in the DRAFT Terms of Reference and more specifically; a. Appoint one voting member of the IJB who is a non-executive member of the Health Board, namely Ms Waddington and one voting member of the IJB who is an elected member of the Council as members of the CCPGC, namely Mr Fox; and b. Agree that the appointment of the Chair of the CCPGC will be made on behalf of the IJB by the Health Board; 5. Note that the Joint CCPGC cannot be established unless and until the proposals are approved by the Council and the Health Board and the appointments of all the members of the Joint Committee have been made; and 6. Recommend that the Health Board consider seeking specific GP representation on the list of CCPGC Membership.
06/15	**IJB Risk Management Strategy**
Report No. CRP-17-15-F	The Board considered a report which presented a draft IJB Risk Management Strategy for approval and a first draft IJB Risk Register for consideration. The Director of Corporate Services introduced the report and expressed thanks to the Risk Management Officers of the Audit Risk and Improvement Team for their assistance and for compiling the Risk Register presented today. She explained that the IJB would be asked to consider two risk registers the first would be for the business of the IJB and the second would be to have an overview of services through the strategic plan. She said it was important to keep the two distinct so that the IJB is aware of its own risks. Ms Waddington suggested the addition of a risk relating to localities as part of the IJB register. It was agreed by the Director of Community Health and Social Care that he would liaise with Ms Waddington to agree a form of words for that

	entry. In response to a query, the Board were advised that the Risk Register was a live document and although it would be presented quarterly, as a minimum, it was important that members advise the Chief Officer of risks they have identified promptly. Changes/additions should be informed directly to the Chief Officer, Director of Community Health and Social Care, in order that the register is kept updated, and not wait until the next quarterly meeting. Mr C Smith moved that the Board approve the recommendations contained in the report, seconded by Mr Cleaver.
Decision	The Integration Joint Board RESOLVED to: • approve the Risk Management Strategy for the IJB; and • discuss and advise the Chief Officer with regard to the IJB Risk Register.
07/15	**IJB Participation and Engagement Strategy**
Report No. CRP-16-15-F	The Board considered a report which presented the IJB Participation and Engagement Strategy. The Director of Community Health and Social Care introduced the report and thanked L Saunders, CHCP Project Manager for her work in drafting the Participation and Engagement Strategy. The Director of Community Health and Social Care stated the importance of understanding the issues regarding localities and the need to add any risks to the risk register. He said that locality planning was also important and that engagement needs to be flexible and effective. In terms of Shetland wide engagement he referred to the Patient Focussed Public Involvement (PFPI) group set up on a locality basis and the need to build on the existing mechanism where communities come together. He said that an early refresh of the Strategy would be needed. Ms Beer referred to pages 21 and 26 of the strategy document and commented that there was a brief mention of the Carers' Link Group but that there was no mention of the group under status engagement. She provided a note of suggested wording for this and it was agreed that this would be provided to the Director of Community Health and Social Care. Mr Massie referred to page 15 and the review of the remit for Public Partnership Forums (PPF's) and in response to his query the CHCP Project Manager explained that Kathleen Carolan, the Director of Nursing and Acute Services, was looking to widen this Forum to include Social Care so that it is in line with Integration. She said that it was early days in setting up the project. Ms Watson added that Our Voice is also in the strategic

	document and the IJB and Health and Social Care activity seek to reassure there is engagement with the Scottish Health Council nationally and locally through Our Voice. The Director of Community Health and Social care said that one recommendation is for an action plan on how to engage and Ms Watson's expertise in that would be integral to the plan. Ms Waddington referred to the primary audience of the strategy and questioned whether it was intended to be accessible to anyone else. In that case she suggested that an executive summary be provided. In referring specifically to "Performance in respect of localities" on page 29, she understood from the introduction of the report that this was being progressed but the strategy does not say this. She said therefore that there should be more detail in the middle of the document that appeared to be missing. The Director of Community Health and Social Care said that this was the first strategy and was a work in progress but took on board the points raised. He said that an Executive Summary would be useful in linking to the national website. Ms Beer referred to page 20 Paragraph numbered 4 and suggested a correction namely: "Voluntary Voice. The newsletter goes out three times a year." and, change "On the Voluntary Action Shetland webpage there is a ..." to read "On the "Shetland Community portal website there is a....". It was agreed that the CHCP Project Manager would confirm the wording with Ms Beer. Mr C Smith moved that the Board approve the recommendations contained in the report with the changes being asked of the Chief Officer. Ms Waddington seconded.
Decision	The Integration Joint Board RESOLVED to: • approve the IJB Participation and Engagement Strategy with amendments advised; and • instruct the Chief Officer to prepare an action plan for approval by the IJB by 31 December 2015
08/15	**IJB Business Programme 2015/16**
Report No. CRP-18-15-F	The Board considered a report which informed of the planned business to be presented to the IJB for the financial year to 31 March 2016 and sought discussion with Officers regarding any changes or additions required to that Programme. The Director of Corporate Services introduced the report and explained that a date was still to be set for the fourth meeting of the IJB, but now that the Board had approved the core governance arrangements it was important to set a date. The Board will be advised of the date as soon as it was established. The Director of Corporate Services provided an overview of the business expected at the fourth meeting and that Dr Taylor would bring forward principles for the Strategic Planning Group.

	She also explained that the status of the Social Services Committee and CHP Committee was subject to approval by the IJB of a Strategic Plan. She explained that depending upon the IJB assuming its full role, reports would also come to the IJB so that Members remain fully informed and so that the IJB can set up the Strategic Plan in March. The Director of Corporate Services added that unless the IJB adopts the 2015/16 plan the business will remain with the Council and the NHS. At the suggestion of Mr Cleaver the Chair agreed that it would be useful to hold a workshop for the IJB to consider the pros and cons of adopting the 2015/16 Strategic Plan. Mr C Smith approved the recommendations contained in the report. Mr Fox seconded.
Decision	The Integration Joint Board RESOLVED to: 1. Consider the IJB Business Programme for the financial year to 31 March 2016 and 2. approve any changes or additions to the Business Programme.

The meeting concluded at 12.10p.m.

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CHAIR

Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Financial Recovery Plan
Reference Number:	CC-51-15 F
Author / Job Title:	Simon Bokor-Ingram, Director Community Health & Social Care

Decisions / Action required:

The Integration Joint Board is asked to note the financial information presented in this report, and the actions being taken and planned for and to note that assuming the IJB approve the Strategic Plan for 2015/16 a detailed Financial Recovery Plan will be presented to a future meeting of the IJB.

High Level Summary:

This report sets out the current financial pressures across both the Community Health and Social Care Directorate and Acute and Specialist Services Directorate.

At present there are a number of factors which are putting pressure on budgets within the two Directorates. Whilst there has been much work carried out to redesign services over the years, this has not kept pace with the underlying pressure on budgets.

There are cost pressures emerging that both the Community Health and Social Care Directorate and Acute and Specialist Services Directorate will not be able to mitigate without support from the Health Board. Of particular note are cost pressures arising from the need to use locums where recruitment is proving difficult, and a rise in prescribing costs.

Corporate Priorities and Strategic Aims:

The Corporate and Strategic aims of the IJB are set out in the Integration Scheme 2015 drawing on the Public Bodies (Joint Working) (Scotland) Act 2014, associated Regulations and Guidance and the National Health and Well Being Outcomes.

Local outcomes, policies and strategies include Older People Strategy, Primary Care Strategy, Dementia Strategy, all currently being refreshed / developed. Detailed plans are contained in the Strategic (Commissioning) Plan 2015/16, which has been approved by the Council and the Health Board and forms a separate report on today's agenda. Financial sustainability is an imperative from national legislation and regulations.

Key Issues:

If the IJB is to begin to function fully during 2015/16, it is essential that it approves the Strategic Plan 2015/16 and the associated budget allocations. Currently, the allocation that would be devolved to the IJB in 2015/16 from the Council is under spending, whereas the allocation from the Health Board is over spending. This is true of the Health Board overall with acute and specialist services also overspending.

The development of a detailed Financial Recovery Plan for 2015/16 is in hand with a view to achieving a break even position at the end of the year. However, it is likely that the recurring efficiency target for 2016/17 onwards will be £1M plus.

Implications :	
Service Users, Patients and Communities:	Any significant service changes as a result of the Health Board being unable to meet its statutory responsibility would need a separate process for public and user engagement in line with NHS, SIC and IJB policies.
Human Resources and Organisational Development:	Service change may potentially have an impact on staff, and must be planned and delivered in partnership with staff and through due process.
Equality, Diversity and Human Rights:	No equalities issues have been identified to date. An impact assessment will be undertaken for any redesign of how we deliver services.
Partnership Working	There are well established processes in place to engage with the public; third sector, other statutory agencies and for engagement with unions and staff.
Legal:	The IJB has been established under the terms of the Public Bodies (Joint working) (Scotland) Act of 2014. The IJB will have responsibility for the planning and management of services and funding with regard to the delegated functions set out in the Integration Scheme, once it approves and adopts its first Strategic Plan. The IJB can choose to take on the full role during 2015/16 by adopting the 2015/16 Strategic Plan previously agreed by the Council and the Health Board. The IJB is responsible for developing and agreeing the 2016-19 Strategic Plan ready to begin implementation in full from April 2016. The National Health Service (Scotland) Act 1978 obliges health boards to operate within the available resources each financial year.
Finance:	Detailed financial information is included in the main report.
Assets and Property:	There are no implications for major assets and property i.e. buildings and equipment arising directly from this report.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	The IJB has agreed a Risk Management Strategy and Risk Register which includes risks associated with the delivery of the Strategic Plan. Key risks relate to failure to deliver service change including the achievement of recurring savings within some services.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015. The IJB is required to adopt a Strategic Plan and assume its full role by April 2017. The IJB can approve the Strategic Plan for 2015/16, which would mean it would then be required to agree a Financial Recovery Plan for 2015/16 due to the deficit in community heath budgets.
Previously considered by:	This report has not been presented at any formal meeting

Agenda Item

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Shetland Islands Council

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Financial Recovery Plan
Reference Number:	CC-51-15 F
Author / Job Title:	Simon Bokor-Ingram, Director Community Health and Social Care

1. Introduction

1.1 The joint Directorate of Community Health and Social Care reports on a quarterly basis on the performance of its management of the budgets allocated from both the Council and the Health Board. Both the Council and Health Board tasked the Directorate to find efficiencies from their budgets for financial year 2015/16. In addition, the Directorate would be expected to deal with any in-year cost pressures before seeking further financial support from either the Council or the Health Board, depending on which organisation is funding the particular service where the cost pressure has arisen. Acute and Specialist Services and Community Health report to the Board of NHS Shetland on a 2 monthly basis through the Director of Finance.

1.2 For 2015/16, efficiencies were identified during budget setting for the Council, and the budgets at the start of the year are net of those efficiencies. These efficiencies are necessary to cope with inflation and cost pressures and an anticipated real cash reduction in government funding to the Council. The budget for Social Care is currently under spent, and forecast to under spend by year end.

1.3 For the Health Board, efficiency schemes were identified which would need to deliver in year. The efficiency target for the two Directorates was allocated to each Director's budget, with full

allocations given to services with the expectation that they would deliver in-year efficiencies where budget could be given up during 2015/16.

1.4 For Health Board budgets, at the end of Quarter 2, it is clear that efficiency schemes are not delivering the amounts expected, and some will not deliver until 2016/17. In addition, there are cost pressures emerging that both the Community Health and Social Care Directorate and Acute and Specialist Services Directorate will not be able to mitigate without support from the Health Board. Of particular note are cost pressures arising from the need to use locums where recruitment is proving difficult, and the local effect of a national trend of a rise in prescribing costs.

1.5 The Scheme of Integration (2015) is clear on how financial pressures must be dealt with:

"Where there is a forecast overspend against an element of the operational budget, the Chief Officer, the Chief Finance Officer of the Integration Joint Board will work with the LPFT [Local Partnership Finance Team] and the appropriate finance officers of the Parties to agree a recovery plan to balance the overspending budget. The recovery plan shall be subject to the approval of the IJB.

If the recovery plan is not successful the Chief Officer and the Chief Financial Officer will work with the LPFT to develop options to address the overspend which may include the option of making interim funds available with repayment in future years on the basis of a revised recovery plan agreed by the Parties and the IJB."

2. Background

2.1 The Scottish Government financial strategy requires NHS Scotland to achieve year on year recurring efficiency savings of three percent. The funds released from the achievement of efficiencies are retained locally to re-invest in services to address local cost pressures, demographic pressures, new drugs costs, and to deal with the impact of inflation.

2.2 The current NHS Shetland efficiency savings plan was set to cover the five years from 2012/13 to 2016/17. This plan set Corporate and Support Services an ambitious efficiency saving target over the five years that was equivalent to 25% of their 2011/12 baseline budgets. The balance of the efficiency targets was assigned to

Clinical Services, which at that time consisted of a single directorate. Clinical Services was subsequently divided into two directorates - Acute and Specialist Services and Community Health and Social Care. The combined target for clinical services required achievement of £4.1 million efficiencies over the five year period. At the end of 2014/15, the first three years, £1.8m of the clinical efficiency target had been realised.

2.3 The total Health Board budget in 2011/12 amounted to £51.4 million. In 15/16 the total Health Board budget is £54.5 million.

2.4 The main areas of pressure this year are the costs of locums for key posts (including GPs and hospital doctors); prescribing costs; laboratory activity; and unachieved savings. In addition to the efficiency target for this year, both Acute and Specialist Services and Community Health have the added amount of their respective unachieved savings target from last year.

2.5 Appendix 1 outlines the current position in respect of achieved and unachieved savings for last year and this year for both Community Health and Acute and Specialist Services. 2.6 lists the details of the current Month 6 budget position for all services included in the Strategic Plan.

2.6 The current position for health services in the Community Health & Social Care directorate and the whole of Acute & Specialist Services is summarised as follows:

	2015/16 month 6 Variance	**2015/16 year end Projection**
	'000s	'000s
Prescribing	(210)	(262)
Primary Care	(188.4)	(388.5)
Mental Health	18.6	34
Community Nursing	(10.9)	0
Public Dental Service	16.8	50
Other community services	26	(94.5)
Unachieved savings	(240)	(480)
Sub-total	(587.9)	(1141)
Acute and Specialist Services	(403)	(809)
Total	(990.9)	(1950)

2.7 In year the potential for a budget over spend has been recognised by the Health Board, and where possible efforts have been made to

limit spend. Whilst non-recurrent savings will contribute significantly to this year's budget, this is not a sustainable long term solution. In the short term, limiting discretionary spends; delaying recruitment and using vacancies that arise as an opportunity to redesign delivery need to be implemented.

2.8 The Health Board is experiencing a very challenging year but is aiming to reach a break even position at the end of 2015/16. The forecast at the end of September 2015 is detailed in the table below.

There is a current projected overspend of £0.611m, which will require corrective action by the Health Board. The forecast includes a presumption that the Government funds the Highlands and Islands Travel Scheme costs at outturn.

Shetland NHS Board, Financial Position as at the end of September 2015	**Annual Budget at Month 6**	**Month 6 Variance**	**Projected Month 12 Variance**
Dir Acute & Specialist Service	12,411,659	(403,204)	(809,012)
Dir Comm Health & Social Care	17,829,454	(591,589)	(1,141,235)
Patient Travel – HITS	2,750,000	(154,029)	0
Off Island Clinical Services	7,750,112	81,591	189,258
Sub-total Clinical Services	40,741,225	(1,067,231)	(1,760,990)
Dir Public Health	760,309	17,129	17,129
Dir Finance	2,231,915	86,807	216,480
Reserves	1,286,112	0	452,149
SG Allocations to be allocated	96,517	0	96,517
Profit on Sale of Brevik House	0	309,720	309,720
Head Of Estates	3,616,688	48,030	57,018
Medical Director	21,200	542	542
Dir Human Res & Support Svs	2,483,151	(25,089)	0
Office Of The Chief Executive	2,491,708	(5,498)	0
Overall Financial Position	53,728,825	(635,590)	(611,435)

The Board is currently developing a recovery plan which will be presented to the Strategy & Redesign Committee meeting on 27th November, in order to close the projected gap of £0.611m.

3. Impacts

3.1 The Health Board has a statutory responsibility each year to reach an in-year break even position on its finances. Up until now NHS Shetland has achieved this each year.

3.2 At present there are a number of factors which are putting pressure on budgets within the two Directorates. Whilst there has been much work carried out to redesign services over the years, redesign has not kept pace with the underlying pressure on the Health Board budget. Non recurrent funding has been used in increasing amounts in the last few years to balance the overall budget at year end.

3.3 Non-recurrent savings will need to be identified not just within the Directorates but also across the Health Board to support an in-year break even position.

3.4 The two Directorates will need to continue to focus on their budget positions, and the efficiency and redesign agenda. The Directorates, with the Health Board, will need to consider all opportunities in year to generate further non-recurrent savings; control discretionary expenditure levels; and to plan for schemes in 2016/17 that will restore recurrent financial balance.

3.5 There will need to be an IJB programme of work between now and the end of March 2016 to develop detailed efficiency schemes, with clear timeframes, that will create sustainability for 2016/17 and beyond. This will need to be done in conjunction with the work being undertaken by the Health Board to meet the same objectives.

3.6 Between now and February 2016, intensive work will be required to develop detailed efficiency schemes for 2016/17 so that these can be presented to the IJB alongside the Strategic Plan for 2016/19.

4. Conclusions

4.1 With such a focus on finances, it is important that the commitment to safety and quality in delivering care is maintained, and the full governance structure of the Health Board is used to ensure that. The proposal for a Joint clinical, Care and Professional Governance Committee for NHS Shetland, Shetland Islands Council and the Integrated Joint Board has recently been agreed and this Committee will be key to ensuring safety and quality. At the same

time, it is imperative that the Directorates operate within the available resources allocated to them.

4.2 Monitoring and reporting maintains the audit trail of where spend is made against budget for both Council and the Health Board, and delineates between each organisations budget and expenditure.

4.3 Whilst the task ahead is going to be very challenging, NHS Shetland has a long history of delivering within its financial budget each year. The Health Board is fully committed to creating a sustainable position for the long term. The NHS Board and Executive Management Team of NHS Shetland are currently developing the efficiency programme for 16/17. The programme will be presented to the IJB as part of the process to agree the Strategic Plan for 2016-19.

For further information please contact:
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16 November 2015

Appendices:
Appendix 1 - Achieved and Unachieved Savings for both Community Health and Social Care, and Acute and Specialist Services.

Achieved and Unachieved Savings for both Community Health and Social Care, and Acute and Specialist Services.

Directorate of Community Health & Social Care	Non Recurring	In Year Recurring	
Brought forward efficiency target 2014/15			£466,692
2015/16 efficiency target			£342,600
			£809,292
Efficiency Schemes Actioned			
Pay base budget - Superann savings		£37,007	
Non Domestic Rates rating revaluation appeals		£4,906	
Physio - reduction of 1 vehicle		£2,400	
Surplus on corporate property sales allocated	£272,285		
Reduction in dietetic supplies		£5,000	
Wheelchair repairs - Orthotics technician taking over service		£7,000	
Orthotic work in Aberdeen			
Total Efficiencies Achieved	**£272,285**	**£56,313**	**£328,598**
Current Efficiency GAP			**£480,694**

Directorate of Acute & Specialist Services	Non Recurring	In Year Recurring	
Brought forward efficiency target 2014/15			£403,945
2015/16 efficiency target			£342,500
			£746,445
Efficiency Schemes Actioned			
Pay base budget - Superann savings		£48,811	
CDU Non Pay Reduction		£5,000	
Surplus on corporate property sales allocated	£137,715		
Hospital Managers Post	£57,984		
Specific funding allocations given up as savings	£129,028		
Total Efficiencies Achieved	**£324,727**	**£53,811**	**£378,538**
Current Efficiency GAP			**£367,907**

Agenda Item

3

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	20th November 2015
Report Title:	Joint Strategic Commissioning Plan 2015-2016
Reference Number:	CC-48-15 F
Author / Job Title:	Dr Sarah Taylor, Director of Public Health and Planning

1. Introduction

1.1 This report presents the draft Joint Strategic Commissioning Plan for 2015/16 to the Integration Joint Board (IJB). The draft Joint Strategic Commissioning Plan (known as the Strategic Plan) is attached at Appendix 1.

2. Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint bodies (in Shetland the Integration Joint Board) to create a Strategic Plan for the integrated functions and budgets that they control. In Shetland for the last few years the Community Health and Care Partnership (CHCP) has developed a Joint Commissioning Strategy within the CHCP Agreement and we have built on this to develop a Strategic Plan in line with national guidance on integration.

2.2 The Shetland Joint Strategic (Commissioning) Plan for 2015/16 was developed jointly in partnership with stakeholders, and agreed by Shetland Islands Council and Shetland NHS Board in February 2015, for adoption by the new Integration Body once it was established.

2.3 Now the Shetland Integration Joint Board (IJB) is established and has agreed on governance arrangements, its next task is to adopt a Strategic Plan in order to be able then to assume responsibility for the functions delegated to it by the Council and the Health Board.

3. The Plan

3.1 The Strategic Plan is structured around the client groups / services that are included within the delegated authority of the new Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

3.2 Each section is designed to outline policy context and drivers for change, relevant demographics and brief details of any needs assessment undertaken including any unmet needs identified, a brief description of current services, any risks to service delivery, funding and resources including savings targets and workforce implications, plans for change including priorities for 2015-16, performance targets and outcome measures.

3.3 Sections include links to local strategies that have been developed in relation to those client groups, for example on Mental Health, Older People and Dementia, and to more detailed delivery plans on topics such as Unscheduled Care or the Substance Misuse Services Redesign programme.

3.4 The Plan is also required to set out the arrangements for carrying out the integration functions in Shetland over the period of the plan as follows:

3.5 The arrangements for each locality established for locality planning purposes: the IJB is obliged to establish localities as a process for developing clinical, professional and community engagement to inform future strategic plans, and we have agreed 7 localities for strategic planning purposes, detailed in Appendix 1 to the Plan. During 2015/16 a round of meetings has been held across localities to inform the development of joint commissioning, and more detail on this is included in the 2016-19 Plan.

3.6 The operation of the Strategic Planning Group for the purposes of preparing the strategic commissioning plan: during 2015 a shadow Strategic Planning Group was established for the purposes of preparing the strategic commissioning plan, consisting of members of the Health & Social Care Integration Steering Group and the Community Health and Care Strategic Group, to ensure representation in line with national guidance. The Integration Joint Board will be asked to approve the establishment of a substantive Strategic Planning Group to take forward preparation of future plans. This, and the process for Strategic Commissioning to support development of future plans is detailed in a separate report to the IJB and, once adopted, will be appended to the Joint Strategic Commissioning Plan for 2016-17.

3.7 The date on which functions are to be delegated will be determined by the adoption of the Strategic Plan by the IJB and will be included in the final publication of the Strategic Plan on the Shetland Integration web-site.

3.8 Some of the arrangements require further development work where further detail will be included in the Joint Strategic Commissioning Plan for 2016-19:

3.8.1 The current CHCP Procurement Strategy will be replaced by an updated Joint Commissioning and Procurement Strategy with the ambition of providing one strategy that will be adopted by the Council, NHS Shetland and Shetland's Integration Joint Board for health and social care.

3.8.2 An agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions, will be developed, building on an update of the NHS Board's Decision Making Policy and current best practice in both NHS Shetland and Shetland Islands Council.

3.8.3 A Market Facilitation Plan will be developed in line with national guidance and relevant to the Shetland context.

3.9 The Plan includes headline figures on service budgets, more detailed work has been undertaken during the year to inform budget setting for integrated services and for localities (see Appendix 2). A separate report on the budget for 2015/16 will be presented to the IJB.

4. Performance monitoring

4.1 Once adopted, the IJB will monitor progress against the plan through its performance monitoring systems.

5. Recommendation

5.1 The Integration Joint Board is asked to approve the Joint Strategic Commissioning Plan for 2015 -2016.

6. Conclusions

6.1 The Joint Strategic Commissioning Plan for 2015/16, as approved by Shetland Islands Council and Shetland NHS Board, is presented to the Shetland Integration Joint Board for adoption, to allow it to assume its responsibility for the functions delegated to it by the Council and the Health Board. Further development work on the process of joint commissioning to support future plans is underway.

For further information please contact:
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01595 743072 *sarahtaylor1@nhs.net*
1 November 2015

Appendices:
Appendix 1 - The Draft Joint Strategic Commissioning Plan 2015-16
Appendix 2 – IJB Finance Report

Background Documents:

Strategic Commissioning Plans Guidance issued by Scottish Government
http://www.gov.scot/Resource/0046/00466819.pdf

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20th November 2015
Report Title:	Joint Strategic Commissioning Plan 2015-2016
Reference Number:	CC-48-15 F
Author / Job Title:	Dr Sarah Taylor, Director of Public Health and Planning

Decisions / Action required:

The Integration Joint Board is asked to approve the Joint Strategic Commissioning Plan for 2015 -2016.

High Level Summary:

The Joint Strategic Commissioning Plan (referred to as the Strategic Plan) sets out plans for how resources are to be delivered through integrated services; how services will contribute to improving people's lives, health and wellbeing; and plans for change to improve the health, wellbeing and care of people in Shetland, as measured through national and local outcomes.

It is structured around the client groups / services that are included within the delegated authority of the new Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

Each section includes policy context and drivers for change, relevant demographics and brief details of any needs assessment undertaken including any unmet needs identified, a brief description of current services, any risks to service delivery, funding and resources including savings targets and workforce implications, plans for change including priorities for 2015-16, performance targets and outcome measures.

Corporate Priorities and Strategic Aims:

The Plan supports delivery of the following outcomes in the Shetland's Single Outcome Agreement (SOA):
"We have tackled 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.";
"People are supported to be active and independent throughout adulthood and in older age"; and "We live longer healthier lives".

The Plan sets out how the Integration Joint Board and integrated services will deliver on the National Health and Wellbeing Outcomes (as detailed in the Strategic Plan).

Key Issues:

The Strategic Plan is built on the previous Community Health and Care Partnership Agreement (in 2014/15 the Joint Commissioning Strategy & Integration Plan).

The IJB is required to adopt a Strategic Plan in order to assume its responsibility for the

functions delegated to it by the Council and the Health Board. Once adopted, the IJB will monitor progress against the plan through performance monitoring, and oversee the work of developing future plans via the establishment of a Strategic Planning Group (the subject of a separate report to the IJB).

Arrangements for carrying out the integration functions are included in the Plan, and further development work identified for this year in a number of areas including Locality Planning.

Headline budget figures for individual services are included in the Plan, but a separate report on finance and joint budgets will be presented to the IJB.

Implications :	
Service Users, Patients and Communities:	The Strategic Plan is intended to bring about improvements in the health and wellbeing of service users and the Shetland community. It is also written to describe service change and should detail any expected impacts on users. Any significant service change would need a separate process for public and user engagement in line with NHS, SIC and IJB policies.
Human Resources and Organisational Development:	Service change may potentially have an impact on staff, and should be planned and delivered in partnership with staff and through due process. Headline workforce change should be signalled in individual service sections.
Equality, Diversity and Human Rights:	Some sections of the plan deal specifically with some services and client groups relevant to the equality legislation. No equalities issues have been identified to date.
Partnership Working	The Plan is written to deliver partnership working across Health and Social Care. A range of services and activities in the Plan also support and rely on wider partnership working particularly with third sector partners.
Legal:	The Plan is developed to comply with the requirements of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014, and associated guidance.
Finance:	The Plan describes services commissioned to be delivered within the budgets delegated to the IJB from SIC and NHS Shetland.
Assets and Property:	The Plan does not describe any implications for major assets and property i.e. buildings and equipment.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	The IJB has agreed a Risk Management Strategy and Risk Register which should include risks associated with the delivery of the Strategic Plan. Key risks relate to failure to deliver service change including the failure to achieve recurring savings within some services.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015. Once it has approved a Strategic Plan it assumes responsibility for the functions delegated to it by the Council and the Health Board	
Previously considered by:	The draft Strategic Plan was approved by Shetland NHS Board Shetland Islands Council.	 10th Feb 2015 18th Feb 2015

NHS SHETLAND

SHETLAND ISLANDS COUNCIL

Draft Joint Strategic (Commissioning) Plan 2015-16

Version 6 – October 2015

Contents

Introduction

The Joint Strategic (Commissioning) Plan for 2015/18 is developed jointly in partnership with stakeholders, for adoption by the new Integration Body. It builds on the previous CHCP Agreement (in 2014/15 the Joint Commissioning Strategy & Integration Plan), and is intended to be compliant with Strategic Commissioning Plans Guidance issued by Scottish Government: http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

It is structured around the client groups / services that are included within the delegated authority of the new Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

The strategic commissioning plan takes account of other local policy directions as outlined in the Shetland Single Outcome Agreement, Shetland NHS Local Delivery Plan, Shetland Islands Council Housing Strategy, Shetland Community Plan and other local corporate plans.

Historically, Shetland Islands Council has written Directorate and service plans to describe how services are currently delivered (how it is done now), drivers for change, and key actions / priorities for the coming year, and the NHS LDP has highlighted planned progress towards improvement in meeting national targets. In future the Strategic Commissioning Plan will increasingly describe how people's lives, health and wellbeing will be improved (how it should be done in future). This will include decisions about disinvesting in current provision of services in order to reinvest in other services and supports that are required to meet on-going and changing demand.

In addition, we expect future iterations of the Joint Strategic (Commissioning) Plan to increasingly reflect the developing engagement with stakeholders and local communities in Shetland, through Locality Planning and links to Community Planning, professional involvement and user and carer fora (through strategic planning on older people and primary care strategy development etc). The Integration Body's Participation and Engagement Strategy sets out more detail of this.

Guidance sets out the need for Joint Strategic Needs Assessments (JSNAs) to inform the development of the Strategic Plan through the analysis of the needs of local populations. These Needs Assessments will also inform and guide the commissioning of health, wellbeing and social care services within the area.

In Shetland the specific strategies that have informed the Strategic Plan (on Carers, Mental Health, Older People, Dementia) include Joint Strategic Needs Assessments, as well as Locality Profiling to inform Locality Planning, and components of Needs Assessments have been included in Service Plans. Again, this will be an area of development in future iterations of the Strategic Plan, taking into account the NHS National Services Scotland (NSS) linked longitudinal health and social care datasets as they become available.
A further area for development in the first year of the Strategic Plan will be on performance monitoring, and developing the key performance indicators already in place to show progress towards meeting the national health and wellbeing outcome indicators.

Similarly, financial analysis at the level of service delivery and change, and to support analytical processes such as programme budgeting / marginal analysis and locality planning, will be developed in the first year of the plan as part of the Joint Finance work in place to support the development of Integration.

Framework for the Shetland Joint Strategic Commissioning Plan

Principles

The integration **delivery principles** are:

- that the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users,
- that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:
    - is integrated from the point of view of service-users
    - takes account of the particular needs of different service-users
    - takes account of the particular needs of service-users in different parts of the area in which the service is being provided
    - takes account of the particular characteristics and circumstances of different service-users
    - respects the rights of service-users
    - takes account of the dignity of service-users
    - takes account of the participation by service-users in the community in which service-users live
    - protects and improves the safety of service-users
    - improves the quality of the service
    - is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
    - best anticipates needs and prevents them arising
    - makes the best use of the available facilities, people and other resources

The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.

National health and wellbeing outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

Integration is designed to bring about fundamental change in the way we deliver services in order to achieve these outcomes, for instance in shifting the balance of care from institutions to the community e.g. preventing unnecessary hospital admissions and addressing delayed discharges.

The Plan is written to identify the resources that are being used to help address these challenges, and will set out how service provision will shift over time to support anticipatory and preventative care.

Separate sections of the plan focus on particular sections of the population such as older people and adults with a physical disability, and on specific delegated services such as primary care, mental health services and criminal justice.

Arrangements for carrying out the integration functions in Shetland over the period of the plan are as follows:

- The arrangements for each locality established for locality planning purpose: in Shetland we have agreed 7 localities for strategic planning purposes, detailed in Appendix 1. These are the localities defined by the Shetland (Community Planning) Partnership for community planning purposes, so that building locality planning for health and social care integration can be done together with the work planned for partnership community engagement, and development work in preparation for the enactment of the Community Empowerment Bill in 2016.

- The operation of the Strategic Planning Group for the purposes of preparing the strategic commissioning plan:
  During 2015 a shadow Strategic Planning Group was established for the purposes of preparing the strategic commissioning plan, consisting of members of the Health & Social Care Integration Steering Group and the Community Health and Care Strategic Group, to ensure representation in line with national guidance. The Integration Joint Board will be asked to approve the establishment of a substantive Strategic Planning Group to take forward preparation of future plans.

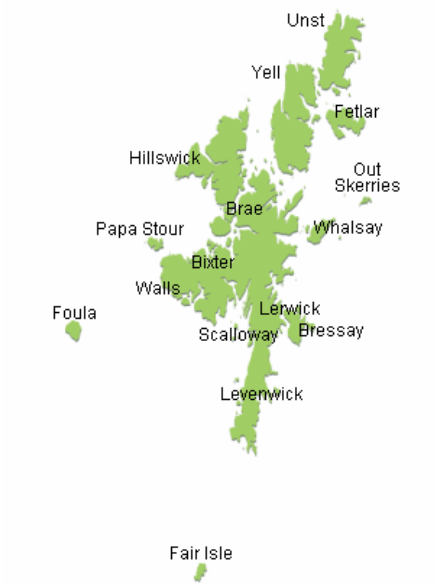
- Functions are to be delegated once the Joint Strategic Commissioning Plan has been adopted by the Integrated Joint Board, and the date of this will be included in the final version of the Strategic Plan to be published on the Integration page of the SIC and NHS web-sites.

- The current CHCP Procurement Strategy will be replaced by an updated Joint Commissioning and Procurement Strategy with the ambition of providing one strategy that will be adopted by the Council, NHS Shetland and Shetland's Integration Joint Board for health and social care.

- An agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions, will be developed, building on an update of the NHS Board's Decision Making Policy and current best practice in both NHS Shetland and Shetland Islands Council.

- A Market Facilitation Plan will be developed in line with national guidance and relevant to the Shetland context.

Adult Services
2015-16 Service Plan



Supporting Health and Care vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community health and Social Care Directorate is required to produce a Service Plan for the following year. This service plan contributes to the planning for the council, the health board and the Joint Integration Strategy. This Service Plan provides an overview of the Adult Services for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.
Service plans are approved and "signed off" at Director Level as part of the Executive Manager's Employee Review and Development process.

Vision Statement

The Adult Services is committed to supporting the Community Health and Social Care Directorate's Vision of "To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".*

Drivers for Change

Government Policy and Legislation

There are a wide range of legislative provisions which impose powers and duties on the local authority with regard to the care and support of people with learning disabilities. The main statutory duties are contained in Sections 25 and 26 of the Mental Health Care and Treatment (Scotland) Act 2003. For the purposes of this Act a mental disorder includes learning disabilities and autistic spectrum disorders.

Section 25 provides that a local authority is obliged to provide or arrange the provision of care and support to people who have or have had a mental disorder and are in need of services. Section 25 states that the care and support services provided shall be designed to:-

- minimise the effect of the mental disorder on such persons; and
- give such persons the opportunity to lead lives which are as normal as possible

Section 26 provides that the local authority shall provide services which promote the social development and well being of persons with a mental disorder. This includes services which provide the following:

- Social, cultural and recreational activities;
- Training for such of those persons as are over school age;
- Assistance for such of those persons as are over school age in obtaining and in undertaking employment:

Further information can be found here http://www.scotland.gov.uk/Publications/2005/08/29100428/04330

The Scottish Government, COSLA and ADSW have been working in partnership to review services for people with learning disability. The strategy entitled, *'The Keys to Life*' covers the period 2013 to 2023 and aims to build on themes of independence and joint working approaches from the first strategy '*The Same as You?*' (SAY), which ran from 2000 to 2010.

'The Keys to Life' aims to progress priority topics which include improved health outcomes, equality and the personalisation agenda. It also focuses on the potential of Self Directed Support; addresses challenges around the affordability and outcomes for people with high cost support needs and aims to advance the adult protection agenda.

Addressing need in relation to autistic spectrum disorder is recognized as a national priority. In 2011the Scottish Government and COSLA launched the Scottish Strategy for Autism. The vision of this policy is to ensure progress across Scotland in delivering quality services to people with autism and their families underpinned by values that have been recognised as important, namely; being respected, accepted, treated fairly, valued by the community and being able to have satisfying and meaningful lives.

The following legislation has an ongoing impact on service delivery locally for people with learning disabilities and autistic spectrum disorders:

- Adults with Incapacity (Scotland) Act 2000
- Regulation of Care (Scotland) Act 2001
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Adult Support & Protection (Scotland) Act 2007
- The Autism Strategy Scotland (Nov 2011)
- Social Care (Self-directed Support) (Scotland) Act 2013

Comprehensive information on the provisions of the legislation is available from the Scottish Government website http://www.scotland.gov.uk/

About Us

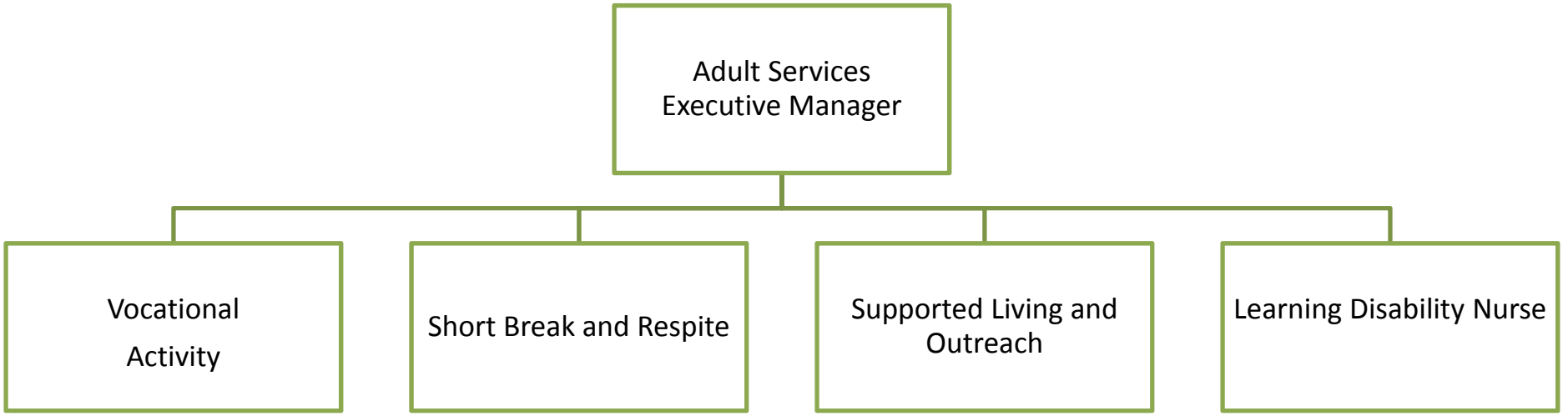
The Service was created as part of the Council organisation and management re-structure in 2011 and was placed in the Community Health and Social Care Directorate following the decision by the Council and Health to jointly appoint a director of Community Health and Social Care in February 2014. This structure was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

The Service comprises a team of professionally qualified managers; learning disability nursing service; senior social care workers; front line staff and administration support staff who undertake a range of resource management, health and care management, care coordination and care and support delivery functions.

Who We Are

This Service sits within the Community Health and Social Care Department which is led by the Director of Community Health and Social Care. The following Services are also in the Community Health and Social Care Department: (Adult Social Work, Community Care – Resources, Criminal Justice, Occupational Therapy, Mental Health, Community Nursing, Criminal Justice, Oral health, Pharmacy)

Organisational Chart



Locations

The Adult Service is located at:

Upper Floor, Montfield – Adult Services Executive Manager

Eric Gray Resource Centre, Kantersted – Vocational Activity

Newcraigielea, Seafield Road – Short Break and Respite

Grantfield Office - Supported Living and Outreach and Learning Disability Nurse

Governance

The Adult Service is part of the Community Health and Social Care Directorate which reports to the Social Services Committee and Community Health Partnership Committee which are held concurrently. The Directorate's performance is reported to this committee 4 times per year.

Regulation and Compliance

Services for adults with learning disability, autistic spectrum disorder and complex needs provided by Supported Living and Outreach; Vocational Activity and Day Services at Eric Gray Resource Centre; Short Break and Respite Services at Newcraigielea; and day care at Newcraigielea are registered with and are subject to inspection by the Care Inspectorate. http://www.careinspectorate.com/

The Care Inspectorate is working more closely with Health Improvement Scotland and in 2015 it is likely that Adult Services will be subject to joint inspection.

Staff must be registered with and are regulated by the following bodies:

Professional Group	**Professional Body**
Managers, Senior Social care Workers and Social Care Workers	Scottish Social Services Council http://www.sssc.uk.com/
Learning Disability Nurse	Nursing and Midwifery Council http://www.nmc-uk.org/

What We Do

Supported Living and Outreach Service;

- Supported Tenancies for adults with learning disability, autistic spectrum disorder, complex needs. To deliver services to meet the level of WYFY assessed need in line with SL&O criteria.
- Develop a person centred support plan that assist the customer achieve goals and managing risk (welfare and financial) using enablement , equality and achieving potential as core values in their own supported accommodation or community based tenancy.
- Assist individuals maintain and keep safe their tenancy.
- Consider applications and agree allocation of any vacant supported tenancies that arise.

Supported Vocational Activity Service;

- Eric Gray Resource Centre provides a range of educational, recreational and social activities to meet the assessed need of adults with a learning disability, autistic spectrum condition and complex needs in line with EGRC criteria.
- Supported Employment - Supported employment opportunities are currently provided through third sector providers. COPE offers employment in a range of small businesses including retail and recycling and works closely with EGRC service. Moving On Employment Project works in conjunction with EGRC to focus on young people with support needs in transition from school to ensure those that would benefit from work experience, paid work or volunteering have that opportunity.

Short Break and Respite Service;

- Newcraigielea facility offers 8 en-suite bedrooms and 1 self-contained bedsit for short breaks and respite to meet the assessed need of adults with a learning disability, autistic spectrum disorder and complex needs and that of any unpaid carer in line with NCL criteria. As well as overnight stays, Newcraigielea can offer short stays during the day or evening where this offers support to an assessed need.

Growing Older with Learning Disabilities 'GOLD' day care service;

- Newcraigielea offers a day care services for older people with learning disability to meet the level of WYFY assessed need in line with NCL GOLD Group criteria.

Learning Disability Nurse;

- Single handed, community nursing service offered throughout Shetland for people aged 5 - 75 with a learning disability in addition to a health need.
- The nurse works with a range of services such as Education, Voluntary, Social Work, Supported Employment and Day Services. There is a consultative and liaison service with Secondary Health Care, Adult Mental Health, CAMHS, Community and Children's Nursing.

Specialist Psychiatry and Clinical Psychology;

- A visiting Consultant Psychiatrist and a visiting Clinical Psychologist offer outpatient appointments or home visits as appropriate.

Our Customers

Any individual (16+) with an assessment of need linked to their learning disability, autistic spectrum condition or complex need.

At present there are approximately 157 adults known to the local authority living in Shetland with learning disabilities or autistic spectrum disorders. This equates to about 0.7% of our population, slightly above the national average. It is clear from data collected that the number of people in Shetland with assessed needs requiring specialist services will continue increasing into the foreseeable future. This is a local and national trend.

Contributing factors to the demographic increase includes;

- Improved detection rates
- Individuals surviving premature birth
- Individuals living longer
- Increase in autism
- Closure of long stay hospitals for people with learning disability

Adults with learning disability and/or autistic spectrum disorder have a wide range of needs in relation to health and wellbeing, including accommodation; communication; maintaining and developing skills; access to day opportunities, leisure and social activities; barrier removal to employment and meaningful work opportunities. In addition many people need assistance with activities of daily living, personal care and keeping safe.

A significant number of people will have additional disabilities, for example, sensory impairment or physical disabilities. People with learning disability and autistic spectrum disorder are inclusive within the ageing population and so also experience age related issues.

The Council, NHS and other community based agencies must work together with people with learning disability and autistic spectrum disorder and their families to ensure supportive networks are in place to ensure inclusion in all aspects of daily life.

Access to Community \Health and Social Care resources is via an *Understanding You* assessment, which is part of the With You, For You process. To receive services for people with learning disability and / or autistic spectrum condition, a person must normally have a diagnosis and be in need of support. If no formal diagnosis has been made, information about the person's abilities will be gathered during With You, For You process in order to make a decision as to whether the person is eligible and will benefit from these services.

Our Costs and Income

The Service has [around] 140.16 full time equivalent staff and annual net expenditure of £4,880,746 [and a capital budget of £1.62 million]. As detailed below:

Community Health & Social Care – Adult Services	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1	92,945	0	92,945	Nil
SL&O	80.53	2,920,788	357,448	2,563,340	Nil
Vocational Activity (EGRC)	39.35	1,497,257	28,283	1,468,974	1,620,000
Short Break and Respite (NCL)	18.28	721,854	19,588	702,266	Nil
Learning Disability Nurse	1	53,221	0	53,221	Nil
Adult Services Total	**140.16**	**5,286,065**	**405,319**	**4,880,746**	**1,620,000**

Funding and resources

Funding predominantly covers staff costs across the service. There is also spending in relation to resourcing and operationally running services. There has been no directive to reduce staff numbers in Adult Services.

Services commissioned by Adult Services;

Organisation Name	Service Description	Funding 2015/16
Citizens Advice Bureau - Direct Payments	A Direct Payments Support Service for people who have opted for Direct Payments as an alternative to services arranged by Shetland Islands Council.	£ 4,590
Citizens Advice Bureau - With You For You	Provision of information and advice regarding the With You For You First Point Contact customer relations service.	£ 31,185
C.O.P.E. Ltd – Supported Employment Placements	Provision of a supported employment service that offers placements and training opportunities to adults with learning disabilities or autism or physical disabilities.	£102,600
Crossroads	A respite service for carers in the cared for person's own home following an assessment of need in accordance with the Single Shared Assessment process With You For You.	£86,640 (£41,640 Spot purchase care hours £45,000 administration)
Moving On Employment Project Limited	Employment opportunities for adults with physical, sensory or learning disabilities and/or mental health problems.	£54,484

Services Grant Funded by Adult Services;

Organisation Name	Service Description	Funding 2015/16
Disability Shetland	Access Project	£18,576.00

Aims and Objectives

Directorate Plan Aims	Action
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	There will be no need for a customer's needs to be assessed for eligibility for services by more than one relevantly qualified member of staff. Where possible, a customer will have allocated to them a named individual who looks after their service needs so that they need only have to "tell their story once"
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.	Financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions. Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system Resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need. Services are delivered to the best possible standard and quality, at the best possible price. The Directorate will have a single planning and design process with clarity in what they are trying to achieve in the short, medium and longer term. Services will be planned and designed in partnership with customers and the general public.

Adult Services Plan 2015/16

Service Aims/Priorities	**Objectives/Actions (Details below)**
Services are aligned with recommendations in the Keys to Life.	Review services and provision in Shetland against the seven broad policy themes; • Health; • Independent living; • Shifting the culture and keeping safe; • Breaking the stereotypes; • People with profound and multiple learning disabilities; • Criminal justice; • Complex Care Implement change where required.
Develop a local Autism Strategy and implement identified actions to ensure the needs of individuals in Shetland on the spectrum will be acknowledged and addressed	Review and consolidating existing practice and measure against Scottish Governments 10 indicators of best practice in the provision of effective Autism Spectrum Disorder (ASD) services**.** Develop a plan to prioritise actions to improving outcomes for people on the autism spectrum.
New EGRC funding is identified.	Explore all avenues to gain external funding to assist in the building and furbishment of the new Eric Gray Resource Centre

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15		
Description	**Delivered Early/on-time/late**	**Achieved original intention?**
To review the feasibility study and proposals for day services for people with learning disabilities to ensure that facilities meet the needs of this client group in a way that is effective and sustainable in the longer term.	Delivered	The initial report was delivered to Social Services Committee in March 2014. Committee noted further work was required to complete the analysis of the current situation and future projections for the service. A final report was presented to the Social Services Committee on 23rd June 2014, to Policy and Resources Committee 23rd June 2014 and to Shetland Islands Council on 2nd July 2014. Option 3: New Build on the old hockey pitch site for inclusion in the Council's Asset Investment Plan was approved by Council and to be funded through borrowing. All avenues to gain external funding to assist are to be explored.
To undertake a full review of the Supported Living Model for adults with learning disabilities.	Delivered	Comprehensive review of Supported Living model concluded in 2014. ILP (Independent Living Project), Banksbroo, Seaview and Stocketgaet services realigned under single 'Supported Living & Outreach' structure, realising efficiencies. Intensive Support Services (ISS) is now re-provided and as a separate service has ended. Ongoing service development will continue within existing resources, and in line with other Community Health and Social Care Projects (SDS, Integration etc).

Ongoing Actions/Projects started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
New EGRC funding identified		Yes		Started in August 2014	This will support Community Health and Social Care's Integrated Aim; Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Review of Adult Services short break and respite provision		June 2015	March 2016		More flexible and responsive short break and respite services based on assessed need are offered. This will support Community Health and Social Care's Integrated Aims; Outcome 6. People who provide unpaid

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
					care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being. Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.
Develop Shetland's local Autism Strategy and implement identified actions.		April 2015	March 2016		This will support Community Health and Social Care's Integrated Aim; Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer. Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Refresh Shetland Disability Strategy		April 2015	March 2016		Strategy will be revised and updated to reflect current priorities, express ongoing vision and inform actions
Introduction of anticipatory care and support plans for the LD/ASD/complex needs		May 2015			To support people living with LDs/ASDs/Complex needs plan for change in health or social circumstances

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
community.					
Review of needs of vulnerable people without formal diagnosis who lead chaotic lives		November 2015			To recognise the needs of people without formal diagnosis who are vulnerable and/or lead chaotic lives and develop proposals on how best to meet/support those needs

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

1. Failure to recruit staff, in particular where the contract is temporary.
2. Insufficient resource to meet exceptional circumstance.
3. Loss of key staff
4. Single learning disability nursing post.

Key Service Indicators

Performance Measure	Performance 2014/15	Target 2015/16	Performance Statement	Improvement Statement
Number of individuals with LD/ASD holding own tenancy or occupancy (and as % of individuals with assessment of need known to LA)	New indicator	Benchmarking		
Number of individuals with LD/ASD engaged in recognised qualification to support learning; development and maintaining skills	New indicator	Benchmarking		
Number of respite and emergency respite nights provided	New indicator	Benchmarking		
Number of LD/ASD short breaks provided (Hrs)	New indicator	Benchmarking		
LD Nurse. HEAT Target – Number of Social Care staff trained to implement Positive Behaviour Support.	4 social care staff	4 social care staff	Staff will have the knowledge and theory of Positive Behaviour Support	Customers with LD who's behaviour is perceived as challenging will have a Positive Behaviour Support Care Plan - which includes pro active and reactive strategies

Contact Details

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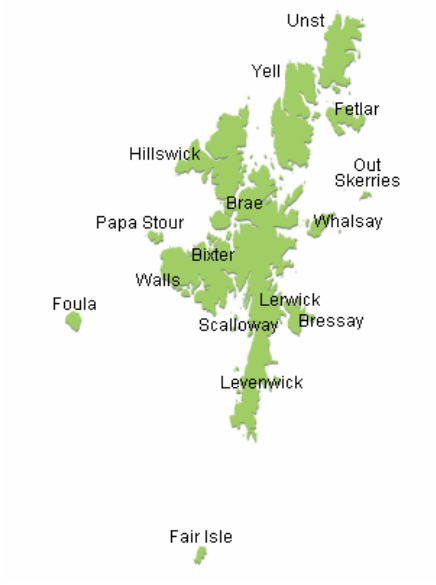
Adult Protection Plan 2015/16



Supporting Health and Care vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy Community”

Policy Context

Shetland Adult Protection committee is constituted under Section 42 of the Adult Support and Protection (Scotland) Act 2007. It is a partnership of all key agencies and the responsibilities of the committee are defined by the Act and the Code of Practice for Adult Protection.

Drivers for Change

Adult Protection Committee Business Plan 2014/15

OBJECTIVE 1 - Have an interagency protocol and clear framework for improvement through self-evaluation					
Actions	**Managed By**	**Due Date**	**Progress Statement**	**Desired Outcome**	**Status**
APBP01 Revise and Finalise interagency protocol	Kate Gabb	24-Oct-2014	Protocol completed and approved by APC – 31st October 2014	Framework for self-evaluation in place and feedback loop to demonstrate improvement	Completed October 2014
APBP02 Gather quality assurance information from member agencies re AP in preparation for inspection	QASC	31-Oct-2014	Information that will assist with self evaluation and preparations for inspection	Effective preparation for inspection	Completed by 5/12/14 Completed
APBP03 Review management information being reported to QASC, to be consistent in collecting AP data	QASC	31-Mar-2015	Discussed at QASC on 12 December	Improved data collection	On course
OBJECTIVE 2 - Plan and complete self-evaluation activity and any improvement plans that follow					

APBP04 Complete actions from July 2013 Social work case review	Kate Gabb	Actions completed	Learning from case review disseminated and embedded	Learning Disseminated	Delayed
APBP05 Plan for and carry through interagency case review	Kate Gabb	31-Oct-2014	Case review completed	Improved practice	Case review completed
APBP06 Complete action plan from July 2014 Inter agency case review	QASC	31-Mar-2015	Action plan agreed and added to updated business plan	Action plan is SMART and aimed at improving practice	On course
APBP07 Interagency case review to include views of adults who have been subject to protection processes	Kate Gabb	31-Mar-2015	Views included in any action plan. Interviews with adults at risk planned	Unable to complete due to workload pressures. Agreed to include in future quality assurance work as part of feedback systems	On course
OBJECTIVE 3 - Through the Short Life Working Group establish a carers and users strategy and some events to raise awareness					
APBP08 Support "Forward Direction Group" with film project and users conference	ASP and Kate Gabb Sarah Johnston	30-Nov-2014	Film used in publicity and placed on website	Meaningful involvement of service users and improve publicity materials	Completed 30/10/2014
APBP09 Support Carers Groups with information sharing – For example	AS&P; Kate Gabb;Sarah Johnston;	30-Jun-2014	Improved information to carers	Meaningful engagement with carers and better understanding of what supports them bests.	Completed June 2014

- Carers Cruise and Workshop event groups throughout Shetland, ensuring contact with as many groups as possible.					
APBP10 Contact with any carers group and other voluntary organisations that were not included in the first round of visits by Lead Officer in 2013.	AS&P; Kate Gabb; Sarah Johnston	31-Mar-2015	Ensuring contact with as many Shetland carers groups as possible – on going	Continued work with carers and users group	On course
OBJECTIVE 4 : Continue to improve the awareness of financial abuse					
APBP11 Further discussion with local banking sector and credit union re AP and representation on the committee.	Kate Gabb	31-Oct-2014	Better understanding of adult protection in financial sector	Positive link between financial sector and Adult Protection Committee. Follow up meeting to be arranged.	Work delayed but to be picked up early 2015
APBP12 Inclusion of Post Office	AS&P; Kate Gabb;Sarah Johnston	31-Oct-2014	Information shared with Post Office manager - Complete	Positive link between financial sector and Adult Protection Committee	Appointment made January 2015
APBP13 Implement Scottish Government Protocol re Financial abuse when issued	APC	10-Mar-2015	Compliance with national guidance	Positive link between financial sector and Adult Protection Committee	No national Guidance yet issued

OBJECTIVE 5 - Once the revised Code of Practice for Adult Support and Protection is issued by Scottish Government revise and reissue interagency procedures					
APBP14 Establish SLWG to revise procedures	Kate Gabb	31-Mar-2015	Completed and updated procedure. Initial meeting planned 2nd September 2014	Effective procedures that support staff to protect adults from harm	On course
OBJECTIVE 6 - Continue with regular publicity campaign and press releases to raise awareness of adult protection					
APBP15 To link into national TV campaign	Max Barnett; Sarah Johnston	28 February 2015	Awareness of adult protection.	Link made with Scottish Government Publicity Team	Completed
Scottish Government Priorities					
APBP16 A+E Staff - share good practice guide	K Gabb	30-Nov-2014	Guidance shared. Lead Officer to attend A & E Staff Meeting.	To build on training offered to A+E staff in August 2014	Delayed but date to be set early 2015
APBP17 Data Collection - new information to Scottish Government	AS&P; Kate Gabb; Sarah Johnston;	01-Sep-2014	Data given to Scottish Government. Data ready to email on 1st September 2014.	Data given to Scottish Government	Completed September 2014
OBJECTIVE 8 - Adult Protection in care settings					
APBP18 Monitor local referrals APC	APC	31-Mar-2015	Monitoring information re numbers of care home referrals available Historically low numbers. Important to monitor.	Data collected quarterly- no current concerns re care home referrals	On course
APBP19 Link with local Care	Kate Gabb	31-Jan-2015	Meeting held 15/10/14 and to be ranged twice yearly	Improved working relationship with Care	Completed

Inspector re any issues				Inspectorate	
APBP20 Good practice session re safe caring and encouraging non abusive staff cultures	Kate Gabb	31 March 2015	Session completed and evaluated Information from research and Scottish Government document Shared – Lead Officer no able to complete by March 2015 to carry forward	Sharing good practice	Delayed due to other work and preparation for inspection
OBJECTIVE 9 – Training					
APBP21 Continue to support the training team who are delivering AP training	Training sub committee	31-Mar-2015	Training sessions booked and evaluated	10 sessions of AP training completed by Jan 2015	Completed
APBP22 Offer workshop event to an interagency group (current topic to be agreed)	Kate Gabb	30-Nov-2014	Senior social workers to advise topic of use to social work staff Relevant topic supports practice. Positive evaluation.	Sharing good practice	Delayed
APBP23 Establish access to e learning for police.	Kate Gabb and Lindsay Tulloch	31-Dec-2014	Discussed at QASC on 12/12/14- agreed to share workbook version with Police Scotland locally.	Sharing good practice	Completed

Current Service

There is an obligation to investigate any referrals from any source that indicate an adult may be at risk. This falls to Social Workers in the Community Care Team acting as Council Officers. Adult Protection work is taking up an increasing amount of time and can be complex and stressful. Not all referrals meet the 3 point test but many adults need other services or action to be taken under different legalisation (e.g. Adults With Incapacity Act, Mental Health Care and Treatment Act) to help keep them safe. Safeguarding adults is a responsibility that extends to all services both voluntary and statutory and also to the wider public, carers and service users.

Needs

All adults who may be at risk of harm require everyone to be able to recognise that and make appropriate referrals so action can be taken or support given to safeguard the adult. Adults at risk of harm are defined in the Act as being over 16, unable to safeguard their own wellbeing property, rights or other interests, are at risk of harm, and are affected by disability, mental disorder, illness, physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected. This is referred to as the “3 point test”.

Unmet Needs

Under reporting of adult protection issues is a concern and consistent training, vigilance and awareness raising is required. The Scottish Government set priorities for adult protection that act as drivers for change. For 2013/14 these were abuse in care settings, improving the knowledge of A+E staff about adult protection, involvement of carers and service users, financial abuse and national data collection of statistics.

Regulation and Compliance

The key pieces of regulation that has a bearing on Adult protection is,

- Adult Support and Protection (Scotland) Act 2007,
- Mental Health Care and Treatment (Scotland) Act 2003, and
- Social Work Scotland Act 1968

Our Customers

We would want anyone who had a concern about an adult to report it. The situation may not meet the 3 point test, but the adult may still require support.

Funding and resources

The Lead Officer for Adult and Child Protection holds a budget to fund the committee's work and business plans for both APC and CPC. There have been no targeted savings from this budget although it has been a standstill budget which brings pressures when there are increasing calls for work in the area of public protection. Issues re the funding of training have been noted below.

Aims

Broadly the committee's aims and responsibilities as laid down in the Act and Code of Practice are to develop and introduce arrangements and protocols for inter-agency working, auditing and evaluating the effectiveness of these arrangements, developing and keeping under review effective procedures for protecting adults, quality assurance work in respect of adult protection activity, raising awareness, training for staff, improving local ways of working in the light of national and local developments.

Detailed Actions/Plan for Change

Planned Actions for 2015/16

- work on improvement through self-evaluation;
- improving the awareness of financial abuse;
- awareness raising and focussed staff training;
- updating of Adult Protection procedures to be consistent with the new Code of Practice;
- responding to any findings from the inspection of older people's services that is related to adult protection and
- being aware of any Scottish Government priorities for adult protection that may be agreed in 2015.

Risks to Delivery

Protecting adults from harm is a high risk area of work for all agencies. Missing something could result in very serious consequences for an adult at risk and consequent issues for all services and staff.

Reductions in the training budget and the current staffing pressures, make it difficult for staff to be released for training, are concerns for adult protection.

Performance Indicators

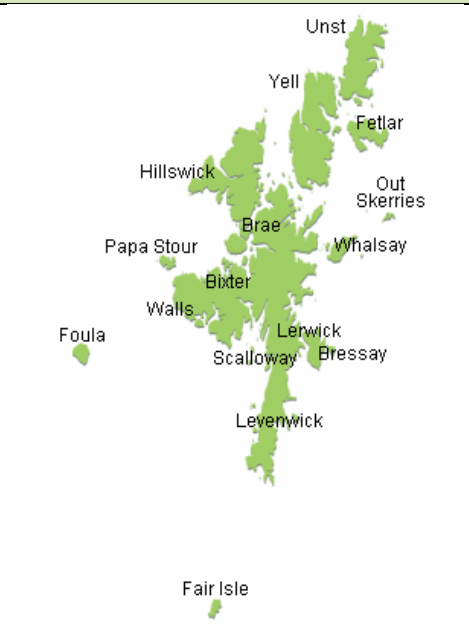
There are no specific external targets other than Scottish government priorities.

Contact Details

Lead Officer for Adult and Child Protection Kate Gabb Kate.gabb@shetland.gov.uk 01595 744435

Convener of Shetland Adult Protection Committee Max Barnett contactable via Kate Gabb.

Adult Social Work Service
2015-16 Service Plan



Supporting Community Health and Social Care Departments vision:

"To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community"

Introduction

Every year, each Service within the Council is required to produce a Service Plan for the following year. This Service Plan provides an overview of the Adult Social Work Service for 2015/16, the Adult Social Work Service is in the Community Health and Social Care Directorate. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Adult Social Work Service is committed to supporting the Community Health and Social Care Directorate's Vision of "To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community".

Drivers for Change

The drivers for change for Adult Social Work are:

1) Independent review of the Social Work Function in Shetland which recommended the establishment of an Executive Manager for Adult Social Work to lead the service and social work function for adults.

2) The review of the With You For You process which recommends clearer guidance around assessment of need and care management.

3) Implementation of the Social Care (Self-directed Support) (Scotland) Act 2013, on the 1st April 2014 set out new duties for local authorities in relation to how we assess and support people. The person requiring support is to be central to the whole process and is to be encouraged to participate in their assessment and delivery of their support as much as they wish to be.

About Us

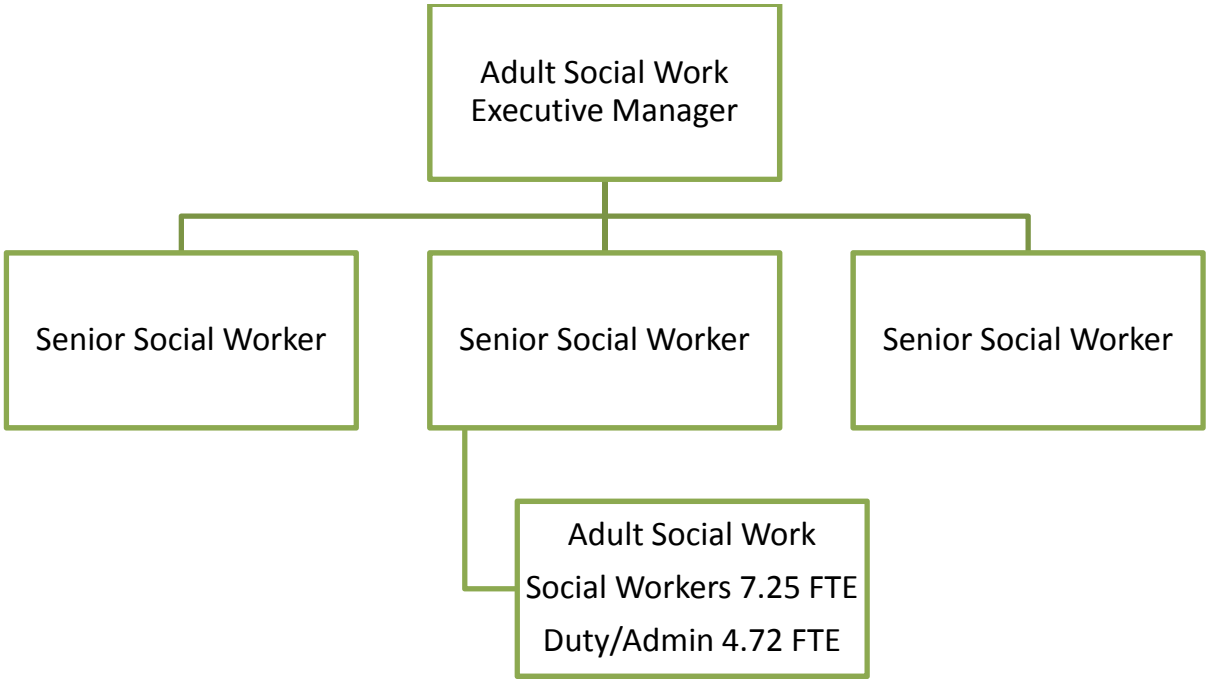
This service was combined with Adult Services following the Council organisation and management re-structure in 2011. The service does not yet formally exist as a standalone service although an Interim Executive Manager has been in post with a remit for this service / function since April 2014. A recent independent review of the Council's Social Work function has recommended the re-establishment of Adult Social Work as a specific service with a dedicated permanent Executive Manager.

The Service comprises a team of professionally qualified social workers and administration support staff who undertake a range of statutory social work functions, primarily in three areas: Community Care Assessments and Care Management, Adult Support and Protection, and Mental Health Officer functions.

Who We Are

This Service sits within the Community Health and Social Care Department is lead by the Director of Community Health and Social Care (Simon Bokor-Ingram) the following Services are also in the Community Health and Social Care Department: (Adult Services, Criminal Justice, Mental Health, Occupational Therapy & Community Care – Resources)

Organisational Chart



Locations

The Adult Social Work Service is located at the Grantfield Office and provides a service to the whole of Shetland and oversees a number of specialist off-island replacements.

Governance

The Adult Social Work Service is part of the Community Health and Social Care Directorate and reports to the Integrated Joint Board.
The Service's performance is reported to the Directorate Management Team monthly and 4 PIs from this plan is reported to the Integrated Joint Board 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

Social workers are required to be registered with the Scottish Social Services Council in order to practice. They also have to abide by the Scottish Social Service Code of Practice.

Mental Health Officers require an additional post qualifying award and express permission from the Chief Social Work Officer in order to practice.

Social Workers who act as a "Council Officer" for Adult Protection assessments and investigations require specific training and express permission from the Chief Social Work Officer in order to fulfil this function.

Regulation of performance is carried out by the Care Inspectorate in the form of inspections. The frequency of inspection is based on an "intelligence model" and reflects how well the service currently operates. The Care Inspectorate is to inspect this service as part of a multi agency inspection of services to older people in January, February and March 2015. Any actions required of this service will be reflected in this service plan once they are known.

The function of this service is broadly governed by the following legislation: Social Work (Scotland) Act 1968, NHS and Community Care Act 1990, Mental Health (Care and Treatment) (Scotland) Act 2003, Adults with Incapacity (Scotland) Act 2000, Adult Support and Protection (Scotland) Act 2007.

What We Do

The Adult Social Work Team, responsible for:

Screening referrals to establish whether or not a social work response is required. This area of work may result in no further action, offer of advice, signposting or referral to other service areas, referral to soical work assessment.

Assessment of social need and care management – assess whether or not an adult (aged 18 or over) requires support. For complex cases the team will manage the case, this is called care management.

Mental Health assessment, support and intervention – assess whether or not an individual requires support due to a mental health disorder. There are a number of specific functions only a Mental Health Officer can perform.

Adult Support and Protection – receive and assess adult protection referrals which involves working with police and health services, investigate whether or not an adult is in need of protection from abuse. If this is the case a protection plan will be put in place to support the individual. This will be care managed by a social worker. Additionally working with adults who are subject to protection plans to reduce risk of abuse and to provide them with support.

Our Customers

The Adult Social Work Team provides a service to any adult who requests or requires an assessment under the legislation listed above. Customers include adults with dementia, mental health difficulties, brain injuries, lifelong conditions, learning disabilities, physical disabilities, older and frail people.

The amount of people supported by this service through care management is typically around 180 at any one time. The number of people supported on a short term basis, either through screening or assessment will be higher than this and can fluctuate.

Population projections for our customer base show the following:

Adults

The population of adults (18-64) is predicted to decrease by 6.6% (13,691 to 12,791) between 2013 and 2023 and by 15% by 2033 (to 11,641).

Over 65's

The population of over 65's is predicted to increase by 32% (4,200 to 5,544) between 2013 and 2023 and by 65% by 2033 (to 6,924).

Over 85's

The population of over 85's is predicted to increase by 44% (533 to 769) between 2013 and 2023 and by 143% by 2033 (to 1,294).

Our Costs and Income

The Service has around 14.07 full time equivalent staff and annual net expenditure of £ 1,125,155 and no capital budget. As detailed below:

Health & Social Care – Adult Social Work Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Adult Social Work (includes Preventative Budgets)	14.07	634,250	0	634,250	Nil
Self Directed Support Options (includes CAB SLA)	-	621,463	130,558	490,905	Nil
Adult Social Work Service Total	**14.07**	**1,255,713**	**130,558**	**1,125,155**	**Nil**

Funding and resources

There are interim arrangements in place to provide leadership to the team. Funding predominantly covers staff costs and provision of funding for those who chose to purchase their own support under Self-directed Support. There has been no directive to reduce staff numbers in this area.

Aims and Objectives

Directorate Plan Aims	Action
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish. There will be ease of access to services, with clear understanding within the community of who to contact and where to go Information will be available to each household in Shetland which explains how to access services, what service standards they can expect and how each organisation is performing through an effective public performance reporting regime
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	There will be more flexible services and more choice for our customers, within available resources Systems, procedures and information will be shared between organisations wherever possible and there will be clarity in the decision-making process, thereby reducing bureaucracy and delays in decisions about service delivery.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Customer's needs will be assessed for eligibility for services using a person centred approach. Where possible, a customer will have allocated to them a named individual who looks after their needs and care services.

5. Health and social care services contribute to reducing health inequalities.	There will be equity in access to services through better information, more locally based services and better transport arrangements where provision needs to be centralised. Everyone will be able to access services to meet their needs irrespective of their race, religion/faith, sexual orientation, age, disability, gender or socio-economic background.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	We will improve our identification of people who are carers and offer a carer's assessment so that the appropriate support can be put in place. We will continue to work with the Third Sector to develop strategies to support carers and to continue with training programmes and carer's events.
7. People using health and social care services are safe from harm.	We will build on our governance and quality assurance systems. Early reporting of incidents and near misses will help us to put in place actions that will improve procedures and processes. Effective responses to concerns that adults may be being harmed sexually, financially, physically or by being neglected or emotionally abused will be built into staff training.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	There will be in place a system of team working which recognises and values individuals' skills and knowledge, provides good professional supervision and encourages joint training and secondment opportunities and works to meet the needs of our customers. There will be in place a seamless method of service delivery, not restricted by organisational or professional boundaries – modelled on a "one-stop-shop" methodology There will be an individual within Shetland who is publicly recognised as being the

	manager of each service area
9. Resources are used effectively and efficiently in the provision of health and social care services.	Financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions. Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system Resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need. Services are delivered to the best possible standard and quality, at the best possible price. The Directorate will have a single planning and design process with clarity in what they are trying to achieve in the short, medium and longer term. Services will be planned and designed in partnership with customers and the general public.

Service Aims/Priorities	**Objectives/Actions (Details below)**
To enable older people to remain at home	We will provide good quality and timely assessments to help people get the correct support to improve their outcomes. We will work with multi agency partners to assist people to get the best possible support to improve their outcomes, including consideration of the 4 options of Self-directed Support.
To maintain or increase levels of independence	We will provide good quality and timely assessments to help people get the correct support to improve their outcomes. We will work with multi agency partners to assist people to get the best possible support to improve their outcomes, including reablement and consideration of the 4 options of Self-directed Support.

To reduce unplanned, emergency and inappropriate admissions to hospital	We will provide good quality and timely assessments to help people get the correct support to improve their outcomes. We will work with multi agency partners to assist people to get the best possible support to improve their outcomes, including reablement and consideration of the 4 options of Self-directed Support. We will work with individuals, their families, carers and partners to increase the number of people with complex social and health problems including long term conditions who have an anticipatory care plan.
To facilitate early discharge from hospital	We will work with multi agency partners to coordinate early discharge from hospital, including timely comprehensive assessments.
To protect adults from abuse	We will investigate all cases where an adult might be in need of support and protection. Where it is the case an adult is in need of support and protection we will lead in the preparation and implementation of protection plans, including appropriate legal interventions.

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Review of the With You For You Process	Delivered on time	Recommended changes to the assessment and care management process in Shetland

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Participate in the implementation of the Social Work Review recommendations				Firmed up leadership arrangements for Adult Social Work	Well supported Social Work team who are well led and supervised with association QA processes regularly used. This will help achieve National health and wellbeing outcomes 8 & 9.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Implementation of recommendations of the review of With You For You	CHSC	April 2015	March 2016	Delivery of plan.	To develop more efficient and robust referral and assessment structure. This will help to achieve National health and wellbeing outcomes 1,2, 3, 4, 5, 6, 7 and 9

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Develop a quality assurance framework This will include: accurate information on the number of assessments completed on time; accurate information on the number of reviews completed on time; accurate information on whether or not and how outcomes are met for individual service users; accurate information from service users on their experience of services and support received.	Interim Exec manager Senior Social Workers Social work team Social work team Social work team Social work team	April 2015	September 2015	Comprehensive information to inform service delivery and development Individuals who require support will have their assessments completed and support needs met as soon as possible This will ensure people's needs are monitored to ensure progress is being made and needs are still appropriate This will ensure people's outcomes are progressing as planned, if not why not and will help with future service planning This will ensure that people receiving support are satisfied with services and will help inform improvements	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. This will help to achieve National health and wellbeing outcomes 1,2 & 6 This will help to achieve National health and wellbeing outcomes 1, 2 & 6 This will help to achieve National health and wellbeing outcomes 1, 2, 4, 5, 6, 7 & 9 This will help to achieve National health and wellbeing outcomes 3, 4

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

- Recruitment of staff

Performance Indicators

Performance Indicators from Council Wide Performance Measures

Indicators / Measure	Council		XXX Directorate 2013/14		XXX Service 2013/14		Performance Statement	Improvement Statement
	2014/15 Performance	2015/16 Target	2014/15 Performance	2015/16 Target	2014/15 Performance	2015/16 Target		
Overtime Cost								
Sickness Absence Rates								
Energy Usage								
Employee Review and Development								
Return to Work Interviews				100%		100%		

Key Service Indicators

Performance Measure	Performance 2012/13	Performance 2013/14	Performance 2014/15	Target 2015/16	Performance Statement	Improvement Statement
Number and percentage of assessments completed on time	55.4%	66.3%	72.1%	100%	Ensure all assessments are completed on time	
Number and percentage of reviews completed on time	N/A	N/A	N/A	100%	Ensure all reviews are completed on time	
Number and percentage of outcomes for individuals are met	N/A	N/A	N/A	80%	Outcomes are improved for individuals	
Customer satisfaction is recorded at point of review	N/A	N/A	N/A	80%	Customers are satisfied with the service they have received	

Contact Details

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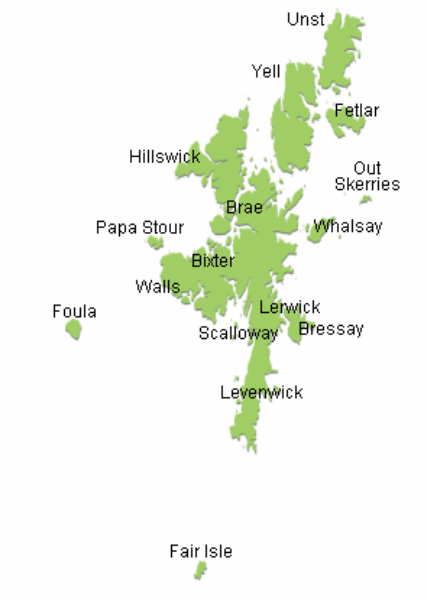
Allied Health Professional's 2015-16 Service Plan



Supporting Health and Care Directorate vision:

"To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community"

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service Plan contributes to the planning for the council, the health board and the Joint Integration Strategy. This service plan provides an overview of the Allied Health Professional Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Allied Health Professions (AHP's) are committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".*

The Allied Health Professions Strategic Vision is that:

> "AHPs will work increasingly to transform well-being and recovery, promoting prevention, earlier diagnosis and reducing unnecessary referrals and admissions to hospital and care by working "upstream" and supporting early year's development to strengthen user and carer capabilities and assets in the communities they serve."
>
> Source: AHPs as agents of change in health and social care: The National Delivery Plan for the Allied Health Professions in Scotland, 2012–2015, Scottish Government, Edinburgh 2012

Drivers for Change

The overarching drivers for change are laid out in the Community Health and Social Care Directorate plan. The policy rationale for integrating health and social care services is: to improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.

The most relevant drivers for AHP's have been summarised in the Scottish Government's National Delivery Plan for the Allied Health Professions in Scotland, Scottish Government, (2012). Allied Health Professionals in Scotland work through partnerships across health, social care, education, voluntary and independent sectors with adults and children of all ages. The challenges are many: of particular note are

demographic changes which mean that the number of people over 60 will increase by 50% by 2033 and the rise in the over-85 population will be 144%: this is especially significant given the increased prevalence of dementia among this age group.

The strategy also notes that “almost a third of total annual spend on older people’s services is accounted for by unplanned admissions to hospital: that is more than is spent on social care for older people. Delayed discharges of less than six weeks account for around £54 million per annum in bed days lost, to 9 say nothing of the cost to individuals and their carers of remaining in an environment not appropriately reflecting their needs.”

The delivery plan focusses on the provision of “enabling” services, shifting the focus away from professional dependency and towards supported self-management and resilience, which will be central to achieving better outcomes for people who use services, their families and carers. It currently contains 27 separate recommendations based around reshaping and redesigning services around individuals, families and carers. These recommendations are due to be revised in late 2014 and a more succinct version produced. This service plan will be updated accordingly once these are available. Progress against these recommendations are reported on to government at 6 monthly intervals.

Other relevant strategies are as follows (this list is not exhaustive):

Strategy/ Guidance	**Aims**
Maximising Recovery & Promoting Independence: intermediate care's contribution to reshaping care, a framework for Scotland (Scottish Government, 2012)	Preventing unnecessary acute hospital admission or premature admission to long-term care; Supporting timely discharge from hospital; Promoting faster recovery from illness, and Supporting anticipatory care planning and the self management of long-term conditions.
A Right to Speak - Supporting Individuals who use Augmentative and Alternative Communication The Scottish Government, Edinburgh, 2012 http://www.scotland.gov.uk/Resource/0039/00394629.pdf	The communication needs of people who require to use AAC are universally recognised. Individuals who require to use AAC are supplied with appropriate equipment in a timely manner

Diabetes Action Plan 2010: Quality Care for Diabetes in Scotland, The Scottish Government, Edinburgh 2010 http://www.scotland.gov.uk/Resource/Doc/321699/0103402.pdf	Improving the health of people with diabetes in Scotland and reducing health inequalities Improving the quality of healthcare and healthcare experience
See Hear: A strategic framework for meeting the needs of people with a sensory impairment in Scotland, Scottish Government, 2013 http://www.scotland.gov.uk/Publications/2013/04/2067	Development of care pathways for people with a sensory impairment, Assessment of performance against the care pathway Service improvement and identification of the relevant responsibilities across agencies for delivery
National Personal Footcare Guidelines, Scottish Government, 2013 http://www.scotland.gov.uk/Publications/2013/09/9130	Effective personal footcare should address the individual support and personal footcare needs of Scotland's population. It should be of a high standard, inclusive of communities and be responsive to the needs of people and their families.
Emergency inpatient bed days HEAT target: Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population by at least 12% between 2009/10 and 2014/15	Development of proactive community support; planning ahead to manage anticipated crises; earlier access to specialist assessment and treatment at home, in the accident and emergency unit or within hospital; and better co-ordination of health and social care support to enable a timely, safe and supported return home.
Delayed Discharges HEAT target: No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015.	Patients should not have to wait unnecessarily for more appropriate care to be provided after treatment in hospital. Waiting unnecessarily in hospital is a poor outcome for the individual, is an ineffective use of scarce resource and potentially denies an NHS bed for someone else who might need it.
Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012 – 2021 (Scottish Government, Edinburgh, 2011) http://www.scotland.gov.uk/Publications/2011/12/16091323/0	Emphasises the role of housing and housing-related support in 'shifting the balance of care' towards independent living in the community and reducing the use of institutional care settings.

Scotland's National Dementia Strategy 2013-2016 (Scottish Government, 2013) http://www.scotland.gov.uk/Resource/0042/00423472.pdf	More people with dementia living a good quality life at home for longer Better post-diagnostic support for people with dementia and their families.

About Us

The Allied Health Professions were brought together under one manager in May 2012 and were placed in the Community Health and Social Care Directorate following the decision by the Council and Health Board to jointly appoint a director of Community Health and Social Care in February 2014. This structure was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the council.

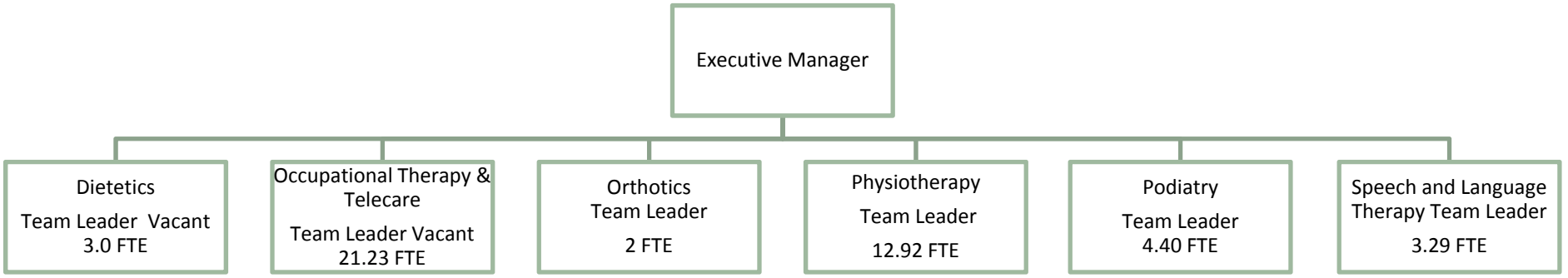
AHPs are a distinct group of practitioners who apply their expertise to diagnose, treat and rehabilitate people of all ages across health, education and social care. They work with a range of technical and support staff to deliver direct care and provide rehabilitation, self-management, "enabling" and health improvement interventions.

The Service comprises front-line and support functions.

Who We Are

This Service sits within the Community Health and Social Care Department which is led by the Director of Community Health and Social Care. The following Services are also in the Community Health and Social Care Directorate: Adult Services, Adult Social Work, Community Care Resources, Community Nursing, Criminal Justice, Mental Health, Oral Health, Primary Care, Pharmacy and Prescribing.

Organisational Chart



Locations

The Allied Health Professions are located as follows:

Team	Location
Dietetics	Breiwick House
Occupational Therapy	Gilbert Bain Hospital and Independent Living Centre
Orthotics	Gilbert Bain Hospital
Physiotherapy	Gilbert Bain Hospital
Podiatry	Lerwick Health Centre
Speech and Language Therapy	Independent Living Centre

The Allied Health Professions (with the exception of Orthotics who are mainly clinic based) provide services at health centres, in hospital, at care centres, and through home visits throughout Shetland.

Governance

The Allied Health Professions Service is part of the Community Health and Social Care Directorate and from April 2015 will report to the Integrated Joint Board. The Service's performance is reported to the Directorate Management Team monthly and Performance Indicators from this plan are reported to the Joint Board 4 times per year as part of the Directorate's quarterly performance report.

Regulation and Compliance

All Allied Health Professional staff must be registered with the Health and Care Professions Council (HCPC) http://www.hpc-uk.org/

The Health and Care Professions Council sets out standards which must be met by each professional in order to remain registered. There are standards relating to character, health, proficiency, conduct, performance, ethics and continuing professional development. More information on each of these areas can be obtained on the HCPC website.

Each Allied Health Professional group also has its own professional body. These are listed below:

Profession	**Professional Body**
Dietetics	British Dietetics Association https://www.bda.uk.com/
Occupational Therapy	British Association of Occupational Therapy http://www.cot.co.uk/
Orthotics	British Association of Prosthetists and Orthotists http://www.bapo.com/public/report.aspx?memberqueryid=E57A2BD5-3667-45E5-833D-5ED64B88C171&atc=aag&nodeid=0E00D4ED-905A-439E-8535-644160E68803
Physiotherapy	Chartered Society of Physiotherapists http://www.csp.org.uk/
Podiatry	College of Podiatry http://www.scpod.org/#
Speech and Language Therapy	Royal College of Speech and language Therapy http://www.rcslt.org/

At Scottish Government level, Allied Health Professions are represented by the Chief Health Professions Officer

Statutory functions

The Health and Social Care Integration Public Bodies (Joint Working) Scotland Act 2014 Regulations, Health and Social Care Functions Supporting Note (Scottish Government) advises that “Statutory functions of Local Authorities, in relation to social care, generally describe fairly clearly the support that they entail, and for whom services are to be provided. Health legislation, functions of Health Boards are generally described very broadly.” For this reason, the specific guidance relevant to the Local Authority is set out below.

The Social Work (Scotland) Act 1968 places a general duty on local authorities to promote social welfare (Section 12 of the 1968 Act) by making available advice, guidance and assistance. There are also specific duties to assess needs and decide whether those needs call for the provision of services, which essentially means services under part II of the 1968 Act. There is a duty under the National Assistance Act, Section 2 of the Chronically Sick & Disabled Persons Act 1972, Social Work Act to assess need including that of support or instruction within the home. Occupational therapists particularly have a key role in carrying out these assessments of need and prescribing appropriate advice, treatment programmes, equipment or adaptations.

Local authorities have specific duties under the Health and Safety at Work etc. Act 1974; Manual Handling Operations Regulations 1992, the Management of Health and Safety at Work regulations 1999 - Occupational Therapists are qualified to carry out moving and handling risk assessments, assess for and provide suitable equipment to meet the employer's responsibilities.

The local authority has duties under the Disability Discrimination Act 2005 to ensure disabled people have equal access to opportunities, which Occupational Therapists assist in achievement through treatment, advice, adaptations and equipment provision. This includes the needs of people with sensory impairment.

The Housing (Scotland) Act 2006 describes an obligation to provide financial assistance with a range of structural adaptations attracting a mandatory grant. Guidance on this in the Implementing the Housing (Scotland) Act 2006, Parts 1 and 2: Statutory Guidance for Local Authorities: Volume 6 Work to Meet the Needs of Disabled People. Generally, applications for assistance should be referred to a suitable specialist, usually an occupational therapist employed by the local authority.

What We Do

Team	Role
Dietetics	Dieticians assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. They use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. Dieticians treat complex clinical conditions such as diabetes, food allergy and intolerance, IBS syndrome, eating disorders, chronic fatigue, malnutrition, kidney failure and bowel disorders. They

	provide advice to caterers to ensure the nutritional care of all clients in NHS and other care settings such as care homes, they also plan and implement public health programmes to promote health and prevent nutrition related diseases. A key role of a dietician is to train and educate other health and social care workers. Dieticians also advise on diet to avoid the side effects and interactions between medications.
Occupational Therapy	Occupational therapy takes a whole-person approach to both mental and physical health and wellbeing, enabling individuals to achieve their full potential. It provides practical support to enable people to facilitate recovery and overcome any barriers that prevent them from doing the activities (occupations) that matter to them. This helps to increase people's independence and satisfaction in all aspects of life. Occupational therapists work with adults and children of all ages with a wide range of conditions; most commonly those who have difficulties due to a mental health illness, physical or learning disabilities. They can work in a variety of settings including health organizations, social care services, housing, education and voluntary organisations. In Shetland the Occupational Therapy Team provides Occupational Therapy Assessments at home, in the Gilbert Bain Hospital or as outpatient appointments, a rehabilitation and reablement service, advice, assessment and provision of Equipment and Adaptations; a Sensory Impairment Service, Telecare and Telehealth provision and advice, Wheelchair Assessments and Blue Badge Assessments
Orthotics	Orthotists provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. They are able to design and provide orthoses that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They treat patients with a wide range of conditions including Diabetes, Arthritis, Cerebral Palsy, Stroke, Spina Bifida,Scoliosis, MSK, sports injuries and trauma.
Physiotherapy	Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as

	possible. Physios use their knowledge and skills to improve a range of conditions associated with different systems of the body, such as: Neurological (stroke, multiple sclerosis, Parkinson's) Neuromusculoskeletal (back pain, whiplash associated disorder, sports injuries, arthritis) Cardiovascular (chronic heart disease, rehabilitation after heart attack) Respiratory (asthma, chronic obstructive pulmonary disease, cystic fibrosis).
Podiatry	Podiatrists triage, assess, diagnose and treat the full range of podiatric conditions of the foot and lower limb. We provide treatment for nail management, wound management, vascular and neurological assessment, advise on foot health and footwear, provide advise and practical solutions for personal footcare, work with the multidisciplinary "high risk limb" team, musculoskeletal clinics, manufacture and prescription of orthoses, nail surgery, undertake diabetic foot screening and assessment, assist patients in preventing trips and falls, work towards prevention of foot problems therefore reducing non-planned hospital admissions, provide treatment for patients with long term conditions (LTC), work jointly with other health care professionals, provide training to care workers, hold joint assessments with Physiotherapy and work closely with the Shetland Voluntary Nail Cutting Service (SVNCS)
Speech and Language Therapy	Speech and language therapy is concerned with the management of disorders of speech, language, communication and swallowing in children and adults. For children, mild, moderate or severe learning difficulties, physical disabilities, language delay, specific language impairment, specific difficulties in producing sounds, hearing impairment, cleft palate, stammering, autism/social interaction difficulties, dyslexia, voice disorders and selective mutism. For adults - adults with communication or eating and swallowing problems following neurological impairments and degenerative conditions, including stroke, head injury, Parkinson's disease and dementia, head, neck or throat cancer, voice problems, mental health issues, learning difficulties, physical disabilities, stammering, hearing impairment

Our Customers

AHPs treat people with a very wide range of disabilities or conditions as described in the table above. The last Disability Strategy for Shetland was completed in 2005. At this point it was it was estimated that there were approximately 3,300 people living in Shetland with some form of disability. The 2001 census showed there were 3,500 people in Shetland with a long term limiting illness; this included chronic medical conditions as well as disabilities. It was estimated, in 2005 (using national rates) that there were approximately:

- 240 people who had had a stroke (half of these are likely to be left with disabilities)
- 220 people have rheumatoid arthritis;
- 50 people have multiple sclerosis
- 45 people have Parkinson's Disease;
- 35 people have disabilities following a head injury.

(Source: Shetland's Disability Strategy, 2005)

A key action for 2015 is to refresh the Disability Strategy, and more up-to-date data will be collated at this point. As the move towards integration progresses, more joined up information will become available as to the role of AHPs within this area – a minimum data set for AHPs is under development by the government which should assist with this coordination, and will assist with work force planning. Sharing of the CHI number across health and social care will also facilitate improved data sharing.

In terms of self-reporting, the **2011 census** shows the following:

Total Population of Shetland: 23,167		
	Percentage of population	No. of people
% With one or more long-term health conditions	29.9	6927
% With deafness or partial hearing loss	6.6	1529
% With blindness or partial sight loss	2.4	556
% With learning disability (for example, Down's Syndrome)	0.5	116
% With learning difficulty (for example, dyslexia)	2	463
% With developmental disorder (for example, Autistic Spectrum Disorder, Asperger's Syndrome)	0.6	386
% With physical disability	6.7	1552
% With mental health condition	4.4	1019
% With other condition	18.7	4332

Source: Scotland's Census 2011 http://www.scotlandscensus.gov.uk/ods-web/area.html#!

The Allied Health professionals work in partnership with colleagues from across the Shetland Islands Council and NHS Shetland directorates and with other statutory and third sector agencies.

Examples of joint working include:

- Facilitation of discharges from NHS Grampian and other mainland NHS Trusts.
- Development of exercise programmes in conjunction with Shetland Recreational Trust
- Joint working with the Voluntary Nail Cutting Service
- Provision of wheelchair service in conjunction with NHS Grampian and the Red Cross
- Development and provision of a low vision service in conjunction with Royal National Institute for the Blind, Vision Shetland, and local Opticians Practices
- Provision of adaptations in conjunction with SIC Housing, Environmental Health and Hjaltland Housing Association
- Provision of a Community Alarm Service in conjunction with Hanover Housing

The different services have a variety of referral routes. One action from the National Delivery Plan is to drive the expansion of self referral to all therapeutic AHP services (not diagnostic) as the primary route of access by 2015.

Team	**Referral route**	**Eligibility Criteria**
Dietetics	Currently GP referral	
Occupational Therapy	Self-referral (except to Children's Occupational therapist)	For local authority funded services, National Eligibility Criteria apply. http://www.scotland.gov.uk/Resource/0039/00399040.pdf
Orthotics	Currently GP referral	
Physiotherapy	Self-referral	
Podiatry	Currently accept referrals from GP and all other health professionals	
Speech and Language Therapy	Self-referral	

Our Costs and Income

The Service has [around] 47.84 full time equivalent staff and annual net expenditure of £2,712,319 [and no capital budget]. As detailed below:

Community Health & Social Care – Allied Health Professional Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1	63,735	0	63,735	Nil
Community Alarm	-	18,000	0	18,000	Nil
Dietetics	3	113,279	0	113,279	Nil
Occupational Therapy	20.23	1,489,861	12,808	1,477,053	Nil
Orthotics	2	140,923	0	140,923	Nil
Physiotherapy	12.89	585,690	0	585,690	Nil
Podiatry	4.40	223,641	0	223,641	Nil
Sensory Impairment Specialist Equipment	-	1,500	0	1,500	Nil
Speech & Language Therapy	3.29	81,968	0	81,968	Nil
Telecare	1	37,870	31,340	6,530	Nil
Allied Health Professional Service Total	**47.81**	**2,756,467**	**44,148**	**2,712,319**	**Nil**

Funding and resources

The funding of the service is outlined in the section above.

Aims and Objectives

Directorate Plan Aims	Action
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish. There will be ease of access to services, with clear understanding within the community of who to contact and where to go Information will be available to each household in Shetland which explains how to access services, what service standards they can expect and how each organisation is performing through an effective public performance reporting regime
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	There will be more flexible services and more choice for our customers, within available resources Systems, procedures and information will be shared between organisations wherever possible and there will be clarity in the decision-making process, thereby reducing bureaucracy and delays in decisions about service delivery.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	There will be no need for a customer's needs to be assessed for eligibility for services by more than one relevantly qualified member of staff. Where possible, a customer will have allocated to them a named individual who looks

	after their service needs so that they need only have to “tell their story once”
5. Health and social care services contribute to reducing health inequalities.	There will be equity in access to services through better information, more locally based services and better transport arrangements where provision needs to be centralised. Everyone will be able to access services to meet their needs irrespective of their race, religion/faith, sexual orientation, age, disability, gender or socio-economic background.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	We will improve our identification of people who are carers and offer a carer’s assessment so that the appropriate support can be put in place. We will continue to work with the Third Sector to develop strategies to support carers and to continue with training programmes and carer’s events.
7. People using health and social care services are safe from harm.	We will build on our governance and quality assurance systems. Early reporting of incidents and near misses will help us to put in place actions that will improve procedures and processes.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	There will be in place a system of team working which recognises and values individuals’ skills and knowledge, encourages joint training and secondment opportunities and works to meet the needs of our customers. There will be in place a seamless method of service delivery, not restricted by organisational or professional boundaries – modelled on a “one-stop-shop” methodology There will be an individual within Shetland who is publicly recognised as being the manager of each service area
9. Resources are used effectively and efficiently in the provision of health and social care services.	Financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions. Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system

	Resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need. Services are delivered to the best possible standard and quality, at the best possible price. The Directorate will have a single planning and design process with clarity in what they are trying to achieve in the short, medium and longer term. Services will be planned and designed in partnership with customers and the general public.

Service Aims/Priorities	**Objectives/Actions (Details below)**
Maximise the AHP contribution to achieving delayed discharge targets and reduce overall length of stay in hospital, which will support the delivery of the legal treatment time guarantee	Continue to support development of and effective working of intermediate care and rapid response team Optimise deployment of staff to ensure they are available in the right place at the right time
Support older people and those with disability and complex needs to live independently in their own home/homely setting for as long as possible, delaying or reducing admissions into institutional care.	Continue to support development of and effective working of intermediate care and rapid response team Optimise deployment of staff to ensure they are available in the right place at the right time
Reconfigure “enabling” services, such as rehabilitation and reablement, to deliver best value and enhance care experiences for people who use services and their families and carers.	Continue to support development of and effective working of intermediate care and rapid response team Optimise deployment of staff to ensure they are available in the right place at the right time
Work with primary care leads, general practitioners and across their NHS board to support enhanced pathways in primary care which maximise AHP	Introduce self-referral to all teams

expertise as first-point-of contact practitioners to improve the care experience and reduce unnecessary referrals to secondary and unscheduled care	
Work collaboratively to significantly increase the utilisation of telecare and telerehabilitation as an integral approach to “enabling” services development, implementing pulmonary rehabilitation roll out as an exemplar model.	Continue to develop Telecare and Telerehabilitation pathways

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15		
Description	**Delivered Early/on-time/late**	**Achieved original intention?**
Implementation of National Footcare Guidelines	On time	Yes
Partnership working with Red Cross set up to improve wheelchair provision	On time	Yes

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Introduce self-referral as the primary route of access.	Orthotics Podiatry	Ongoing	Ongoing	Self-referral will be main method of access	Resources are used effectively and efficiently in the provision of health and social care services.
Continue to develop intensive rehabilitation service/model to support transitional rehabilitation from the hospital setting into the intermediate care service in the community. AHPs will follow patients through from the hospital to community.	OT Physio	Ongoing	Ongoing	Intensive rehabilitation model will be in place	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Implementation of the recommendations from the Sensory Impairment Strategy	OT SLT and partners	Dec 2014	March 2016	Development of care pathways for people with a sensory impairment, Assessment of performance against the care pathway Service improvement and identification of the relevant responsibilities across agencies for delivery	People who use health and social care services have positive experiences of those services, and have their dignity respected.

New Planned Actions Due to Start in 2015/16

Description	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Review staffing levels and structure across AHP services to maximise productivity	All teams	April 2015	March 2016	Effective and efficient staffing structure will be in place	Resources are used effectively and efficiently in the provision of health and social care services.
Review revised National Delivery Plan Actions once available and devise new plan accordingly	All teams	April 2015	September 2015	New action plan will be in place	Service in working towards achievable aims outlined in National Delivery Plan
Work with partners locally and nationally to ensure data collection is achieved to required standards, particularly in relation to the nationally agreed outcomes for integration of health and social care services	All teams	April 2015	March 2016	Data collection systems will be in place and operating effectively	Data will be collected to support the monitoring of the quality of AHP service delivery, including user experience

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service Plan.

Risks to Delivery

There are frequently difficulties in attracting professional staff to vacancies.

NHS Shetland's Workforce Plan states:

"For specialist roles (clinical and professional) it is generally necessary to advertise nationally in order to attract skills from off island. This incurs additional costs in respect of advertising, interview expenses, relocation expenses and increased time required to fill vacancies."

(Source: Economic Workforce Plan NHS Shetland 2014-17)

The particular workforce challenges noted by NHS Shetland and common to both organisations, that will impact on future ability to provide quality services for the population, include:

- attracting and retaining suitably skilled staff , particularly in specialist clinical and practitioner roles
- supporting staff working in isolated (single handed) roles and small teams
- implementing changes to services and our workforce to support the delivery of safe, efficient, sustainable services.
- developing and maintaining the skills of our current workforce
- maximising the cost effectiveness of our workforce so we also deliver financial balance

Performance Indicators

Key Service Indicators

Performance Measure	Performance 2014/15	Target 2015/16	Performance Statement	Improvement Statement
Maximum Waiting Time from Referral to First Consultation for Dietetics Services (weeks)	N/A	100%	No patient waiting more than 18 weeks	
Acc8 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment	N/A	0	No client waiting longer than agreed referral to	

Performance Measure	Performance 2014/15	Target 2015/16	Performance Statement	Improvement Statement
(count)			assessment timescale	
Maximum Waiting Time from Referral to First Consultation for Orthotics Services (weeks)	N/A	100%	No patient waiting more than 18 weeks	
Acc9 Maximum Waiting Time from Referral to First Consultation for Physiotherapy Services (weeks)	N/A	100%	No patient waiting more than 18 weeks	
Maximum Waiting Time from Referral to First Consultation for Podiatry Services (weeks)	N/A	100%	No patient waiting more than 18 weeks	
Maximum Waiting Time from Referral to First Consultation for Speech and Language Therapy Services (weeks)	N/A	100%	No patient waiting more than 18 weeks	

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Carers
2015-16 Service Plan

Supporting Health and Care vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

With the introduction of the public bodies legislation, carers services now formally becomes part of an Integrated structure for strategic planning processes for health and care. It has long been part of the Shetland CHP, however this piece of legislation takes that to the next level.

Vision Statement

"Voluntary Action Shetland seeks to respond to and support voluntary services in Shetland by meeting present and emerging needs, developing and promoting new ways of responding and encouraging people in Shetland to offer voluntary service to their community."

Drivers for Change

- Work in partnership with local authority and NHS on integrated project work, locality projects.
- Work in partnership with Yell/Unst Care Home to deliver support and carer assessments.

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Unmet Needs

Continued project funding remains an unmet need as salary costs are currently met through Change Fund and Carers Information Strategy funding and feedback from funders suggests that staff salary should be met through core funding.

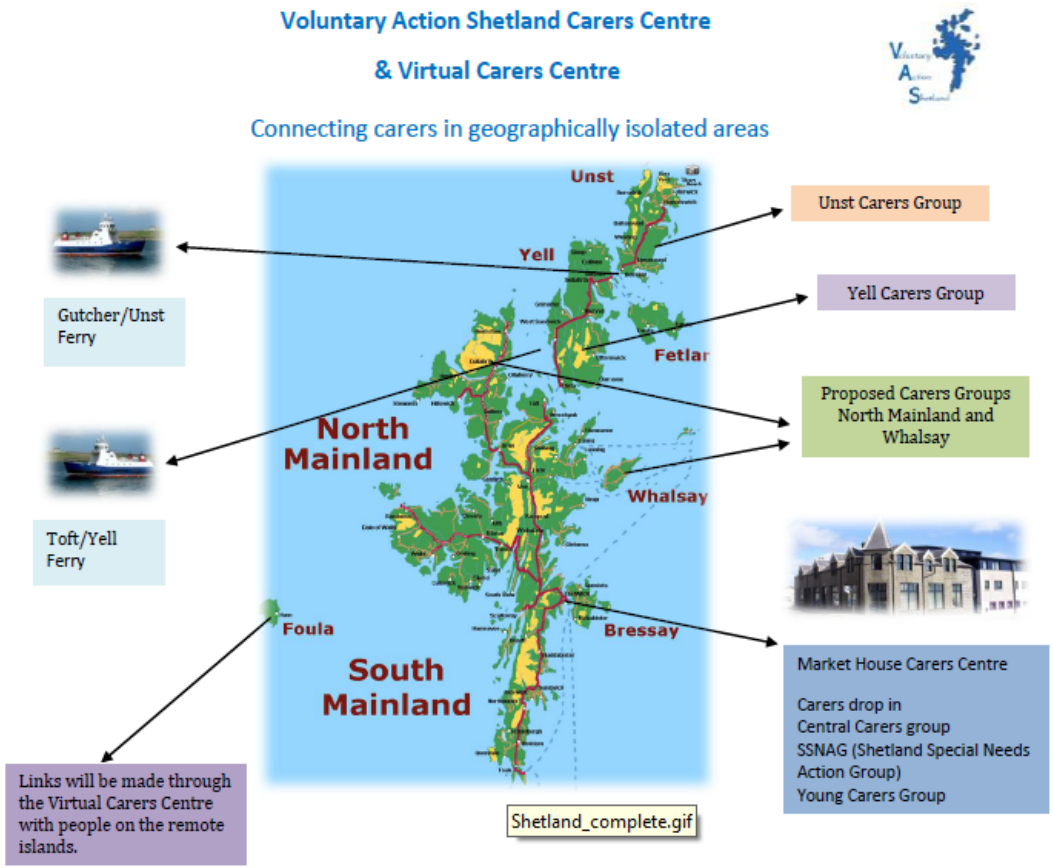
Other unmet service needs have been put forward in a Change Fund PID and include:

- Development of carer referral system across all Shetland health care practices and at the point of hospital discharge.
- Extended work on Carers Assessments.
- EPIC training to staff involved with service
- Carer information point at Gilbert Bain Hospital similar to the one developed with Aberdeen Royal Infirmary.
- Earlier carer identification and referral needed by all services.

About Us/Who we are

Current Services

www.shetlandcarers.org



- Carers assessments
- Carer support groups
    - cuppa and chat sessions
- Meeting support
- Support with signposting to support services
- Virtual Carers Centre – one stop to information for carers and new support and learning project.
- Carer identified training
- Short break `Me Time` carer grants and travel assistance
- Carer trips
- Online support
- Facebook information page
- Focus groups
- Carers Cruise

The eligibility criteria for our service is to be an unpaid carer in Shetland and we are located at Market House, Lerwick but provide outreach.

Regulation and Compliance

The Scottish government is currently proposing to bring into law new legislation to further support carers in Scotland. The Key elements within the legislation would be;

To change the term *Carer's Assessment*, many carers do no like the term, believing that it is judgemental and assesses their ability to provide care rather than considering what help they need to support their caring role. To address this issue and encourage carers to come forward, the Scottish Government have proposed a change of name to **Carer's Support Plan.**

Under current legislation, local authorities only have to offer the assessment to carers who care on a regular and substantial basis. There is no set definition for what is considered regular and substantial, and those carers providing low levels of support (no matter what the impact this has on them) are not eligible. This means that it can be more difficult to provide preventative support and carers are unable to access support until a crisis point is reached. To address this, the Scottish Government have proposed **removing the substantial and regular test** so that all carers will be eligible for a Carer's Support Plan.

The national Carers Organisations have supported these two proposals.

Our Customers/Needs

VAS is aware that some of its members may be in caring roles and works in partnership with unpaid carers and other voluntary organisations and local statutory bodies to identify the needs of unpaid carers and together work in partnership to look at ways to address them.

All carer support service development is based on The Scottish Government Caring Together 2010-15, the Carers Strategy for Scotland and 6 key outcomes for carers and our local Shetland Carers Strategy and Action plan.

- **Carers are identified**
- **Carers are supported and empowered to manage their caring role**
- **Carers are enabled to have a life outside of caring**
- **Carers are free from disadvantage and discrimination related to their caring role**
- **Carers are fully engaged in the planning and shaping of services**
- **Carers are recognised and valued as equal partners in care**

Needs

We work on identified or unmet needs so carry out regular carer consultation and scoping work linked to census stats and the above outcomes for carers. Carers assessments are also carried out through VAS.

Based on the 2011 census In Shetland out of a total population- 22,981

Of that, **8.8%** are carers to some degree.

Of that 8.8%-

- **38.6%** are 50-64 years old
- **17.4%** are 60+ years old
- **42%** of carers have one or more long term condition.

Of that 42%-

- **23.5%** have deafness or partial hearing loss
- **6.9%** have blindness or partial sight loss
- **0.1%** have a learning disability
- **6.8%** have a learning difficulty
- **1.2%** have a developmental disorder
- **18.8%** have a physical disability
- **12.3%** have a mental health condition
- **73.5%** have an additional or other condition

Funding and resources

Health & Social Care – Carers Service	Net Budget
Respite Care at Home Service	86,640

Key Risks to Delivery

Continued funding and capacity are key risks

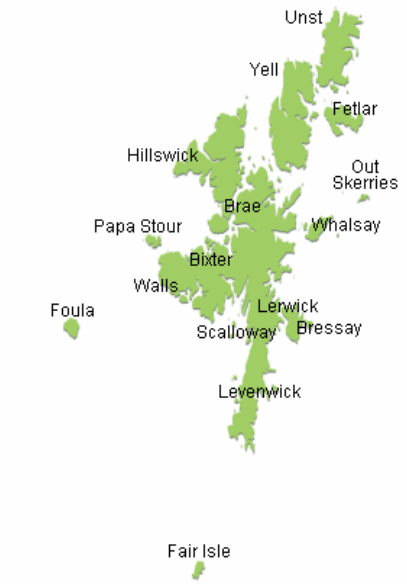
Funding for both project work and core salary costs is being sought.
Volunteering is being encouraged where appropriate.

Targets/Outcomes

HEAT, Single Outcome Agreement

- Carers are identified
- Carers are supported and empowered to manage their caring role
- Carers are enabled to have a life outside of caring
- Carers are free from disadvantage and discrimination related to their caring role
- Carers are fully engaged in the planning and shaping of services
- Carers are recognised and valued as equal partners in care

Community Care - Resources Service
2015-16 Service Plan



Supporting Health and Care vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service Plan contributes to the planning for the council, the health board and the Joint Integration Strategy. This service plan provides an overview of the Community Care - Resources Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.
Service plans are approved and "signed off" at Director Level as part of the Executive Manager's Employee Review and Development process.

Vision Statement

The Community Care Resources Service is committed to supporting the Community Health and Social Care Directorate's Vision of "To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community".

Drivers for Change

Our population is ageing fast. In Shetland it is anticipated that by 2016, the number of people aged 65 or over will be 38% greater than in 2006 and 92% greater by 2031. This is higher than the national average and the fourth highest rate of change across Scotland's 32 local authorities

The biggest challenge for the foreseeable future will be to maintain, with limited resources, both the level and quality of care the people of Shetland have come to expect

- Growing public expectations that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
- Demographic change with increasing life expectancy, a larger older population, greater social mobility of the population and a rise in the number of people living alone;
- Increasing prevalence of long term conditions and increasing multiple morbidity;
- Technological change e.g. in how care can be delivered through telecare, for example, and through changing public expectations in how services can be accessed through advances in internet and mobile technology;
- Reductions in public funding due to the recession and current ongoing difficult economic climate;

- Persisting inequalities in health;
- The need to demonstrate outcomes not just process; and
- The need to consider the sustainability of services.

In March 2010, Reshaping Care for Older People: A Programme for Change 2011-2021 set out the Scottish Government's vision and immediate actions for reshaping the care and support of older people in Scotland.

The programme provides a framework, built on consensus across all sectors and interests, to address the challenges of supporting and caring for Scotland's growing older population into the next decade and beyond. It aims to improve the quality and outcomes of current models of care, whilst developing services in a sustainable way that address current demographic and funding pressures.

The framework is based on the vision that: "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting." Within the Programme there are three core themes (Care Settings, Complex Care and Community Capacity) with two supporting themes (Workforce and Finance and Analysis).

About Us

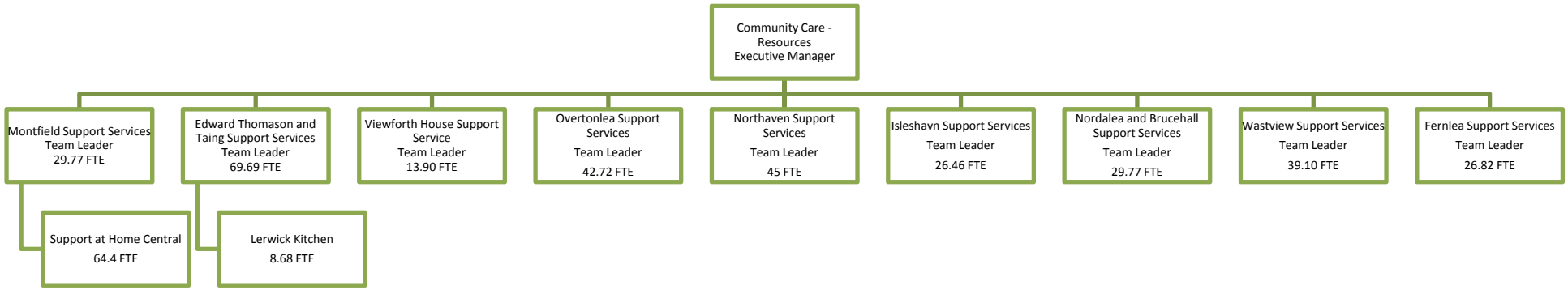
The current structure of services was created as part of the Council organisation and management re-structure in 2011. It was placed in the Community Health and Social Care Directorate following the decision by the Council and the Health Board to jointly appoint a director of Community Health and Social Care in February 2014. This structure was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the council.

The service comprises front line functions

Who We Are

This Service is part of an integrated Directorate that consists of Adult Services, Adult Social Work, Community Nursing, Criminal Justice, Mental Health, Occupational Therapy, Oral Health, Primary Care and Pharmacy. This strengthens opportunities for integrated service planning and delivery. The Directorate is led by the Director of Community Health and Social Care.

Organisational Chart



Locations

The Community Care Resources Service delivers services throughout as detailed below:

Edward Thomason and Taing Support Services, Lerwick – 41 beds – 14 day support places	**Fernlea, Whalsay** – 10 beds – 8 day support places
Isleshavn, Mid Yell – 10 beds – 4 day support places.	**Montfield Care Home** - 15 short stay beds - providing short term enablement and rehabilitation to support long term care in the community
Nordalea, Unst – 7 beds – 12 day support places	**North Haven, Brae** – 15 beds – 12 day support places.
Overtonlea, Levenwick – 15 beds – 12 day support places.	**Wastview, Walls** – 15 beds – 12 day support places.
Viewforth House, Lerwick – Reprovison exercise underway beds, currently 4 residents in situ	

In addition, we also commission services from Crossreach and specifically the Walter and Joan Gray Home, Scalloway which provides16 beds and 10 day care places.

Governance

The Community Care Resources Service reports to the Integrated Joint Board. The Service's performance is reported to the Directorate Management Team monthly and 5 PIs from this plan is reported to the Integrated Joint Board 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

Social Work Services, Care Homes, Respite Providers and Care At Home Services are subject to inspection by the Care Inspectorate. Each service is inspected at least annually and is measured against the National Care Standards. Inspection reports are published and any recommendations or requirements are implemented and progressed through individual service action plans. Inspection reports can be accessed at: www.careinspectorate.com

The Care Inspectorate are working more closely with Health Improvement Scotland and in 2015 services for older people will be subject to joint inspection.

The Team Leader of each service area must be registered with the Care Inspectorate as a Registered Manager. All social care staff must be registered with Scottish Social Services Council in order to practice and must abide by the Codes of Practice. www.sssc.uk.com

What We Do

We enable older people to remain at home by increasing levels of independence, self-care and self-managed care. We reduce unplanned, emergency and inappropriate admissions to hospital and facilitate early discharge from hospital wherever possible through the use of Care at Home and Care Centre resources.

The service has the following elements, delivered from a number of hubs around Shetland:

- Residential care used for long term care or short breaks (respite)
- Day services
- Care at home
- Domestic
- Meals on Wheels

Our Customers

In a week, the services deliver approximately 2200 hours of personal and domestic care in peoples own homes to approximately 350 clients.

Example of Care at Home Hours by Area (June 2014)

	Domestic	**Personal**
Central	172.5	674.5
ET	2	146
North	18	274.75
South	29.5	235
Unst	13	95
West	30.25	136.75
Whalsay	12	61.75
Yell	11.5	81.75
Dementia Services	5	220.75
	293.75	**1926.25**

National Eligibility Criteria for older people are applied. These can be found at the following link: http://www.scotland.gov.uk/Resource/0039/00399040.pdf

Our Costs and Income

The Service has around 397.31 full time equivalent staff and annual net expenditure of £ 9,909,221 and a capital budget of £70,000. As detailed below:

Health & Social Care – Community Care Resources Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1	124,398	0	124,398	Nil
Edward Thomason & Taing Support Service (residential and day care services)	69.69	2,683,823	1,453,163	1,230,660	70,000
Support at Home Central (care at home service for Lerwick, Scalloway, Burra & Tingwall)	64.40	2,256,585	151,865	2,104,720	Nil
Lerwick Kitchen (centralised kitchen providing meals for Viewforth, Montfield, Lerwick Meals on Wheels, Edward Thomason & Taing, Eric Gray and GOLD Group)	8.68	273,408	272,512	896	Nil
Montfield Support Service (residential short stay service)	29.77	1,119,034	415,971	703,063	Nil
Crossreach Services (Walter & Joan Gray) (residential and day care)	-	740,289	123,095	617,194	Nil
North Haven (residential, care at home, day care and meals on wheels services)	45	1,634,657	471,404	1,163,253	Nil
Overtonlea (residential, care at home, day care and meals on wheels services)	42.72	1,582,653	579,583	1,003,070	Nil
Wastview	39.10	1,443,987	400,959	1,043,028	Nil

(residential, care at home, day care and meals on wheels services)					
Fernlea (residential, care at home, day care and meals on wheels services)	26.82	980,882	530,345	450,537	Nil
Isleshavn (residential, care at home, day care and meals on wheels services)	26.46	979,264	439,940	539,324	Nil
Nordalea (including Brucehall) (residential, care at home, day care and meals on wheels services)	29.77	1,138,499	403,831	734,668	Nil
Viewforth (residential service)	13.90	582,713	388,303	194,410	Nil
Community Care Resources Service Total	**397.31**	**15,540,192**	**5,630,971**	**9,909,221**	**70,000**

Funding and resources

The Shetland Charitable Trust commission services to support the care centres in rural areas, and contribute £2.4M towards this model. As part of the council's Medium Term Financial Plan, staffing levels were reviewed in 2013/14 and significant efficiencies have now been realised.

There is a statutory duty to charge for residential care. In 2013/14, charging for non-residential services was introduced through a policy decision of the council.

Aims and Objectives

Directorate Plan Aims	Action
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish.

	There will be ease of access to services, with clear understanding within the community of who to contact and where to go. Information will be available to each household in Shetland which explains how to access services, what service standards they can expect and how each organisation is performing through an effective public performance reporting regime.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	There will be more flexible services and more choice for our customers, within available resources. Systems, procedures and information will be shared between organisations wherever possible and there will be clarity in the decision-making process, thereby reducing bureaucracy and delays in decisions about service delivery.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Customer's needs will be assessed for eligibility for services using a person centred approach. Where possible, a customer will have allocated to them a named individual who looks after their needs and care services.
5. Health and social care services contribute to reducing health inequalities.	There will be equity in access to services through better information, more locally based services and better transport arrangements where provision needs to be centralised. Everyone will be able to access services to meet their needs irrespective of their race, religion/faith, sexual orientation, age, disability, gender or socio-economic

	background.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	We will improve our identification of people who are carers and offer a carer's assessment so that the appropriate support can be put in place. We will continue to work with the Third Sector to develop strategies to support carers and to continue with training programmes and carer's events.
7. People using health and social care services are safe from harm.	We will build on our governance and quality assurance systems. Early reporting of incidents and near misses will help us to put in place actions that will improve procedures and processes.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	There will be in place a system of team working which recognises and values individuals' skills and knowledge, encourages joint training and secondment opportunities and works to meet the needs of our customers. There will be in place a seamless method of service delivery, not restricted by organisational or professional boundaries – modelled on a "one-stop-shop" methodology. There will be an individual within Shetland who is publicly recognised as being the manager of each service area.
9. Resources are used effectively and efficiently in the provision of health and social care services.	Financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions. Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system. Resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need. Services are delivered to the best possible standard and quality, at the best possible price. The Directorate will have a single planning and design process with clarity in what

	they are trying to achieve in the short, medium and longer term. Services will be planned and designed in partnership with customers and the general public.

Service Aims/Priorities	**Objectives/Actions (Details below)**
To enable older people to remain at home	We will provide good quality and appropriate volumes of care at home.
To maintain or increase levels of independence	To promote and support individuals and their families/carers to do much as they can for themselves, with provision of reablement support.
To reduce unplanned, emergency and inappropriate admissions to hospital	To work with partners in localities to increase the number of anticipatory care plans wherever possible through the use of Care at Home and Care Centre resources. To provide appropriate levels of support to people complex social and health problems including long term conditions.
To facilitate early discharge from hospital	To provide flexible and responsive solutions to individuals in localities including multi-agency reablement work.

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15		
Description	**Delivered Early/ on-time/late**	**Achieved original intention?**
Consolidation following review of staffing and skill mix levels	On time	Meet the aims and objectives of the Medium term Financial Plan
ET & Taing House additional accommodation and merger of two care homes	Completed on time	Yes. Integrated service under one registration. Increased capacity through 6 new rooms.
Viewforth Reprovision	Within timeframe	Yes. More individuals with dementia are being cared for at home or in a more appropriate care setting.

Ongoing Actions/Projects Started prior April 2015					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
ET/Taing House additional accommodation Phase 2	ET & Taing	Yes	TBC	3 additional rooms to be create be created	Creation of efficiency and flexibility in the use of resources
Review of referral and assessment process	EM Adult Social Work CHSC	Yes	April 15	Written report on current processes and areas for improvement.	To develop a more efficient and robust referral and assessment structure.

New Planned Actions Due to Start in 2015/16					
Description	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Stocktake of community care resources by locality.	EM Resources CHSC	April 2015	July 2015	A comprehensive understanding of local services. Benchmarking of local need and capacity	Resources are used effectively and efficiently in the provision of health and social care services
Improve recruitment and retention of staff	CHSC HR	April 2015	March 2016	Appropriate staffing levels in all localities Staff are appropriately supported, supervised and trained.	People who work in health and social care settings feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Develop a quality assurance framework	Exec manager Team leads	April 2015	September 2015	Consistent approach to quality assurance across the services. Programme of assessment and monitoring of activities. Comprehensive information to inform service delivery and development	Resources are used effectively and efficiently in the provision of health and social care services. People who use health and social care services have positive experiences of those services, and have they dignity respected.
Implement Action Plan from WYFY Review	CHSC	June 15	Mar 16	Delivery of plan.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
To review the current processes for older people living in an inappropriate hospital or care setting.	CHSC Acute Health Services	July 15	Sept 15	Agreed process fit for purpose. KPIs to monitor progress	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

Recruitment of staff

Performance Indicators

Performance Measure	Performance 2014/15	Target 2015/16
To review the current processes for older people living in an inappropriate hospital or care setting. KPIs to be developed following review.	0	No delays exceeding 4 weeks hospital setting. No delays exceeding 8 weeks – care centres.
Number of people over 65 being supported in a non institutionalised setting	444	5% Increase
Number of people receiving intensive care at home	93	5% Increase
Quality Assurance measures to be agreed following the development of a QA framework.	N/A	
Occupancy of care homes	86% (indicative figure, awaiting national care home census)	90%
Recording of unmet need	N/A	100% recording of unmet need

Contact Details

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Community Nursing Services

"Delivering Care Directly to Your Door"

2015-16 Service Plan

Supporting Health and Care vision:

"To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community"

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for the council, the health board and the Joint Integration Strategy. This Service Plan provides an overview of the Community Nursing Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Community Nursing Service is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".*

Drivers for Change

The direction for healthcare in NHS Scotland was first set out in the Scottish Government's strategic document Better Health Better Care (2007). Since 2007, the Government has published the Quality Strategy (2010) and set 3 Quality Ambitions that underpin the delivery of care within NHS Scotland, namely that care is safe, effective and person-centred.

The 2020 Vision for NHS Scotland set out in 2011 notes that the Scottish Government's 2020 vision is "that by 2020 everyone is able to live longer healthier lives at home or in a homely setting". NHS Scotland notes that they will achieve this vision by delivering a healthcare system which has

- An Integrated Health & social care service
- A focus on prevention, anticipation, and supported self management
- Person-centred care, delivered to the highest standard of quality and safety
- Care provided in community settings unless hospital treatment is required
- People back to their home/community as soon as possible with minimal risk of readmission.

The delivery of the Scottish Government's vision will be influenced by the demographic challenges posed by the local community, as well as those experienced within the District Nursing workforce which is also an ageing workforce. The ageing population sees people living longer

with more complex healthcare needs, and with more longterm conditions. The ageing workforce means that there is a need to review and reconfigure how services are provided in order to be able to provide a sustainable service to meet the needs of the population as we go forward. These challenges will be considered as part of the annual workforce planning process.

The District Nursing service assists with the delivery of the following targets

- Reduction in the number of avoidable A&E attendances and admissions;
- Early supported discharge and reduction in delayed discharges from hospital;
- Reduction in emergency in-patient bed day rates for people aged 75years or over;
- Percentage of time in the last 6 months of life spent at home or in a community setting;
- Shifting the balance of care into an anticipatory model rather than reactive model to support long term conditions management; and
- Proportion of people aged 75years and over living at home who have an Anticipatory Care plan shared.

Through implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 Joint Integration Boards will be responsible for ensuring that the Community Health and Social Care Directorate delivers on the Health and Wellbeing Outcomes for their local population.

About Us

The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting.

The District Nursing service is the largest part of Community Nursing services and provides a nursing service to individuals within their own home, or a care home, on a 24 hours a day, seven days a week, 365 days a year basis.

Whilst the service predominantly focuses on individuals who are over the age of 16 years, are housebound and who have a health care need, the service will endeavour to meet the needs of any individual within the community setting who has a need for nursing care.

The District Nursing service provides

- Acute care at home;
- Complex care at home;
- End of life care at home.

From April 2012, the District Nursing service has provided a shift based, 24 hours a day, 7 days a week service on mainland Shetland.

The Service is pivotal in preventing unnecessary admission to hospital and in supporting safe, early discharge from hospital back to the community.
District nurses also promote healthy lifestyle choices; promoting independence and supporting selfcare, wherever possible. Physical, psychological and social support and encouragement is provided for people with disabilities and long-term conditions to enable them to live as an independent life as possible.

District Nurses also support patients with terminal illness to die in their preferred place of care, which may be at home.

The Queen's Nursing Institute of Scotland (QNIS) identifies the role of the District Nurse as

- Expert in the Care of the Older Adult;
- Caring for individuals with an Increasing number of co-morbidities;
- Caring for individuals with an Increasing number of Longterm conditions;
- Caring for individuals with Polypharmacy;
- Supporting complex social care needs with an emphasis on the importance of case management and utilising the specialised clinical skills possessed by District Nurses; and
- Proactively managing care by promoting health, anticipating health needs, enabling and supporting self care, and providing support and supervision to the well older adult.

The following groups of staff who provide care in a community setting are also provided, and managed, via the Community Nursing service:

- Practice Nurses – the Practice Nursing service for all of the Board provided general practices, namely Lerwick, Yell and Whalsay;
- Advanced Nurse Practitioners – the Advanced Nurse Practitioner posts based at the Lerwick Health Centre;
- Specialist Nurses, eg Continence Nurse Advisor. NB there is a separate service plan for this area of practice;
- Non-Doctor Island/Out of Hours Nursing – there are resident nurses on the non-doctor islands of Fair Isle, Foula, Fetlar, Skerries and Bressay. Some of these postholders, along with their relief colleagues, provide the overnight nursing service on mainland Shetland; and

- Intermediate Care Team – this multi-disciplinary, partnership team provide additional support at home for individuals to prevent unnecessary admission to hospital or provide additional support to increase independence on discharge home from hospital. This additional support is provided on a time limited basis of up to 6 weeks. The team are based at the Independent Living Centre, Gremista, Lerwick.

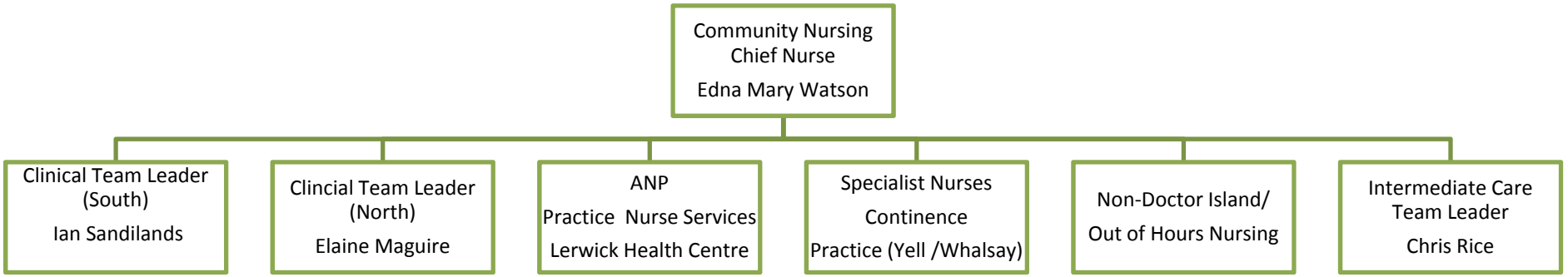
The Community Nursing Service was placed in the Community Health and Social Care Directorate following the decision by the Council and Health Board to jointly appoint a director of Community Health and Social Care in February 2014. This was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

The Community Nursing Services provide a front line clinical service to individuals with a nursing and/or health need.

Who We Are

The Community Nursing Services sit within the Community Health and Social Care Directorate and are led by the Chief Nurse, Directorate of Community Health and Social Care. The following Services are also in the Community Health and Social Care Directorate - Adult Services, Community Care Resources, Social Work (including Criminal Justice), Mental Health services, Occupational Therapy services, Dental Services and Pharmacy services.

Organisational Chart



Locations

District Nursing services are practice based at each of the Health Centres throughout Shetland with the exception of Bixter/Walls and Hillswick/Brae where the District Nursing team is based at Bixter and Brae respectively.

The District Nursing service model for **Mainland Shetland** comprises:

0830hrs-1700hrs – normal day service provided by Community Nursing staff based at each Health Centre.

1700hrs-2130hrs – there is a Community Nurse based at Gilbert Bain Hospital.

2115hrs-0815hrs – a dedicated overnight service is covered by one District Nurse/Advanced Nurse Practitioner post holder based at Gilbert Bain Hospital.

For the **remote outer islands** (Yell, Unst and Whalsay) and the **non-doctor islands** (Fair Isle, Foula, Fetlar, Bressay and Skerries) - District Nurses are available between 0830hrs-1700hrs daily and then provide an on call service overnight for individuals who need emergency assistance in the out of hours period.

On the Non-Doctor Islands, the District Nurse presence is the only resident healthcare provider on the island and therefore the postholder has a role and remit wider than that held by the District Nurses on mainland Shetland.

NHS24

NHS24 is used to triage all calls to the District Nursing Service on Mainland Shetland.

Access to District Nursing services on the Non-Doctor Islands of Fair Isle, Foula and Bressay is also via NHS 24.

Access to District Nursing services on Yell, Unst and Whalsay in the out of hours period is via contacting the District Nursing office number.

Access to District Nursing services on Fetlar and Skerries is via contacting the District Nursing office number.

The other areas of nursing (Practice Nursing, Non-Doctor Island/Out of Hours, Advanced Nurse Practitioners) and the Intermediate Care Team are based at the locations specified on page 7 and page 9.

Governance

The Community Nursing Service is part of the Community Health and Social Care Directorate and reports to the Social Services Committee and Community Health Partnership Committee which meet concurrently.
The Service's performance is reported to the Directorate Management Team monthly and XXX PIs from this plan is reported to the Social Services Committee and Community Health Partnership Committee 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

All nursing staff working within the Community Nursing service are required to have current active registration with the Nursing and Midwifery Council (NMC).

The nursing service is provided in line with national clinical guidelines eg the Royal Marsden Manual of Clinical Procedures as well as being subject to external scrutiny through the various service/condition specific inspections led by Healthcare Improvement Scotland.

All staff within the Intermediate Care Team have to meet the regulation requirements of their respective Regulatory bodies eg NMC, Health and Care Professions Council (HCPC) or Scottish Social Services Council (SSSC).

What We Do

District Nursing

The District Nursing service operates to the following Principles for Practice:

- To provide high quality, culturally sensitive nursing care to individuals whether in their own homes or in a community setting.
- To adopt a public health approach in promoting healthy lifestyles and reducing ill health.
- To promote and maintain individuals' independent lifestyles through rehabilitation and re-ablement approaches.
- To promote improved patient care and a clinically effective use of resources by adopting an evidence-based approach in all areas of practice.
- To encourage user involvement in service planning and delivery.
- To reduce incidences of admission and re-admission to hospital through education of patients and carers to seek early intervention for potentially debilitating conditions.
- To promote a co-ordinated approach to hospital discharge that facilitates a seamless service leading to improved health outcomes.

Services Available

The District Nursing service offers planned, individual, person-centred care in relation to the following:

- Comprehensive assessment and management of complex, chronic and acute nursing needs.
- Holistic wound assessment and management.
- Chronic and acute long term conditions management.
- Health promotion and education to support self-care management.
- Early patient contact to allow for the building of supportive relationships for end of life care.
- Technical nursing interventions such as e.g. setting up of syringe drivers, care of central lines.
- Receipt of referrals from other District Nurses or disciplines.

Practice Nursing

Practice Nurses provide a nursing service for individuals who can attend their local Health Centre for care.
The nursing care provided ranges from nursing procedures, Longterm Condition Management, Cervical cytology to Immunisations (including travel medicines).

Advanced Nurse Practitioners

In 2015-2016 there will be an increase in the number of Advanced Nurse Practitioners employed in the service. Advanced Nurse Practitioners can see individuals, make a differential diagnosis, treat, prescribe medication and discharge patients without recourse to a Doctor. Advanced Nurse Practitioners act as a first point of contact for healthcare and generally treat individuals with minor illness/ailments and minor injuries.

Specialist Nurses eg Continence Nurse Advisor

Specialist Nurses have an enhanced level of knowledge, generally in one particular area of practice. See separate service plan for Continence Nursing Services.

Non-doctor Island/ Out of Hours practitioners

Nurses resident on the Non-doctor islands provide a first point of contact for all healthcare needs. This covers all scheduled and unscheduled healthcare contacts. In the out of hours period, some of the non-doctor island staff provide a nursing response on mainland Shetland to District nursing calls as well as being able to see and treat individuals presenting with a range of conditions, which are generally minor ailments.

Intermediate Care Team

The Intermediate Care Team comprises nurses, therapists (physiotherapy and occupational therapy), support workers with medical input being sourced via either a Consultant Physician or General Practitioner. The team provide an intensive support package for up to 6 weeks, during which time individuals are supported to regain their independence again.

Our Customers

Accessing the District Nursing Service/Referral criteria

The District Nursing service operates an open access referral system with referrals being accepted from other health and care professionals, individuals themselves or from carers.

All referrals to the District Nursing service will be treated as new admissions to the district nursing caseload. The District Nurse is the caseload holder.

District Nurses use their skills, knowledge and experience to assess the appropriateness of referrals within the resources of the community nursing service. Using their professional judgement District Nurses, in partnership with the patient and patient's carers decide when home nursing is the best option for a particular patient. A holistic assessment will determine the home nursing needs of the patient with care planned appropriately to meet the individual's needs.

A person-centred care plan will be jointly agreed with the patient and the District Nurse. The individual is expected to participate in their care plan. Failure of patient concordance will result in further discussion with the District Nursing caseload holder, having the potential for withdrawal of the District Nursing service.

As part of the assessment process referrals may be made to other agencies, e.g. Social Services, voluntary agencies or specialist nurses. In order to facilitate patient care, consent to share information on an inter-agency basis is sought e.g. the 'With You For You' assessment.

District Nurses will work flexibly with other disciplines and agencies to deliver a service that meets individual's healthcare needs.

Prioritisation of Visits

The District Nursing service does not operate a waiting list, but the following criteria are in place for prioritising visits and assessments:-

Urgent – immediate access required – visit within 4 hours. This includes acutely and terminally ill patients wishing to be nursed at home; visits that can prevent a hospital admission or attendance to the A&E department (e.g. blocked catheters; patients needing intensive nursing care for diabetes, cancer, chronic disease management etc.)

Non-urgent – access required within 24-48 hours. This includes patients in need of curative care such as acute and chronic wound management, postoperative care or medication reviews.

Routine – access at a time convenient to patient and staff, and includes e.g. appointments for health checks, support visits, bereavement visits, administration of immunisations, and continence assessments.

In 2013-2014 approx 25,000 visits were undertaken by the District Nursing service

In 2014-2015 approx 12,500 visits have been undertaken by the District Nursing service to date (October 2014).

The Practice Nurses, Advanced Nurse Practitioners, Specialist Nurses and Non-doctor island/Out of Hours nurses all operate an open access referral system with referrals being accepted from other health and care professionals, individuals themselves or from carers.

The Intermediate Care Team only accepts referrals from hospital or community based health and care professionals.

Our Costs and Income

The overall Community Service has approx 48.98 full time equivalent staff and an annual revenue expenditure of £2.3 million. The staffing establishment is as detailed below:

Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1				Nil
Team 1 – District Nursing staff	26.93				Nil
Team 2 – Practice Nursing – LK, Yell, Whalsay	5.93				
Team 3 – Advanced Nurse Practitioners	5				
Team 4 – Specialist Nurses	0.4				
Team 5 - Non-Doctor Island/Out of Hours staff	8				
Team 6 – Intermediate Care Team (staff team currently funded by Change Fund)					
Team 7 – Admin support (service wide)	2.2				
Pay costs	2, 041,713				
Non-pay costs	286,737				
Service Total	**2,328,450**				

Funding and resources

The Community Nursing services are funded from the NHS Board core funding. Over the last 5 years, through redesign of services, recurrent savings have been made from the Community Nursing services budget.

Aims and Objectives

The overall aims and objectives of all the constituent parts of the Community Nursing services are to:

- Support and maximise the health potential of individuals, as well as address the health and care needs of various client groups and/or their carers within the wider community; and
- Utilise a holistic approach to providing safe, effective, person-centred care in a variety of community settings.

Directorate Plan Aims	Action
People are able to look after and improve their own health and wellbeing and live in good health for longer	There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish.
People including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to “tell their story once”.

Service Aims/Priorities	Objectives/Actions
There will be a demonstrably healthier local population who are able to remain in their own	All community based nurses will promote healthy lifestyles to all individuals on the caseload. Anticipatory care plans will be developed with individuals in order to support

Service Aims/Priorities	Objectives/Actions
homes or in a homely environment for as long as they so wish.	them to remain in their own homes for as long as possible.
The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so	District Nurses/Community Nursing service will work as part of a locality service delivery model, influencing and leading care for individuals with a health need.
Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to "tell their story once".	District Nurses will actively adopt the case manager role for individuals with complex health needs.

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Implemented pilot of Intermediate Care Team including overnight nursing service	Delivered	Succeeding in supporting Discharge home from hospital and avoiding some admissions but limited resources available due to challenges in recruiting support worker level postholders
Support development of eKIS Anticipatory Care Plans at individual practice level	Delivered	Work in progress but differing clinical views on implementation of EKIS and therefore variable uptake across Shetland

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Sourcing and implementing electronic Community Nursing system					Initial plan to implement MiDAS Community Nursing system had to be put on hold as system called in by Scottish Government for review. Require to consider alternative options in 2015/2016.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Create sustainable Intermediate Care Team with integral overnight nursing/care service	Intermediate Care Team	April 2015	July 2015	Sustainable service in place	Provides a 24hour nursing and care service at home thus supporting early supported discharge from hospital as well as avoiding unnecessary admissions
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care	Chief Nurse	April 2015	March 2016	Electronic record keeping/management system in place	Enhance communication across multidisciplinary, interagency teams thus supporting improved seamless care for individuals

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Further develop model of case management within Community Nursing services	Chief Nurse	Ongoing		District Nurses undertake case management role	Better co-ordinated care for individuals with complex health needs
Continue to support implementation of eKIS Anticipatory Care Planning across the services	Chief Nurse/ Clinical Team Leaders	Ongoing		Increase in eKIS plans in place across all General Practices in Shetland	Enhance anticipatory approach to care for individuals with complex health needs.
Implement Advanced Nurse Practitioner model at Lerwick Health Centre	Chief Nurse Lead ANP	February 2015	June 2015	Increased range of practitioners available for consultation at Lerwick Health Centre	Enhanced access to primary care services and improved continuity of care for individuals registered with Lerwick Health Centre.

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

During 2014-2015 the Community Nursing service has experienced significant difficulty with recruitment in the service, the effects of this in terms of service provision being further compounded by the number of staff who have had a period of longterm sickness absence whilst awaiting or recovering from surgical interventions. It is hoped that all of these issues will be resolved before we enter 2015-2016. The impact of these issues has been to limit service development in 2014-2015 as staff have had to focus on meeting the current clinical needs of patients on the active caseload.

Performance Indicators

Performance Measure	Performance 2014/15	Target 2015/16
Number of Early Supported Discharges Number of Admissions Avoided through involvement of Intermediate Care Team		
Number of individuals with complex health needs whose care is case managed by a District Nurse		
Number of Anticipatory Care Plans in place and shared across services		
Number of people supported to die in preferred place of care		
Number of early supported discharges with no re-admission in 30 days		
Number of individuals seen by an Advanced Nurse Practitioner as first point of access to healthcare		
Number of individuals seen by an Advanced Nurse Practitioner referred to another practitioner for a “second opinion”		
Patient Experience survey of patients seen by Advanced Nurse Practitioners		

Contact Details

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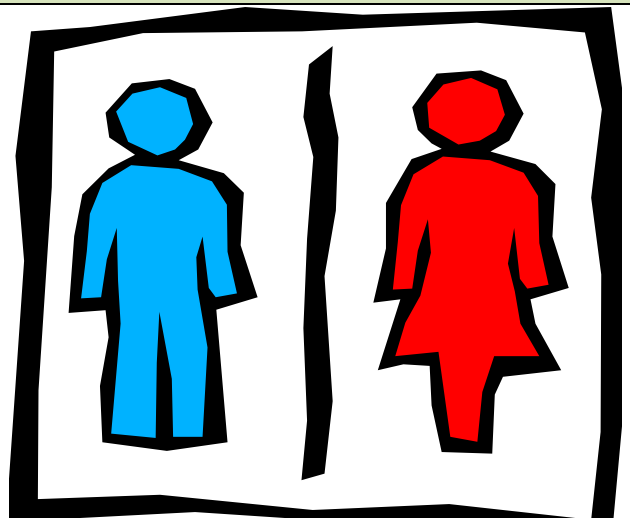
Continence Nursing Services
Promoting Continence, Managing Incontinence, Improving Quality of Life

2015-16 Service Plan



Supporting Health and Care vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for the council, the health board and the Joint Integration Strategy. This Service Plan provides an overview of the Continence Nursing Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Continence Nursing Service is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community".

Drivers for Change

The direction for healthcare in NHS Scotland was first set out in the Scottish Government's strategic document Better Health Better Care (2007). Since 2007, the Government has published the Quality Strategy (2010) and set 3 Quality Ambitions that underpin the delivery of care within NHS Scotland, namely that care is safe, effective and person-centred.

The 2020 Vision for NHS Scotland set out in 2011 notes that the Scottish Government's 2020 vision is "that by 2020 everyone is able to live longer healthier lives at home or in a homely setting". NHS Scotland notes that they will achieve this vision by delivering a healthcare system which has

- An Integrated Health & social care service
- A focus on prevention, anticipation, and supported self management
- Person-centred care, delivered to the highest standard of quality and safety
- Care provided in community settings unless hospital treatment is required
- People back to their home/community as soon as possible with minimal risk of readmission.

Incontinence, urinary or faecal, can restrict employment, educational and leisure opportunities, and lead to social embarrassment and isolation, which affects a person's physical and mental health. It is vital that people who are incontinent are given every opportunity to regain their continence. High quality comprehensive continence services are an essential part of health care.

NHS Shetland has a reputation for providing high quality services to the local population. This has rightly led to an expectation of continued excellence in the development and provision of services. The aim of the Continence Advisory service is to provide a quality, effective, safe and person-centred service to address the needs of individuals with continence problems. This service is delivered in the most appropriate setting for the individual patient, ie clinic, home or residential setting.

The Continence Advisory service will continue to re-design services as required to ensure provision of a modern sustainable service, which provides best value in terms of utilisation of resources within available budget, whilst also addressing the clinical and personal needs of the individual.

The Nurse led Continence service will also continue to respond to feedback gained through patient and staff surveys and other sources, eg consultation on Older People's strategy, to ensure that appropriate conditions are maintained in which individuals, families and their carers can have the confidence, motivation and ability to make healthier choices and to seek professional help and support with continence issues as required.

About Us

Incontinence of urine or faeces is thought to affect millions of people worldwide. It is estimated that in the United Kingdom that between 3 and 6 million people have some degree of urinary incontinence. Bowel incontinence is thought to affect 1 person in every 10 at some point in their life time.

As continence is a fundamental care issue, all Registered Nursing staff can undertake basic patient assessment for those with continence issues. The Continence Nurse Advisor provides specialist assessment, diagnosis, treatment and management of a wide range of conditions for individuals with complex issues that affect the bladder, bowel and pelvic floor.

The Continence Nurse Advisor:

- provides direct patient care, providing advice and information on a routine or emergency basis, to patients and their relatives or carers in a variety of settings including the person's home, hospitals, clinics and health or care centres;
- uses counselling skills, where appropriate, to identify patients' problems, helping them to resolve or accept them;
- assesses, plans and documents the care a patient needs on an individual basis, liaising with other members of the multidisciplinary team, as necessary;
- provides a range of services to adults and children with continence problems, focusing initially on treatment options. Containment is considered for those for whom no treatment option has proved successful.
- liaises with community nurses, other health care professionals, and professional and voluntary organisations, according to the patient's individual needs, to ensure care is continuous and integrated;
- applies relevant research to ensure the delivery of evidence-based practice;
- supports other members of the health and care team in the assessment, planning, delivery and evaluation of initial education to patients, their families and carers about incontinence;
- sets, reviews and monitors the standards of continence care within the NHS Board area;
- plans and delivers education about continence care for both health and care staff across Shetland; and
- acts as a source of expert advice for all who cope with incontinence, including patients, other nurses, health and care staff.

The employment of a Continence Nurse Advisor has ensured that improved assessment processes and regular patient reviews are now in place and that as a service there has been a move towards active treatment options for individuals with a continence issue which has challenged an historical containment "pad " culture within services. The provision of support and education, as well as continuing to promote an "enabling" approach to the delivery of patient care will ensure a cost effective service is maintained.

The Continence Nurse Service was placed in the Community Health and Social Care Directorate following the decision by the Council and Health Board to jointly appoint a director of Community Health and Social Care in February 2014. This was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

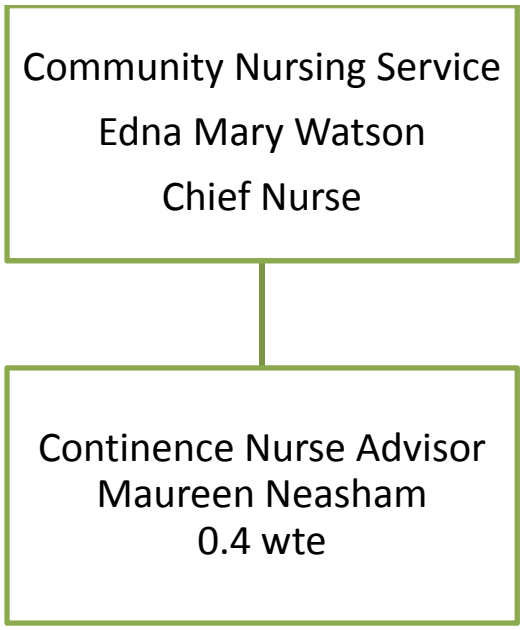
The Service provides a front line clinical service to individuals with complex continence issues.

Who We Are

The Continence Advisory Service sits within the Community Health and Social Care Directorate and is led by the Chief Nurse, Directorate of Community Health and Social Care. The following Services are also in the Community Health and Social Care Directorate - Adult Services,

Community Care Resources, Social Work (including Criminal Justice), Mental Health services, Occupational Therapy services, Dental Services and Pharmacy services.

Organisational Chart



Locations

The Continence Nurse Advisor is District Nurse Maureen Neasham who is based at the Independent Living Centre, Gremista, Lerwick, Shetland, ZE1 OXY.

Mrs Neasham can be contacted via telephone on 01595 743987 on Thursdays and Fridays each week, outwith these times an answer phone facility is available. Alternatively Mrs Neasham can be contacted by email at m.neasham@nhs.net

Governance

The Continence Nurse Advisory Service is part of the Community Nursing Service within the Community Health and Social Care Directorate and reports to the Social Services Committee and Community Health Partnership Committee which meet concurrently.
The Service's performance is reported to the Directorate Management Team monthly and XXX PIs from this plan is reported to the Social Services Committee and Community Health Partnership Committee 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

All nursing staff working within the Acute sector or the Community Nursing service are required to have current active registration with the Nursing and Midwifery Council (NMC). The Continence Nurse Advisor is a postholder who has active Registration with the NMC, possesses a Specialist Practitioner Qualification as a District Nurse and who has also undertaken additional training in the fields of Urinary and Faecal Incontinence.

The Continence Nurse Advisory Service is provided in line with national clinical guidelines eg the Royal Marsden Manual of Clinical Procedures, Association for Continence Advice (ACA) Guidance as well as guidance from Health Protection Scotland eg Care Bundle for preventing Catheter Associated Urinary Tract Infections (CAUTI).

What We Do

Continence services are provided across the NHS Board area at 2 different levels.

As part of the admission process either to hospital or to the District Nursing caseload, individuals will have a holistic assessment of their healthcare needs carried out. This assessment will include exploring whether the individual has any continence issues, either urinary or faecal. If continence issues are identified a more detailed assessment is then undertaken to assess the likely causes and then a treatment plan can be put in place.

The Continence Nursing Advisory Service offers a specialised assessment and treatment plan for adults who have bladder, bowel and or prolapse problems with or without incontinence. The Continence Nurse Advisor will:

- conduct an initial assessment which will include a detailed discussion about the history of the problem;

- discuss any medications taken; and
- test a sample of your urine.
- An ultrasound examination of the bladder and a physical examination may be required.

The overall aim of the Continence Advisory service is to

- promote continence;
- manage incontinence; and
- improve an individual's quality of life.

Our Customers

The Continence Nurse Advisor accepts the following referrals:

- Self referrals from anyone with a continence problem; and
- Referrals from all health care professionals. These should be made in writing or email and sent to the Continence Advisory Service at the Independent Living Centre, Gremista, Lerwick.

Referrals regarding children and adults with a Learning Disability should be made in writing to the Learning Disabilities Nurse in the first instance.

The Continence Advisory Service is based at the Independent Living Centre, Gremista, Lerwick and is available on Thursdays and Fridays each week between 09.00 and 17.00 hrs.

Whilst the service is based at the Independent Living Centre, individuals with continence issues can be seen in a variety of locations eg a home, in a care centre or at the nurse led clinic which is held the first Friday of every month in the Out patient's Department, Gilbert Bain Hospital. The Continence Advisory services provides a Shetland wide service.

The service is supported by a multi-professional team and supports individuals with continence related issues which have been referred from either General Practitioners in primary care or by local or visiting Consultants in secondary care.

Services provided by the Continence Nurse Advisor are

- full clinical assessment;
- bladder residual scan;
- pelvic floor exercises post pelvic floor repair;
- bladder re-training;
- intermittent self catheterisation and dilatation;
- advice on complex elimination problems;
- catheter management advice; and
- product advice and fitting for containment products.

Training and education is also provided for professionals, carers and informal carers

The Continence Nurse Advisor has a caseload size of 35-40 individuals at any one time.

The Continence Service which supports individuals with the provision of containment devices, eg incontinence pads, has approx 430 individuals on the register. These individuals receive products free of charge from the NHS. Individuals in receipt of continence services live in a community setting, either in their own homes or in a residential setting. All individuals on the register have a 6 monthly review scheduled with either the District Nursing team or Continence Nurse Advisor, depending on the complexity of the individuals continence issues. Six monthly patient and product review is a nationally recognised standard for continence services.

Our Costs and Income

Basic continence assessments are undertaken by all Registered Nurses and the costs of this is part of the overall cost of which ever service they are employed in.

The Specialist Continence Nurse Advisory Service has 0.4 whole time equivalent staff. There is no capital budget. This is detailed below:

Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management (managed within Community Nursing service)					
Continence Nurse Advisor	0.4wte				
Containment Products		£87,000			Nil
Service Total	0.4wte	£87,000			

Funding and resources

The assessment and management of Continence issues is a core part of the role of all Registered Nurses.

The Specialist Continence Nurse Advisory Service provides an enhanced level of specialist nursing resource for the assessment, management and treatment of individuals with complex continence issues. This dedicated post is funded from the NHS Board core funding.

The costs of all containment products are met through the NHS Board core funding.

Aims and Objectives

The aims and objectives of the Continence Advisory Service are

- To promote continence and manage incontinence in a clinically efficient manner, based on best practice and current research.
- To progress a community based continence nursing service which is available to the population of Shetland, on a Shetland wide basis.
- To provide education, training and development for medical, nursing and care staff in relation to continence care.
- To contribute to operational and strategic planning decisions about continence management issues in Shetland and work in partnership with colleagues in the community, within care settings and hospitals acting as a resource for all who require assistance or support with issues relating to continence care and management.

Continence Nursing Service Plan 2015/16

Directorate Plan Aims	**Action**
People are able to look after and improve their own health and wellbeing and live in good health for much longer	Individuals with a continence issue will be supported to regain continence, where possible, or if re-gaining continence is not possible will be supported to manage incontinence and thus improve their quality of life
People including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	The promotion of continence or management of incontinence will assist individuals to live independently at home or in a homely setting for as long as possible
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	The promotion of continence or management of incontinence improves the quality of life for people who have a continence issue

Service Aims/Priorities	**Objectives/Actions**
There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish.	Individuals will have their quality of life and ability to maintain an independent lifestyle for longer by having their continence needs addressed, either by promotion of continence or appropriate management of incontinence
The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so.	The continence services provided by either the District Nursing service or specialist Continence Advisory service supports the delivery of a local service to individuals throughout Shetland.

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15		
Description	**Delivered Early/on-time/late**	**Achieved original intention?**
Develop service database to record activity undertaken in relation to supporting patients with continence issues to manage/treat these issues	Delivered	Database in place which can be used to inform future service planning
Review Continence Documentation and Guidance ensuring it is accurate, up to date and fit for purpose	Delivered	Documentation reviewed to ensure compliance with latest guidance. Training and support provided for staff on completion of documentation.
Develop resources to support the delivery of the Continence Service.	Delivered	Resources developed to publicise service and open drop in session held thus helping to reduce stigmatisation of incontinence and provide support/treatment for those with a continence issue

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Provision of training in Continence care for health and social care staff	Continence Nurse Advisor	Ongoing		No. of staff trained	Increased knowledge for health and care staff in managing continence
Provision of training on Catheter insertion and care for health staff	Continence Nurse Advisor	Ongoing		No. of staff trained	Enhanced knowledge and skills for Registered Nurses in insertion of catheters (Male, Female and Suprapubic)

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Promote use of CAUTI bundle across acute and community based services	Continence Nurse Advisor	April 2015	Ongoing	Reduction in numbers of Catheter Acquired Urinary Tract Infections	Enhanced quality of life for individuals living with an indwelling urinary catheter

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Increase nurse-led clinics	Continence Nurse Advisor	April 2015	September 2015	Increased number of people seen	Increased number of individuals seen and treatment plans put in place to help address their continence problem
Further develop resources available to support individual patient care eg utilising technology such as “continence apps” to help with understanding of the causes of problems and treatment plan concordance	Continence Nurse Advisor	April 2015	Ongoing	Better concordance with treatment plans	An individualised approach taken to continence management and an overall enhanced quality of life for the individual upon successful completion of the treatment plan

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

Within the next twenty years there will be fewer people of working age to care for our older population.

Nurses need to become more “enablers“ than “doers”. There is a continuing shift in the pattern of disease towards long term conditions and we are striving towards the patient becoming an “expert” in the management of their own health.

The geography of Shetland can cause inequalities i.e. access to services. The retention of staff and the economics of managing a small remote and rural health board can also have its problems.

One of the key risks to care delivery can be the risk of infection and the Scottish Patient Safety Programme which evolved in 2008 in the acute sector, now looks at risks in primary care.

We are looking at the events which can cause avoidable harm.

The use of “care bundles “are now being successfully implemented in Shetland NHS.

The CAUTI bundle (catheter acquired urinary tract infection) is used for all patients in the community who have an indwelling catheter in place.

It comprises of a number of steps needed to effectively and safely deliver care to patients who are at a greater risk of infection. It ensures every step is performed every time and the process can be safely audited.

Anticipatory care programmes are now in place to reach out to those who are at greater risk.

In terms of the provision of the Continence Advisory Service there is an inherent risk in this service in that it is provided by a single postholder, on a part-time basis. A full needs assessment requires to be conducted in the future which is likely to indicate that this staffing resource is inadequate to meet the population need. Consideration therefore needs to be given as to how we would meet this additional identified need which could be through upskilling more of the generalist District Nursing staff to be able to undertake some of the more complex assessments, however, there would be capacity issues in the overall service to support this move as well as an additional cost in investing in more training for a greater range of staff.

Currently the risk of a single handed postholder has been mitigated to some extent by having a locally based postholder in the acute sector with some additional knowledge. However this postholder’s knowledge is mainly in the field of urology as opposed to continence management. We also have in place a relationship with the Continence team based in NHS Grampian who also provide support and supervision for the Continence Nurse Advisor.

Prior to the appointment of the current Continence Nurse Advisor NHS Grampian staff did provide some additional support for local staff with patients with complex continence issues but this was limited by their capacity to undertake this on top of their own roles and responsibilities and therefore would not have been a longterm solution had we not been able to recruit to this position. Succession planning is therefore an important issue of concern for this service.

Performance Indicators

Key Service Indicators

Performance Measure	Performance 2014/15	Target 2015/16
Number of Catheter Associated Infections in individuals with an indwelling urinary catheter		
Number of staff who have received training in catheter care and management		
5% reduction in expenditure on containment products		£4350
Number of individuals satisfied with service provided		

Contact Details

Maureen Neasham Continence Nurse Advisor Independent Living Centre Gremista, LERWICK e-mail m.neasham@nhs.net Phone Number – 01595 743987	District Nurses Each Health Centre or Non-Doctor Island Contact Details in Telephone Directory	Edna Mary Watson Chief Nurse NHS Board Headquarters Montfield, LERWICK e-mail edna.watson@nhs.net Phone Number – 01595 743377

Criminal Justice Service
2015-16 Service Plan

Supporting Health and Care vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Council is required to produce a Service Plan for the following year. This Service Plan provides an overview of the Criminal Justice Social Work Service for 2015/16; the Criminal Justice Service is in the Community Health and Social Care Directorate. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks. Service plans are approved and "signed off" at Director Level as part of the Executive Manager's Employee Review and Development process.

Vision Statement

The Criminal Justice Service is committed to supporting the Community Health and Social Care Directorate's Vision of "To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community". The Criminal Justice service will do this by working collaboratively with partners to achieve a service that will help make communities safer, prevent victims and reduce crime.

Drivers for Change

Scottish Government's Redesign of Community Justice Services. http://www.scotland.gov.uk/Publications/2014/04/7616

Reoffending 2 Agenda. http://www.scotland.gov.uk/Topics/Justice/justicestrategy/programmes/reducing-reoffending2

Single Outcome Agreement Safer Outcome to reduce reoffending by 2%.

Statutory duty to consult on Community Payback Orders.

Service commitment to self evaluation.

Women who offend http://www.scotland.gov.uk/News/Releases/2012/04/womenoffenders17042012

Northern Community Justice Area Plan 2015-16 http://www.northerncja.org.uk/

Review of Community Sentences and Community Payback Orders.

About Us

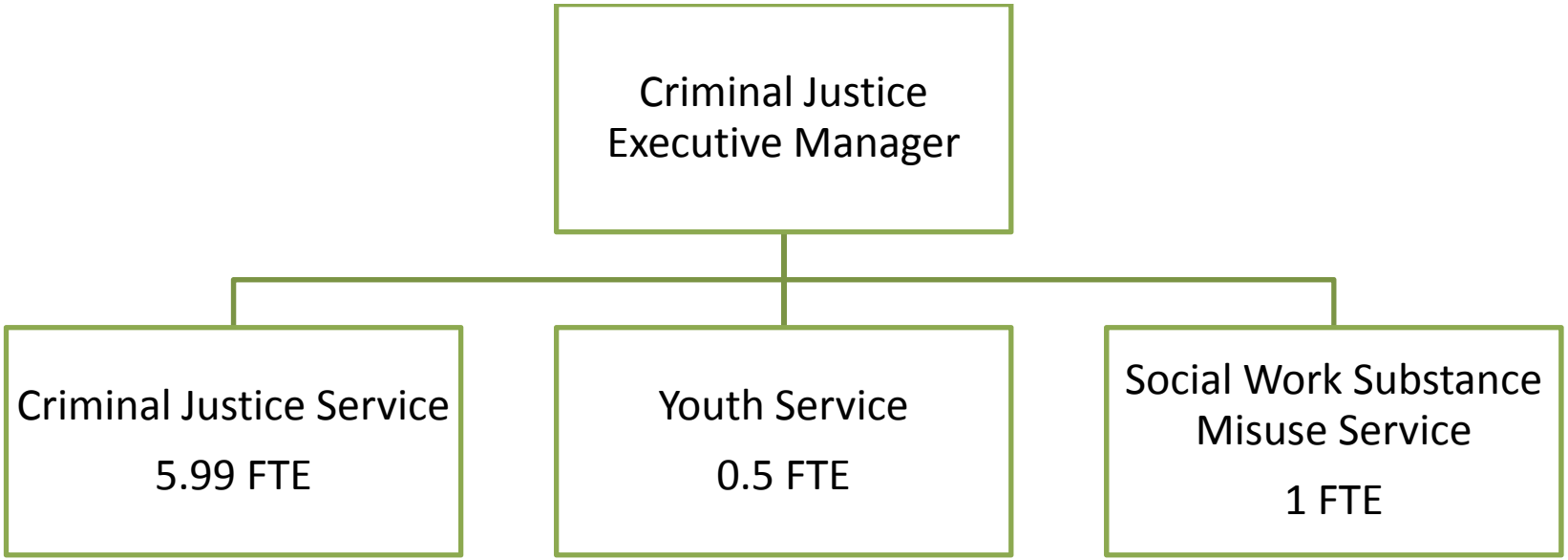
The Shetland Islands Council has had a statutory duty to provide criminal justice social work services since the implementation of the Social Work (Scotland) Act 1968. The service has evolved during this time from a general social work service to a specialist team, which was set up in 1997. The Service became part of the Community Care Department in 2011 following Council reorganisation and then part of the Community Health and Social Care Directorate in February 2014.

The Service comprises of a small team of professionally qualified social workers and support workers who undertake a range of statutory social work functions. The service is responsible for the delivery and development of all criminal justice social work services throughout Shetland. This includes the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences.

Who We Are

This Service sits within the Community Health and Social Care Directorate which is led by the Director of Community Health and Social Care. The following Services are also in the Community Health and Social Care Department: Adult Services, Adult Social Work, Mental Health, Occupational Therapy and Community Care – Resources. The team comprises of 1 FTE Manager, 2.5 FTE Social Workers, 0.5 Senior Social Worker and 1 FTE Support Worker who have responsibility for supervising clients on supervision requirements, diversion schemes etc and 2 FTE Support Workers who are responsible for running and supervising the Community Payback Unpaid Work Scheme and administrative tasks.

Organisational Chart



Locations

The Criminal Justice Service is located at the Grantfield Offices in Lerwick but is responsible for delivering services throughout Shetland and maintaining contact with Shetland residents who are in Prison throughout the United Kingdom.

Governance

The Criminal Justice Social Work Service, as part of the Community Health and Social Care Directorate, reports to the Integrated Joint Board. The Service's performance is reported to the Directorate Management Team monthly and key performance indicators from this plan are reported to the Integrated Joint Board quarterly as part of the Directorates performance report. The Service also reports performance management information to the Northern Community Justice Authority, which has responsibility for the funding, quality assurance and strategic planning of community justice services for the north of Scotland.

Regulation and Compliance

The delivery of Criminal Justice Social Work services and our statutory responsibilities are influenced by several pieces of legislation. Primarily:

The Social Work (Scotland) Act 1968

The Management of Offenders Etc. (Scotland) Act 2005.

The Criminal Justice and Licensing (Scotland) Act 2010

All social workers within the service are registered with the Scottish Social Services Council. The title of Social Worker and some of the duties of a social worker are protected and only those who are suitably qualified and registered can undertake this role. The SSC sets out standards that must be met by each professional in order to remain registered. Social Care staffs also have their own professional body who contribute to national policy and development of the profession.

http://www.sssc.uk.com/

http://www.socialworkscotland.org/

What We Do

This service is responsible for the:

The development, delivery and management of community-based sentences, as an effective alternative to custody.

The supervision and management of offenders from the point of them appearing in Court to the end of a community based or prison sentence. The main community based sentence is called a Community Payback Order. The Community Payback Order provides sentencers with a menu of nine requirements from which one or more can be imposed. The main two requirements are a Supervision Requirement and Unpaid Work Requirement. Individuals who are made subject to a supervision requirement will be required to undertake programme work to address the reasons why they offend and help them to build a more positive lifestyle and reduce their likelihood of reoffending. The Unpaid Work

Requirement subjects an offender to undertake a certain amount of hours of unpaid work within their community. This enables the offender to payback for their crime in a very productive manner, as well as learning new skills to aid rehabilitation.

Risk Management of sexual offenders and high risk violent offenders, through Multi Agency Public Protection Arrangements.
http://www.scotland.gov.uk/Topics/Justice/policies/reducing-reoffending/sex-offender-management/protection

Rehabilitation of individuals who are returning to Shetland following a prison sentence.

Operating a Diversion from Prosecution Scheme which enables certain individuals who commit crime to receive the support they require without having to be prosecuted.

We aim to achieve national outcomes for reducing offending behaviour by working with partner agencies to provide individual offender plans that will address offending behaviour. These will include cognitive-behavioural work programmes, encouraging pro social attitudes and values, linking into learning and employment opportunities and supporting individuals with daily living skills and safe accommodation.

Our Customers

The Criminal Justice Social Work Service works with individuals over the age of 16 years who have committed a crime and have been referred to the service by our partners in the criminal justice system.

We work with the court and fiscal service on behalf of our community in providing effective offender management in the community.

We also offer support and advice to family members.

Our Costs and Income

The Service has [around] 7.49 full time equivalent staff and annual net expenditure of £ 9,834 [and no capital budget]. As detailed below:

Health & Social Care – Criminal Justice Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1	63,735	63,735	0	Nil
Criminal Justice	5.99	261,186	267,085	-5,899	Nil
Youth Crime	0.5	15,733	0	15,733	Nil
Criminal Justice Service Total	**7.49**	**340,654**	**330,820**	**9,834**	**Nil**

Funding and resources

Funding for Criminal Justice Social Work Services is allocated by the Northern Community Justice Authority on an annual basis. The funding covers the meeting of statutory duties. The service works collaboratively with other statutory and third sector partners in Shetland to ensure that offenders receive the assistant and support their need to stop their offending behaviour.

Aims and Objectives

This section is about how Corporate and Directorate Aims are supported by Service Plan Objectives.
Our **"Aims**" are what we want to achieve, our **"Objectives**" are what we will do to achieve those aims.

Directorate Plan Aims	Action
Redesign of Community Justice Services	Work with the Shetland Partnership in the transition to CPPs taking responsibility for the reducing reoffending agenda. Offenders within Shetland have the best opportunities to make positive changes to their lives and reduce the likelihood of reoffending. Consider ways of ensuring the sharing of best practice across NCJA area.
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	There will be in place a system of team working which recognises and values individuals' skills and knowledge, provides good professional supervision and encourages joint training and secondment opportunities and works to meet the needs of our customers. There will be in place a seamless method of service delivery, not restricted by organisational or professional boundaries – modelled on a "one-stop-shop" methodology. There will be an individual within Shetland who is publicly recognised as being the manager of each service area.

Service Aims/Priorities	Objectives/Actions (Details below)
To provide effective community based disposals as an alternative to prison. To operate an effective Unpaid Work Scheme in which offender's payback to their community for their actions.	To provide high quality informative reports and risk assessment to courts to assist with sentencing. To challenge offending behaviour and assist individuals to recognise the harm their behaviour has on others. Assist with problems related to offending such as drug and alcohol misuse To identify unpaid work placements that will enhance services within local communities.

	To help offenders develop skills that they will be able to use in future employment.
Work with the Northern Community Justice Authority to ensure statutory requirements are met.	Quarterly submission of Improvement and Performance and quality assurance data to the NCJA. Ensure strategy and service development meet local need and the NCJA area plan.
Make Shetland a safer place to live through effective risk management of high risk sexual and violent offenders.	Fully contribute to Multi Agency Public Protection Arrangements and ensure service compliance to standards and outcomes.

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Deliver Statutory Core Social Work Services	Delivered on time	Delivered on time and within budget.
Implement the RESPECT programme for working with men who are violent towards women.	Training delivered and now running programme.	Reduce violence towards women.
Establish working protocols with Women's Aid who will be working with the female victims.	On course to be delivered on time.	Ensure victims of domestic violence are supported.
Improved advertisement of unpaid work projects.	Advertised on a regular basis.	Communities aware of the good work undertaken by offenders.

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Redesign of Community Justice Services	CJ CPP	June 14	2016	Work with the Shetland Partnership in the transition to CPPs taking responsibility for the reducing reoffending agenda. Consider ways of ensuring the sharing of best practice across NCJA area.	Successful transition to new arrangements. Offenders within Shetland have the best opportunities to make positive changes to their lives and reduce the likelihood of reoffending..
Inspection of MAPPA	CJSW /POLICE/HEALTH	TBC		Participate in the National thematic inspection of MAPPA	Ensure public protection arrangements are robust and fit for purpose.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Promote use of community sentences as an effective and robust alternative to custody. Provision of gender specific support / interventions for females	CJSW CJSW	April 15 June 15	Mar 2016 Jan 16	Take forward actions arising from 2014-15 review of Community Sentences and national evaluation of CPOs Progress actions as identified by NCJA Women's service development worker	Services for offenders are evidence led and outcome based. Improve outcomes for those women becoming involved in the criminal justice system and reduce the likelihood of their offending.
Implement the Moving Forward: Making Changes Programme (programmed work for individuals who are convicted of committing sexual crimes)	CJSW	TBA		Facilitate roll out to Island Authorities. Set up local delivery structure and arrange staff training.	Sex offenders have increased opportunity to reduce the likelihood of their offending. Safer Communities. Staff are well trained and supported to deliver complex behavioural change programmes.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Implement the extension of MAPPA to serious violent offenders.	CJSW	TBA		Action as appropriate once details of implementation confirmed.	Safer communities through multi agency public protection arrangements.
Ensure Provision of appropriate throughcare services to support community re-integration.	CJSW SPS	TBC		Ensure provision of appropriate support for offenders in prison. Develop agreements with HM P Grampian on prison/community relations.	Reduction of barriers to successful integration for offenders returning to Shetland from prison Improved contact with families during sentence.
Continue to promote the use of Fiscal and Police Direct Measures.	CJSW	July 15	Sept 15	Facilitate the roll-out of Fiscal Work Orders.	Reduce individuals gaining a criminal record. Fewer people appearing in Court.

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

U Risk Rate	Residual Risk Profile	Current Risk Rating	Risk Ref	Risk	Details	Resp Officer	Control Measure	% Complete
0	M	9	07	Breach of legislation	Failure to deliver statutory duties	DM	Appointment of qualified staff, ongoing CPD. QA of work and staff supervision.	
0	H	12	26	Professional Other	Loss of key staff	DM	Well supported workforce. Appropriate skill mix	
0	M	6	03	Redesign of Community Justice Services	CPP taking over responsibility for the reducing reoffending agenda. Lack of knowledge and governance.	DM	Lead on the implementation of the redesign, support partners to understand new responsibilities.	
0	M	6	12	Accidents / Injuries to staff and clients	Accidents or injury to staff. Clients on unpaid work	DM	Risk assessments, Lone working policy, health and safety training.	
0	M	6	10	Professional errors and omissions.	Inadequate assessments and management plans. Human Error	DM	Well trained and supported staff. Quality Assurance Procedures.	
0	H	12	26	Lack of social work qualified managers across statutory services.	Difficulty sustaining manager cover for standby system. Missed timescales for undertaking social work complaints.	CSWO	Raised with Director. Chief social work officer to raise with Chief Executive. Other options to be discussed.	

Performance Indicators

Performance Indicators from Council Wide Performance Measures

Indicators / Measure	Council		Community Health and Social Work Directorate		Criminal Justice Service		Performance Statement	Improvement Statement
	2014/15 (Projected)	2015/16 Target	2014/15 (Projected)	2015/16 Target	2014/15 (Projected)	2015/16 Target		
Sickness Absence Rates	3.9%	3.9%	5.8%		4.2%			
Employee Review and Development Meetings held in Policy Period (Mar-May)	26%	100%	18%	100%	0%	100%		
Employee Review and Development Meetings held in the previous 12 months (as at Jan 2015)	57%	100%	43%	100%	50%	100%		
Return to Work Interviews	N/A	100%		100%		100%		

Key Service Indicators

Performance Measure	Performance 2012/13	Performance 2013/14	Performance 2014/15	Target 2015/16	Performance Statement	Improvement Statement
Court reports submitted on time	100%	100%		100%	Meeting targets.	Continue with good practice.
Offenders commencing supervision within 7 working days of being sentenced.	100%	100%		100%	Offenders are generally seen immediately following court appearance where an appointment time is given.	Continue with current arrangements.
Unpaid Work commenced within timeframes.	100%	93%		100%	The scheme was redesigned in order to meet Government guidelines and this has enabled the service to maximise the agreed outcome for swift justice.	Continue to monitor situation.
Risk and need assessment completed and case management plans in place within 20 days.	81%	100%		100%	All offenders subject to a supervision requirement have a thorough risk assessment and case management plan completed.	To continue with current practice and evidence through the quality assurance and audit of case files.

Reduction in the level of assessed risk and need.	n/a	n/a	n/a	75%	Offenders and supervising officers report positive outcomes for those individuals who are subject to supervision and unpaid work. This is also commented on during inspections.	Follow "what works" interventions. Continue to work with partner agencies to improve outcomes for offenders.
Percentage of offenders completing sentences with no other criminal convictions.	96%	89%		90%	This indicator will provide some evidence of repeat offending but only for those who have appeared at Court. It will not include those who have offended but not appeared in Court.	Continue to work with the reducing reoffending agenda.

Service Performance Indicators from the Local Government Benchmarking Framework

Indicator	Scotland 2012/13			Shetland				Performance Statement	Improvement Statement
	Min	Avg	Max	Year	Value	Rank	Target		
SW4 - % of Adults satisfied with social care or social work				**11/12**	24.34	23		Consistently deliver a high level of care into people's homes as an alternative to receiving residential care services.	Continue to work closely with agencies and integrating services to enable people to stay at home for longer. It should be noted that reablement and telecare services also enable people to stay at home without necessarily delivering an 'intensive care' package.

Contact Details

Criminal Justice Service
Grantfield Office
Lerwick
denise.morgan@shetland.gov.uk

Phone Number: 01595 744449

Domestic Abuse Services / Domestic Abuse Partnership 2015-16 Service Plan

Introduction

Every year, each Service within the Council is required to produce a Service Plan for the following year. However Domestic Abuse services in Shetland are delivered by a number of organisations and departments within the Voluntary Sector, Shetland Islands Council. Police Scotland and NHS Shetland, which are overseen through the Shetland Domestic Abuse Partnership.

This Service Plan provides an overview of the work of the Domestic Abuse Partnership for 2015/16, the Domestic Abuse Partnership Service reports to The Community Safety and Resilience Board which in turn reports to the Community Planning Partnership. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Domestic Abuse Partnership is committed to contributing to the 'Safer' Outcome in the Shetland Community Plan and Single Outcome Agreement: Shetland stays a safe place to live, and we have strong, resilient and supportive communities

Drivers for Change

Policy Context

The Scottish Government provides strategic direction and leadership on tackling GBV. In 2003, the Scottish Government set out its National Strategy on Preventing Domestic Abuse which had short term and long term goals for the prevention of domestic abuse in Scotland. The current framework is *Safer Lives: Changed Lives: A Shared Approach to Tackling Violence Against Women in Scotland. (2009)* www.scotland.gov.uk/Publications/2009/06/02153519/0

This recognises that while male on male violence is the most common form of general public violence, there are a number of crimes, acts of violence and abusive behaviours that are perpetrated mostly by men and affect women and children disproportionately. Included in these are domestic abuse, rape and honour crimes, all of which have their roots in the inequality between men and women in society.

Safer Lives: Changed Lives sets out the shared approach to tackling violence against women in Scotland. It aims to support those working towards this by providing a definition, guiding principles and a suggested focus for future work.

Scottish Government and COSLA are currently developing Scotland's Strategy to Tackle Violence Against Women and Girls '*Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls (2014)* www.scotland.gov.uk/Resource/0045/00454152.pdf which will be formally launched in 2015 .

The Shetland Domestic Abuse Strategy 2013-16 www.shetland.gov.uk/news-advice/documents/SDAPStrategy2013-16.pdf sets out how the Partnership will continue to address and prevent domestic abuse and gender-based violence in Shetland over the next three years in line with the National Strategies, by building on the progress made by the previous Domestic Abuse Strategy, which was implemented between 2008 and 2011.

There has been no recent in-depth needs assessment work to date for domestic abuse.

Unmet needs/Drivers for change

- Recognition of the actual incidence or potential for other gender based violence issues in addition to domestic abuse including human trafficking; forced marriage; sexual assault and rape; childhood sexual abuse; harmful traditional practices; stalking and sexual exploitation.
- Lack of sufficient refuge accommodation.
- Clients are presenting to services with increasingly complex needs.
- As awareness raising, publicity and routine enquiry is further developed and implemented, then more people who have experienced domestic abuse are likely to present or be identified.

About Us

Tackling domestic abuse in Shetland is co-ordinated and overseen by the multi-agency Shetland Domestic Abuse Partnership (SDAP), which is a formal multi-agency approach to addressing domestic abuse and other forms of violence against women in the context of gender based violence. The Partnership reports to the Shetland Community Safety & Resilience Board (CSRB), one of the key strategic partnerships for community planning in Shetland**.** We have an overarching Domestic Abuse Strategy (2013-16) and an action plan that is updated annually. A number of local services and organisations, both public and voluntary sector, are involved in this work; this includes dedicated specialist services such as Women's Aid and generic services such as housing.

Domestic abuse can involve physical, sexual, emotional and psychological abuse and violence, and can be perpetrated by current or former partners. It more likely to be violence or abuse by men against women but not always, women can be perpetrators as well as victims / survivors; and it can occur in both heterosexual and same sex relationships. Domestic abuse is often hidden. It can result in physical and

mental harm, and ultimately can lead to death. There is correlation between domestic abuse and the mental, physical and sexual abuse of children. Domestic abuse can potentially result in an adult protection scenario, or child protection issues.

In recent years, the domestic abuse agenda has widened to include other forms of gender based violence including: harmful traditional practices, sexual harassment and stalking, commercial sexual exploitation, childhood sexual abuse; rape and sexual assault and human trafficking; and we are now recognising these as current or potential issues in Shetland.

Who We Are

The needs of people affected by domestic abuse cannot be met by a single service alone. The following services in Shetland are involved in delivering the action plan:

Shetland Women's Aid

Shetland Islands Council

- Adult & Child Protection
- Adult Services Social Work
- Children & Families Social Work
- Community Care Social Work
- Community Safety
- Criminal Justice Social Work
- Housing Service
- Schools Service

Police Scotland

NHS Shetland (including Maternity, A&E, Primary Care ; community nursing and health visiting, public health and mental health services**)**

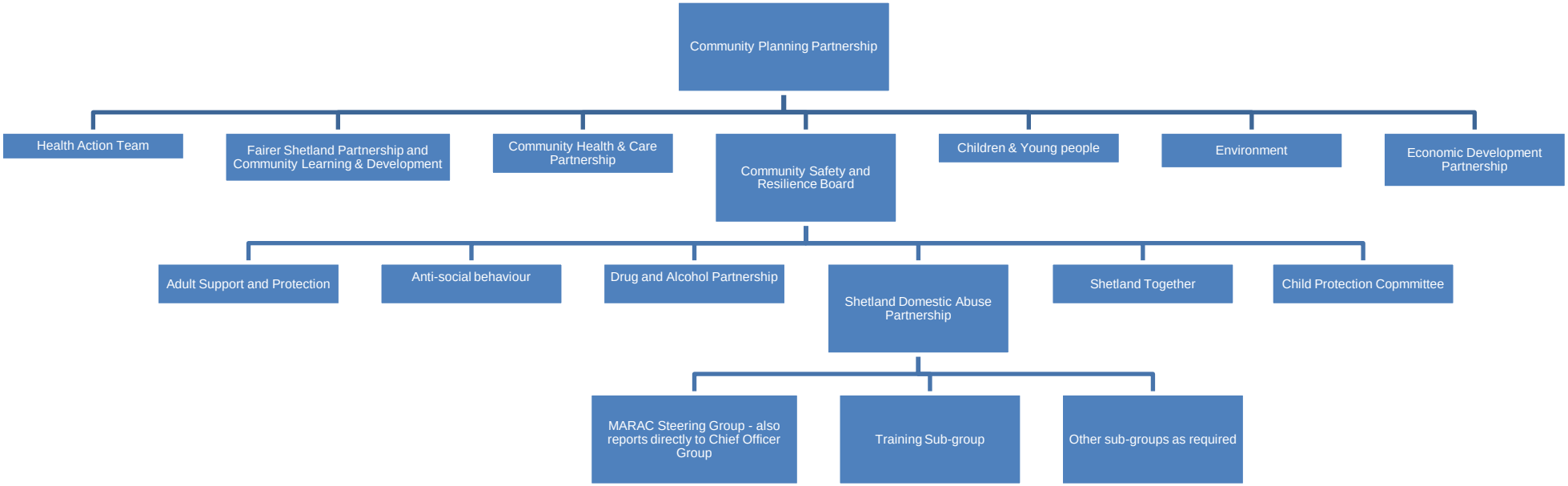
Victim Support Shetland

Community Alcohol & Drugs Services Shetland

Hjaltland Housing Association

The Domestic Abuse Partnership is chaired by a member of the Partnership (currently there is an interim chair).

Organisational Chart



Locations

Services are delivered across a number of locations depending on the organisation or team. Shetland Women's Aid is based at St Olaf St in Lerwick.

Governance

The Domestic Abuse Partnership reports to the Community Safety and Resilience Board on a quarterly basis.

The MARAC core group reports to the MARAC Steering Group, which in turn reports to both the Shetland Domestic Abuse Partnership and the Chief Officers' Group.

All the individual departments and teams have their own Governance structures (refer to individual service plans).

Regulation and Compliance

Refer to the service pans of individual departments.

What We Do

The only service from this list above (Who Are We) that is dedicated to domestic abuse in Shetland Women's Aid which is a registered charity offering counselling, advice and support to women, children and young people. It also provides refuge accommodation for women, and their children, who are being or have been physically, emotionally or sexually abused. The accommodation can only house one family at a time.

In 2013, the MARAC (Multi-Agency Risk Assessment Conference) was launched in Shetland. This is a monthly, local meeting where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the Independent Domestic Abuse Advocate (IDAA), a risk- focused, co-ordinated safety plan can be drawn up to support the victim. In Shetland the MARAC is overseen by a Steering Group that reports to the Domestic Abuse Partnership. There is dedicated funding and staffing for this service.(see below)

Information on the roles of other services can be found in their individual service plans and here (SDAP Directory of Support Services) http://www.safershetland.com/assets/files/Signposting%20Leaflet%20(V2%20June%202013).pdf

Our Clients

The Partnership is committed to raising awareness, challenging beliefs and behaviours and preventing domestic abuse across the whole Shetland population.

There is work with specific groups including young people and training for staff.

Specific frontline services are provided for people who are experiencing or have experienced or been affected by domestic abuse and other forms of gender based violence.

Needs

It is difficult to get accurate information on the prevalence of domestic abuse in Shetland and the resultant health and social care needs because data is collected by a number of agencies, in different ways. And we know that domestic abuse is often hidden, and many victims may not present to services, or may not be recognised as being affected by domestic abuse or other forms of GBV. However, we may also 'double count' because victims / survivors may present to multiple agencies.

We have no reason to think that the prevalence and effects of domestic abuse are significantly different from Scotland as a whole. We know that in Scotland at least one in five women will experience domestic abuse in their lifetime and that the number of reported incidents of domestic abuse steadily increase each year.

Most of the local data that we have is based on demand for services, and so does not include people who do not present to services, or seek help. There is some 'routine enquiry' in some NHS Services which aims to identify people affected by domestic abuse by asking about it routinely in settings where victims / survivors are more likely to attend, even if not overtly because of domestic abuse, for example A&E and the Sexual Health Clinic. It is also routine to ask in maternity, because the risk of domestic abuse increases during pregnancy.

Shetland Women's Aid service provision data (summary)

	2010-11	**2011-12**	**2012-13**	**2013-14**
Total number of women who were active clients	59	51	60	64
Total number of children and young people (CYP) who were active clients	38	38	36	38
Number of women & CYP provided with refuge accommodation	3	6	15	22
Total number of women & CYP in need of refuge accommodation who could not be offered it due to lack of resource	30	20	32	60 (small increase in number of families – but larger families)

Shetland Women's Aid has identified the following trends:

- The numbers of referrals are increasing
- They now have a waiting list for the first time
- There are more clients requiring more intense, complex support
- There has been an increase in the number of sexual assaults and rapes.
- There has been a small increase in the number of women and children and young people seeking access to the refuge, and an increase in provision, but still a large number of women who cannot have their needs met

Police Scotland

Number of domestic abuse incidents recorded by the police in Shetland (Local Authority area) for past ten years up to April 2013.

Year	2003-4	2004-5	2005-6	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2012-13
No. of incidents	32	39	60	48	51	42	37	70	103	101

NHS Shetland: Routine Enquiry
Routine enquiry involves asking all patients if they have experienced domestic abuse as part of their routine assessment. During 2013, 203 pregnant women were asked about domestic abuse, and five had been affected, either currently or in the past. 1050 patients were asked in A&E, and of these 13 had experienced domestic abuse.

Community Alcohol and Drug Services Shetland (CADSS)
CADSS collects information from new clients when they first attend the service. During 2013-14, 11 new clients said they were currently being affected by domestic abuse, as a victim 36 had been in the past. A further five were currently being affected as a witness, and 24 had previously witnessed domestic abuse. There were also six clients who identified themselves as current perpetrators, and eight who had been in the past.

MARAC
During the first thirteen months of operation (August 2013 to September the MARAC (Multi-Agency Risk Assessment Conference) had 37 referrals against a projected number of 40 per year (figure calculated by the national organisation CAADA Co-ordinated Action Against Domestic Abuse which evaluates and monitors MARACs.

Our Costs and Income

It is not currently possible to identify the total Domestic Abuse Services budget, however the budgets and workforce for the two services that are dedicated to Domestic Abuse (Shetland Women's Aid and MARAC) are outlined below. The funding and resources in other services and organisations that are used to provide domestic abuse services can not currently be separated out from their overall budget allocations and work force

Shetland Women's Aid
The Shetland Women's Aid Business Plan contains information on the funding and resources for this organisation, which is dedicated to tackling domestic abuse. It currently receives funding from the SIC, Big Lottery and Violence Against Women (Scottish Government) totalling £239,848 for 2014-15 (excluding MARAC funding). Current staffing consists of:

Role	Hours per week	No. of staff
Office Co-ordinator/MARAC Development Worker	30	1
Specialist Workers for women, children and young people	150	5
Children and Young Persons' Outreach Worker	14	1
MARAC Advocate	15	1

MARAC

In March 2012 Shetland Women's Aid, supported by the Shetland Domestic Abuse Partnership, was successfully awarded funding through the Violence Against Women (VAW) Scottish Government fund to pilot the MARAC. The initial pilot project is funded for 3 years. Women's Aid provides a MARAC Lead to manage the role out of this pilot, to collate all relevant information and report back to the VAW team. The following table shows the breakdown of the funding secured from VAW, Scottish Government by Shetland Women's Aid:

	Total Amount received	Women's Aid Salary	Advocate Salary	Coordinator Salary	Training/ other costs
Year 1 2012-13	£14,953.00	£11,093.00	£0.00	£0.00	£3,860.00
Year 2 2013-14	£54,579.00	£11,093.00	£19,493.00	£19,493.00	£4,500.00
Year 3 2014-15	£54,579.00	£11,093.00	£19,493.00	£19,493.00	£4,500.00
Totals	£124,111.00	£33,279.00	£38,986.00	£38,986.00	£12,860.00

Funding and resources

Refer to the individual service plans for information on savings targets.
Shetland Women's Aid and Shetland MARAC are dependent on external funding as noted above.

Applications are currently being made to the Scottish Government's Violence against Women fund for funding for Womens' Aid and MARAC from April 2015.

Aims and Objectives

The Domestic Abuse partnership has four priority areas (the 4 P's: Prevention, Protection, Provision, Participation), each with an overarching aim:

- Increase awareness and challenge attitudes to domestic abuse and gender-based violence (**Prevention**)
- Develop inter-agency working to increase the ability to protect (**Protection)**
- Provide accessible services to those people affected by domestic abuse (**Provision)**
- Have an inclusive interagency Partnership **(Participation**).

There are eight outcomes identified in the Shetland Domestic Abuse Action Plan (2013-16), each of which links to one or more of the aims (above):

- Those wishing to escape from domestic abuse / gender based violence have safe or alternative accommodation.
- Professionals are confident in identifying and dealing with domestic abuse
- Increased awareness within agencies and the public of what domestic abuse / GBV is, why it continues to happen and the effects it can have.
- Increased awareness within agencies and the public of where and how to access support for those experiencing domestic abuse / GBV
- Children and young people have an understanding of domestic abuse and GBV appropriate to their age and experience
- Reduced repeat occurrences of domestic abuse / GBV
- Increased access to justice for those who experience domestic abuse /GBV
- Provision of appropriate services for those people affected by domestic abuse / GBV

Domestic Abuse Services / Domestic Abuse Partnership Service Plan 2015/16

Service Aims/Priorities	Objectives/Actions 2013-16
Increase awareness and challenge attitudes to domestic abuse and gender-based violence (**Prevention**)	• Increase access to justice for those who experience domestic abuse /GBV • Reduce repeat occurrences of domestic abuse / GBV • Ensure children and young people have an understanding of domestic abuse and GBV appropriate to their age and experience • Increase awareness within agencies and the public of where and how to access support for those experiencing domestic abuse / GBV • Increase awareness within agencies and the public of what domestic abuse / GBV is, why it continues to happen and the effects it can have.
Develop inter-agency working to increase the ability to protect (**Protection)**	• Increase access to justice for those who experience domestic abuse /GBV • Reduce repeat occurrences of domestic abuse / GBV • Professionals are confident in identifying and dealing with domestic abuse • Those wishing to escape from domestic abuse / gender based violence have safe or alternative accommodation
Provide accessible services to those people affected by domestic abuse (**Provision)**	• Provide appropriate services for those people affected by domestic abuse / GBV • Professionals are confident in identifying and dealing with domestic abuse • Those wishing to escape from domestic abuse / gender based violence have safe or alternative accommodation
Have an inclusive interagency Partnership **(Participation**).	Cross cutting objective: ensure service user and stakeholder feedback is incorporated into service delivery and strategic planning in line with equality and diversity agendas

Detailed Actions/Plan for Change

Refer to:

Shetland Domestic Abuse Strategy 2013-16
www.shetland.gov.uk/news-advice/documents/SDAPStrategy2013-16.pdf

Shetland Domestic Abuse Partnership Action Plan 2013-16

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Evaluation of MARAC process by CAADA	On-time	Yes
Secure further funding for MARAC from April 2015 onwards	DUE to complete by end March 2015	

Ongoing Actions/Projects Started prior to 2015/16

Description	Start date/Comments	Expected Outcome
Review refuge provision in line with legislation (ie homeless) and best practice guidance and secure funding to implement appropriate provision by end 2016	Provision of existing refuge accommodation - ongoing 2013	Those wishing to escape from domestic abuse / gender based violence have safe or alternative accommodation
Ensure we engage with clients to understand housing needs	ongoing	Those wishing to escape from domestic abuse / gender based violence have safe or alternative accommodation
Continue to implement routine enquiry (NHS)	ongoing	Professionals are confident in identifying and dealing with domestic abuse
Implement CAADA-DASH MARAC training and	2013 – largely completed in 2013-14 but also	Professionals are confident in identifying and dealing with domestic abuse

protocols	ongoing	
Raising awareness with the judiciary and local legal staff on domestic abuse / GBV	2013 ongoing	Professionals are confident in identifying and dealing with domestic abuse
Deliver awareness raising sessions in schools and other youth settings in line with Curriculum for Excellence	2013 ongoing	Children and young people have an understanding of domestic abuse and GBV appropriate to their age and experience
Develop communications plan with support from SIC communications team	2013	Increased awareness within agencies and the public of where and how to access support for those experiencing domestic abuse / GBV
Promote services leaflet and develop internet links	ongoing	Increased awareness within agencies and the public of where and how to access support for those experiencing domestic abuse / GBV
Explore peer education approaches	2014	Children and young people have an understanding of domestic abuse and GBV appropriate to their age and experience
Undertake mapping and case review to inform a consistent initial approach across agencies	2014	Reduced repeat occurrences of domestic abuse / GBV
Deliver the RESPECT programme	2014 ongoing	Reduced repeat occurrences of domestic abuse / GBV
Explore options and availability re increasing access to justice.	2014	Increased access to justice for those who experience domestic abuse /GBV
Raise profile of civil / legal aid services with victims	ongoing	Increased access to justice for those who experience domestic abuse /GBV
Raise awareness with the judiciary of the difficulties of accessing legal aid (including attending faculty meetings)	ongoing	Increased access to justice for those who experience domestic abuse /GBV
Continue to offer support and counselling for women	ongoing	Provision of appropriate services for those people

who experience DA/GBV (Womens' Aid)		affected by domestic abuse / GBV
Continue to offer support and counselling to children and young people experiencing domestic abuse and family breakdown (Womens' Aid)	ongoing	Provision of appropriate services for those people affected by domestic abuse / GBV
Develop rape crisis service	2014	Provision of appropriate services for those people affected by domestic abuse / GBV
Ensure all professionals are aware of services for men	ongoing	Provision of appropriate services for those people affected by domestic abuse / GBV

New Planned Actions Due to Start in 2015/16

Description	Start date/Comments	Expected Outcome
Develop and deliver an annual publicity plan to incorporate two national campaigns (for 2015-16)	April 2015 (if the Partnership has capacity)	Increased awareness within agencies and the public of where and how to access support for those experiencing domestic abuse / GBV
Update Annual Training Plan (for 2015-16)	April 2015 (if the Partnership has capacity)	Increased awareness within agencies and the public of where and how to access support for those experiencing domestic abuse / GBV
Further MARAC and CAADA DASH RIC training for key professionals Multi-agency training on managing high risk cases	April 2015 (if the Partnership has capacity)	Professionals are confident in identifying and dealing with domestic abuse Reduced repeat occurrences of domestic abuse / GBV

Work with media to increase understanding and appropriate reporting of domestic abuse and GBV: Develop protocol with local media on reported standards for DA/GBV incidents by December 2015	April 2015 (if the Partnership has capacity)	Increased awareness within agencies and the public of what domestic abuse / GBV is, why it continues to happen and the effects it can have.
Revisit Bail procedures with Sheriff including understanding the role of the DALO	Pending RESPECT training and operational guidance	Reduced repeat occurrences of domestic abuse / GBV

Risks to Delivery

During 2014, the SDAP chair and the Community Safety officer, who was the lead officer for the Partnership both left their posts. The chairmanship is currently being picked up on an interim basis. Some of the administrative functions of the lead officer role were picked up for a short time, but currently there is no dedicated lead officer and it is not yet clear how this role is going to be picked up in the future.

Womens Aid, like most voluntary sector organisations, is dependent on short term funding awards.

The current funding for the MARAC runs up to the end of March 2015; further funding is therefore being applied for.

Because the other agencies that are involved in tackling domestic abuse and gender based violence have this as only a relatively small part of their remit, there is a risk that services will be diminished as resources become more scarce for every service.

Performance Indicators

Strategy Monitoring & Evaluation

The Shetland Domestic Abuse Partnership is committed to reducing incidents of domestic abuse throughout Shetland, but to do this effectively it is important to monitor our progress, and regularly carry out self-assessments to ensure that all partners are effectively engaged in the process.

An Action Plan has been developed which details the various activities to be taken forward over the next 3 years by the Shetland Domestic Abuse Partnership. The Plan addresses the priorities highlighted in this Strategy and explains the actions to be taken locally to tackle domestic abuse throughout Shetland.

Progress in delivering this Action Plan will be monitored annually by the Partnership and a review of the Plan will be carried out in 3 years. The results of this will be reported through the:

- Shetland Community Safety Board
- And from there, to the Shetland Partnership.
- And the appropriate committees of:
- Shetland Islands Council
- Police Scotland
- NHS Shetland
- Individual voluntary sector agencies

Service Performance Measures from the Shetland Single Outcome Agreement

Shetland's Single Outcome Agreement (SOA) 2012-2015 contains the following local outcome relating to domestic abuse:

- Shetland stays a safe place to live, and we have strong, resilient and supportive communities
  However, by achieving the actions set out in our Action Plan we will also have a positive impact on a number of other outcomes, namely:
- All our children have the best start in life and we have improved the life chances for any children, young people and families at risk
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens
- We have tackled 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

There is one action within the SOA: Further develop MARAC in conjunction with partners focussing on a multi-agency approach to supporting and protecting victims.

There are no specific indicators related to domestic abuse.

Other Performance indicators

MARAC has a suite of performance indicators. The performance reports are marked as confidential / classified therefore the performance figures are not reported here.

Indicator	2014/15	Target 2015/16
No. of cases discussed		CAADA estimates 40 cases should be identified in our population
No of children		n/a
Referrals from partner agencies		CAADA recommends at least 25-40%
Referrals from Police Scotland		CAADA recommends 60-75%
Repeat referrals		CAADA target, no more than 28-40%
BME referrals		n/a
LGBT referrals		CAADA estimates 5%
Referral where victim has a disability		CAADA estimates 5%
Referral where victim is male		CAADA estimate 4-10%
Agency attendance at MARACs		Target 100% for core agencies (SIC Children and families – as required)
Number of actions		n/a
Referral of cases to MARAC co-ordinator within 1 working day		100%
Referral of cases to IDAA within 1 working day of receipt		100%
MARAC list circulated to MARAC core group 8 working days prior to the meeting		100%
MARAC meeting meetings circulated within 5 working days of MARAC meeting		100%

Contact Details

Shetland Domestic Abuse Partnership (Interim) Chair: Dr Susan Laidlaw at NHS Shetland via email: susan.laidlaw@nhs.net	**MARAC Lead / Chair of Steering Group** Colleen Flaws at Shetland Women's Aid on 01595 692070 or via email: colleen_w.aid@hotmail.co.uk	**MARAC Co-ordinator** Sara Fox at SIC on 01595 744572 or via email: sara.fox@shetland.gov.uk	**MARAC Chair** Lindsay Tulloch at Police Scotland via email: lindsay.tulloch@northern.pnn.police.uk	**Safer Shetland Website, Domestic Abuse webpages**: www.safershetland.com/domestic-abuse

Health Improvement and Health Inequalities

2015-16 Service Plan

Supporting Health and Care vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Policy context

External and national drivers for taking a new approach to health improvement include:

- Increasingly challenging national targets (e.g. HEAT target for smoking cessation which is now focussing on the hardest to reach groups)
- Increasing emphasis on doing things 'with' people rather than 'for' them, including using co-production[1], enablement, and asset based[2] approaches
- Fewer public sector resources to meet increased demand due to factors such as changing demographics (the aging population) and global economics. This was the focus of the recent Christie Commission
- Changes in lifestyle and culture (for example more sedentary work and leisure pursuits, and the use of games consoles and portable devices)
- Changes in diet (for example increased consumption of processed and convenience food, and larger portion sizes)
- A persisting, and possibly worsening, inequality gap between the most advantaged and the most disadvantaged in our society

Aims

The overall aim of health improvement and health inequalities work in Shetland is to help people live longer, healthier lives. To do this we need to:

- reduce the key risk factors for poor health outcomes: substance misuse (smoking, alcohol, drugs) and obesity.
- tackle health inequalities by identifying and meeting the needs of the most vulnerable and hard to reach groups, and targeting services at those that are most in need.
- support people to reach their full potential at all life-stages – from birth and early years through working lives to old age.

[1] Co-production is a new vision for public services based on recognising the resources that citizens already have, and delivering services ***with*** rather than ***for*** service users, their families and their neighbours.

[2] Asset based approaches are based on the principles of appreciating and mobilising individual and community talents, skills and assets, rather than focussing on problems and needs

Achieving these outcomes requires commitment and action from the Integration Body and all partner organisations; and as such they are incorporated into the strategic outcomes of the Shetland Community Plan and the Single Outcome Agreement. It also includes a range of other health and care activity such as re-ablement, support for people with disabilities and mental health problems, and early years work.

Needs

There is a more detailed assessment of need within the overarching health improvement strategy and within each of the individual health improvement strategies. Key statistics for Shetland include:

- There are still approximately 3000 people who smoke
- According to GP figures, smoking rates are higher in the practices covering the more disadvantaged areas of Shetland
- In 2011 10% of pregnant women were smoking at booking
- In 2011/12 23.4% of primary 1 children in Shetland were overweight or obese (Body Mass Index - BMI on 85th centile or above)
- 220 people were discharged from hospital with alcohol related diagnoses in 2011-12
- Seven people died through suicide or deaths of undetermined intent in 2011

Current Services

There are a range of health improvement services and resources available for people and communities in Shetland, most of which are open access. There are also a number of training programmes, usually for staff and volunteers, but some are also open to members of the public. Many of the services listed below are delivered by the Health Improvement Team, but there are other providers including the voluntary sector, primary care and other NHS departments. Services include:

- '**Help Yourself to Health'** information and resources based in the Shetland public library
- **Keep Well** Health Checks in primary care and workplaces
- **Smoking Cessation** Services in primary care; community pharmacies; and drop in sessions
- **Weight Management** including Counterweight in primary care (for adults) and a range of Child and Family healthy weight interventions
- **Drug and Alcohol** services delivered by Community Alcohol & Drug Services Shetland and the NHS prescribing Clinic
- **Sexual Health and Wellbeing** Clinic; a Monday evening drop-in clinic at the Gilbert Bain Hospital
- **A pre-conceptual care** service for people planning pregnancy, which is provided through the maternity department by a specialist midwife.

- **Exercise on referral** as part of cardiac rehabilitation programme (with Shetland Recreational Trust)
- **Falls prevention work** in care centres
- **Healthy Working Lives**: includes advice, resources and training for employers and workplaces
- **ASIST (Suicide Prevention)** and **Mental Health First Aid training**
- **Improving Health: Developing Effective Practice** Training for healthcare and other workers

Other health improvement activities often delivered in partnership: including awareness raising and campaigns; preventative work (often with children and young people); other training events.

Unmet needs/Drivers for change

Whilst there is a wide range of health improvement services and activities available in Shetland, many of these are still centred in Lerwick (e.g. the drop in clinics, community pharmacy services and many of the training events) and people in the more remote and rural areas need better access to the same opportunities.

As well as geographical limitations, there are other restrictions on the services that can be provided because of our very small scale. This can result in widening the health inequalities gap by excluding some of the most vulnerable and disadvantaged groups from being able to access services. There is therefore an unmet need in making health improvement services and activities more accessible to all communities and groups that need them.

There are some specific areas of unmet need that have been identified, and these have not changed in the past year, including:

- Exercise on prescription for more groups (currently just for cardiac rehabilitation patients).
- Greater range of weight management interventions, particularly for those needing a more intensive intervention than Counterweight.
- Psychological interventions and support for individuals with complex needs struggling with behaviour change.

Key Risks to Delivery

The main risk is the requirement to achieve savings, which makes it harder to 'invest to save' in the way that we would like to do. We are addressing this through the use of volunteers, where at all possible, and think of ways to maximise the contributions of staff that we do have. We continue to have a lot of interest in any vacant posts that we advertise.

Funding and Resources

At present Health Improvement is funded through a mixture of core NHS Board funding and specific allocations. In recent years, the health improvement national funding streams have been bundled into 'Effective Prevention Bundles' for Child Healthy Weight Interventions, Sexual Health and Blood Borne Viruses, Smoking Cessation and Smoking Prevention. This has allowed for greater flexibility in using the funding for local priorities, compared to the previous more rigid funding streams. We have developed the core skills within the team (while making savings and being more efficient and effective in the way we work) to use our specialists flexibly across the different programmes. We use the national funding as core funding on the principle that we need the team to deliver the range of skills across topic areas, and increasingly as a resource to train and develop other staff, in clinical and other services, and to engage with communities to embed health improvement in mainstream services and help people to take responsibility for their own health and wellbeing.

Our aim is to use the resources available to us as our Health Improvement 'Invest to Save' fund, so the more detailed strategies / plans will show where the investment will be and how it will pay off in the longer term.

Plans for change

There are a number of areas of service development required to support the implementation of the Health Improvement Strategy. In the last year we have strengthened the public health information intelligence; particularly the use of data from primary care. This is essential to fully understand need, particularly in relation to inequalities and to monitor progress and outcomes. Over the last year, our staff have moved to become partially locality based, in order to develop stronger links with local communities, GP Practices etc, and this has been extremely successful in enabling us to share skills, increase confidence in delivery of health improvement programmes by other staff and increase accessibility of services.

However we still have work to do on:

- Increasing capability and capacity of non specialist staff to support health improvement, particularly in 'raising the issue' with patients and clients
- Increasing community based work, community capacity building and work in partnership with voluntary sector partners

Objectives / Actions:

Increase proportion of adults in Shetland who exercise at recommended levels through improving access to physical activity at a local community level:

- Further expansion of localities based activities such as health walks, aiming in particular to support the least active.
- Roll out of Laterlife chair based exercise programme following training course in early 2015
- Repeat Jogleader training and consider repeating Walk leader training
- Ensure HI involvement with Sports Hubs on locality basis – with specific remit to ensure inequalities addressed
- Implementation of physical activity brief advice and referral / participation pathways in secondary care settings (Health Promoting Health Service)
- Repeat Active Travel Survey & Re launch promotion of walking distances / times for work bases in Lerwick (Health Promoting Health Service)

Reduce percentage of adults who smoke through targeted smoking cessation, smoking prevention and tobacco control work

- Identify needs of Looked After Children & their carers in relation to smoking cessation and second hand smoke
- Respond to any national guidance or initiatives to ensure that the Smoking Cessation Service is appropriately responsive to people who use e-cigarettes
- Work with high smoking prevalence workplaces and minority ethnic groups to provide appropriate and effective smoking cessation services to these groups
- Work with Community Pharmacies to ensure that smoking cessation services are complementary targeted, with the most complex clients being able to access the specialist HI smoking cessation team
- Smoking in pregnancy: HI and maternity / health visiting to ensure that smoking cessation is considered pre-conception where possible; and as early as possible in pregnancy; and that smoking and smoking cessation are always raised with high risk mothers.
- Young people: discuss with OPEN if there is scope for a workshop on smoking / tobacco control

Reduce number of people admitted to hospital with alcohol related conditions through Drink Better Campaign and redesign of substance misuse services.

- Review Drink better initiative to ensure it is focused on the most disadvantaged and vulnerable groups, using social marketing techniques
- Through implementation of the new substance misuse service model, ensure improved access to support for the most vulnerable and disadvantaged people with alcohol (and / or drug) problems.
- Ensure health improvement / public health input to licensing issues including training for bar staff; supporting bar staff and community to deal with drunkenness and antisocial behaviour; enforcement of licensing laws
- Use Keep Well checks to identify people who may be more disadvantage or vulnerable, and need an ABI.
- Identify secondary care settings where there is scope to implement ABIs (Health Promoting Health Service)

Reduce prevalence of mental health problems and suicides (and drug related sudden deaths) through Choose Life Action Plan and implementation of Mental Health Strategy

- Continue to audit every sudden death that may be due to suicide or drugs; identify common themes and trends and take appropriate action if possible
- Continue implementation of Choose Life Plan including ASIST training

Reduce obesity through preventative work; childhood healthy weight interventions and Counterweight.

- Continue to deliver Counterweight programme: promoting access to the most disadvantaged groups through locality working: and ensuring more intensive targeted response to more disadvantaged groups
- Work with partners (eg SRT, Active Schools) to improve access to support and activities to help manage weight. Eg continue to lobby for reduced prices for disadvantage and vulnerable people for SRT (and other) activities. Support Active Schools to identify children who are overweight and encourage them to take up more physical activity
- Work through the Early Years Collaborative, and with the high risk pregnancy service, to identify families where babies / pre-school children are at risk of weight problems and support them to tackle the issue as early as possible.
- Work on understanding 'food deserts' in Shetland: in particular poor access to fruit and vegetables in island and other rural areas and identify ways in which this could be tackled in the community eg veg boxes; grow your own; community co-operatives.

Implementation of outcomes Focussed Action Plan to militate against effects of Welfare Reform.

- Awareness raising / training for staff on health inequalities in general and welfare reform specifically to enable staff to identify issues and signpost / refer patients (and themselves / colleagues) to services such as CAB where appropriate

Continue to roll out implementation of Keep Well inequalities - targeted health checks to vulnerable, socially excluded and disadvantaged groups.

Contribute to Fairer Shetland work including Life Project

Contribute to Early years Collaborative work

Implementation of Older People's Strategy

Performance indicators / Targets
SOA Indicators

Indicator	Source	Baseline data	Target
Physical activity levels: Increase proportion of adults in Shetland aged 16 + completing 30 mins of at least moderate exercise 5 days a week (Until 2011: proportion of adults aged 16 + completing 30 mins of at least moderate exercise 5 days a week. From 2012: proportion of adults completing a minimum of 150mins moderate intensity exercise a week. As measure by the Scottish Health Survey. As only a small proportion of people in Shetland are surveyed, the results are only available every four years. The change in definition has led to a huge increase in the Scottish rate. Using old definition the rate in 2012 was 38%, using new one it is 62%, so it is likely that we will revise our target once we see the next set of figures in 2015) Technical note: http://www.scotland.gov.uk/About/Performance/scotPerforms/TechNotes/physicalactivity	Scottish Health Survey.	41% (2011)	50% (2022) [To be revised in light of changes in the way this is measured nationally]
Number of alcohol related hospital admissions: Decrease the number of hospital discharges in Shetland per 100,000 population where the reason for admission and / or diagnosis was alcohol related. (Measured as the number of hospital discharges per 100,000 population where the reason for admission and / or diagnosis was alcohol related. This information is collected from our hospital statistics on at least an annual basis)	Hospital stats / ISD	689/100k (2010-11)	300/100k in 2022
Percentage of adults who smoke : Decrease the percentage of adults in Shetland aged 16 + who smoke (The percentage of adults (16+) in the population who smoke, as measured by the Scottish Household Survey, As only a small proportion of people in Shetland are surveyed, the results are only available every four years.)	Scottish Household Survey.	16% (2009)	5% in 2022,

Suicide rate: Decrease the number of deaths caused by intentional self harm and events of undetermined intent per 100,000 population (Number of deaths caused by intentional self harm and events of undetermined intent per 100,000 population, 5 year rolling average used to take into account wide fluctuations in rate due to small numbers) *Note that suicide rate is a proxy indicator for mental health and wellbeing: we currently do not have another good reliable indicator to measure this on a population level.*	ISD	22.7/100k (2008)	13/100k average in 20018-22. (5 year rolling average used to take into account wide fluctuations in rate due to small numbers)

Other Performance indicators

Indicator	Baseline data	Target 2015/16
Smoking cessation (HEAT): successful 12 week quits amongst people living in the 60% most deprived areas of Shetland (as measured by SIMD)	N/A	35
Keep Well Inequalities Targeted Health Checks:	N/A	250
Alcohol Brief Interventions (ABIs):	N/A	240
Childhood weight: Reduce the proportion of children with their Body Mass Index outwith a healthy range	21.8% (2011)	15% in 2022 plus no severely obese children
Smoking in Pregnancy: Reduce the percentage of mothers who are smoking at booking	14.5% (2010)	Less than 5% in 2022

Contact Details

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Further Reading

- Public Health Ten Year Strategy ‘Changing the World’ (2012-2022)
- NHS Shetland Public Health Ten Year Strategy ‘Changing the World’ Update August 2014 ‘More than Targets’
- Mental Health Strategy
- Obesity Strategy
- Active Lives Strategy
- Shetland Sports Strategy
- Choose Life Action Plan
- Older People’s Strategy (under development)
- (CEL 01 (2012) Health Promoting Health Service)

Long Term Conditions
2015-16 Service Plan

Supporting Health and Care vision:

"To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community"

Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support.

The definition does not relate to any one condition, care-group or age category. Around two million people, 40 per cent of the Scottish population, have at least one long term condition, and one in four adults over 16 report some form of long term illness, health problem or disability.

Long term conditions become more prevalent with age. According to Audit Scotland, the number of people aged 75 and over will rise by 60 per cent between 2004 and 2031. By the age of 65, nearly two-thirds of people will have developed a long term condition.

Older people are also more likely to have more than one long term condition: 27 per cent of people aged 75-84 have two or more. There is a predicted rise of 38 per cent in the number of people who will be over 85 in the population by 2016, and a 144 per cent rise in the over 85s by 2031.

The human costs and the economic burden for health and social care are profound. 60 per cent of all deaths are attributable to long term conditions and they account for 80 per cent of all GP consultations.

Long term conditions
People with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer, and account for over 60 per cent of hospital bed days used. Most people who need long term residential care have complex needs from multiple long term conditions.

People living with long term conditions are also more likely to experience psychological problems. Prolonged stress alters immunity, making illness more likely and recovery more difficult, especially for those who are already unwell.

There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health. People living with a long term condition are likely to be more disadvantaged across a range of social indicators, including employment, educational opportunities, home ownership and income.

Someone living in a disadvantaged area is more than twice as likely to have a long term condition as someone living in an affluent area, and is more likely to be admitted to hospital because of their condition.[1]

Improving the Health & Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan CEL 23 2009

A 'long term condition' (LTC) is one which cannot generally be cured, but can be managed through medication and/or therapy. It can also be defined as a health problem that lasts more than a year. These definitions cover a wide range of conditions including:

- Diabetes
- Multiple Sclerosis, Parkinson's Disease, Epilepsy and other neurological conditions
- Chronic Obstructive Pulmonary Disease (COPD) and asthma
- Coronary heart disease
- Chronic liver & kidney disease
- Blood borne viruses (BBVs) including HIV , Hep B and Hep C
- Osteoporosis
- Arthritis
- Myalgic Encephalitis (ME) / Chronic Fatigue Syndrome
- Inflammatory bowel disease

Other conditions such as mental health problems, dementia and some cancers are also sometimes considered as LTCs.

In Scotland it is estimated that over a million people have at least one LTC, and a third of all households have at least one person with a LTC.

Managing LTCs is a huge challenge for health services: it is estimated that across the UK, 80% of all GP consultations are for people with LTCs and that these patients are twice as likely to be admitted to hospital and account for over 60% of all hospital 'bed days'. [i]

Some LTCs can occur at any age, and others may be more common amongst older people. Some LTCs can be preventable (including blood borne viruses; coronary heart disease; COPD caused by smoking; osteoporosis and type 2diabetes). For others there is no clear cause but they sometimes run in families.

LTCs can affect people in vastly different ways. Some people take daily medication and / or have other therapy, and then can carry out their day to day lives with the minimum of inconvenience; whereas others might be very disabled by their condition, or might have frequent relapses and admission to hospital despite being on long term therapy. Many people have more than one LTC.

Delivering for Health (2005) outlined a model with three levels of care for people with LTCs

Level 1 Supported self care (also known as self management) covers the majority of people with LTCs (70-80 per cent). Most of these people are thought to be able to manage their own conditions with appropriate advice and support.

Level 2 Shared care relates to around 15-20 per cent of people with LTCs who require additional care and support to manage their conditions.

Level 3 Intensive professional care is a more coordinated and proactive approach known as intensive care management or case management. This approach is required for a small proportion of the population with complex needs, who often have more than one condition (up to 3-5 per cent).

During 2008-2011 a Long Term Conditions Action Plan was developed and implemented through the work of the Community Health & Care Partnership with support from a national team, the Joint Improvement Team (JIT). Most of the work in the plan was completed by 2011, and changes to provide better support for people with LTCs in the community have been implemented. Work to support people with LTCs is a fundamental component of service plans across the Community Health and Social Care Directorate and includes how we work with partners.

A health needs analysis is key to understanding the demand for support and intervention for people with LTCs at a Health Board/ Local Authority level, and when carried out at a locality level provides a good level of intelligence on where particular resources need to be focussed.

Aims

- To ensure preventative strategies are in place to reduce incidence of LTCs where possible
- Early diagnosis so earlier intervention can help individuals to self-manage
- To support people with LTCs to manage their condition and achieve their full potential
- To optimise the management of LTCs to prevent relapses, deterioration and hospital admission

Assessment of Need

The numbers of people with LTCs are recorded in different ways; for example GP practices maintain registers of certain conditions such as diabetes but for other LTCs we have to estimate the number of people affected in Shetland based on national figures. [ii]

- Most recent figures from the Scottish Diabetes Survey show that at the beginning of 2011 there were 958 people on local diabetes registers in Shetland. However there are estimated to be a further 400 people who are undiagnosed. [iii, iv]

- Based on national figures we estimate that there are just over 200 people aged over 65 with COPD.
- In 2011-12, 63 people in Shetland were diagnosed with coronary heart disease and 40 people had cerebrovascular disease (a stroke). There has been little change in the numbers of people affected over the past few years.[v],[vi]
- It is difficult to obtain accurate figures for the number of people with BBVs because they are often small numbers and are therefore not reported. However the most recent available figures suggest that there just over 40 people in Shetland with hepatitis C, with about the same number again who are undiagnosed and about 10 people with HIV. [vii],[viii]
- It is estimated that around 5.9% of the Scottish population has asthma, which would be 1300 people in Shetland.
- It is estimated that 0.7% of the population has epilepsy, about 150 people in Shetland.
- And that around 2% of the population has multiple sclerosis, about 40-50 people in Shetland.

There are five Managed Clinical Networks (MCNs) currently active in NHS Shetland. These are Stroke, Heart, Respiratory, Diabetes and Eyes. We are in the process of implementing an MCN for Chronic Pain and planning one for Palliative Care.

The MCNs have multidisciplinary membership, including clinical leadership, clinical specialists, non-NHS members and patient representatives. Clinical Governance supports the MCNs. All MCNs agree annual objectives for the work of the group. This may be led by national drivers or local ideas for improvements. The objective document includes measures of success and is monitored throughout the year once they are agreed. The local MCNs have a good fit with the guidance laid out in CEL 29 (2012) – Managed Clinical Networks: Supporting and Delivering the Healthcare Quality Strategy.

Services available

Because Shetland is a small community, and the numbers of individuals with specific LTCs are relatively small, it is often not possible to have services dedicated to specific groups of patients. There are some services specifically for people with any kind of long term condition and a wide range of inclusive, generic services which provide input for people with LTCs, people with disabilities and other needs.

Community based services which support people with LTCs include:

- Self management courses (run by voluntary sector organisations including Arthritis Care and the MS Society);
- A support group for people with Long Term Conditions at Eric Gray Centre;
- “With You For You”, Shetland’s process for needs assessment and care management;

- Primary care based clinics in most health centres – e.g. for diabetes and asthma ;
- Community nursing services, including anticipatory care planning;
- Specialist nurses including Community Children's Nurse; Continence nurse; Learning Disability nurse; Dementia Nurse
- Psychological Therapies
- Palliative and End of Life care
- Occupational Therapy, including equipment, adaptations and telehealthcare
- Support for carers; including advice, information, training and short breaks
- Support groups e.g. MS Society; Arthritis Care, Pain Association
- Community Pharmacies and the Chronic Medication Service
- Support at home, day services and residential care
- Employment support including COPE, Moving On and the Bike Project;
- Dietetics;
- Physiotherapy;
- Orthotics;
- Podiatry;
- Speech and Language Therapy.

In addition there are a number of services which help to prevent LTCs including for example:

- Weight management (Type 2 diabetes)
- Smoking Cessation (COPD; heart disease, type 2 diabetes)
- Community Alcohol and Drugs Services Shetland (Liver disease caused by alcohol; BBVs prevention)
- Sexual Health Clinic (BBVs prevention)

In Primary and Community Care GPs conduct polypharmacy (the use of multiple medications by a patient, generally older adults) reviews in conjunction with pharmacists.

GPs and District Nurses hold regular multi-disciplinary team meetings to discuss patients with complex needs – this includes district nursing, practice nursing, pharmacy, mental health, dementia specialists, social services and others as appropriate.

Each care home has one or more GP's responsible for the overall medical care of residents. There are regular multi-disciplinary team meetings to review residents well being and management.

Funding

Most of the expenditure on Long Term Conditions is included in budgets for services provided to other care groups and cannot be identified separately.

Unmet Needs

- Increase range and availability of self management courses
- Support for younger people with LTCs
- Psychological support for people with LTCs
- Support for Carers who are looking after those with LTCs

Further Reading

[i] Audit Scotland Report 2007

[ii] www.scotpho.org.uk/health-wellbeing-and-disease

[iii] Scottish Diabetes Survey
Monitoring Group. *Scottish Diabetes Survey 2011*. Available at: www.diabetesinscotland.org.uk/Publications/SDS%202011.pdf

[iv] www.scotpho.org.uk/health-wellbeing-and-disease/diabetes/data/undiagnosed-diabetes

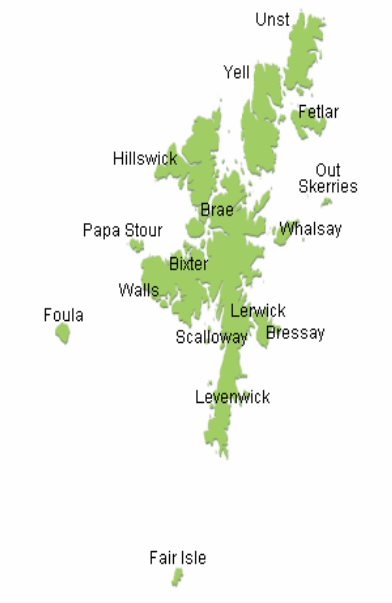
[v] ISD Scotland. *Heart Disease Statistics Update. Year ending March 2012*. ISD Scotland 2012. Available at www.isdscotland.org/Health-Topics/Heart-Disease/

[vi] ISD Scotland. *Stroke Statistics Update year ending March 2012*. ISD Scotland 2012. Available at:
www.isdscotland.org/Health-Topics/Stroke/

[vii] www.documents.hps.scot.nhs.uk/ewr/pdf2013/1321.pdf

[viii] www.documents.hps.scot.nhs.uk/ewr/pdf2013/1318.pdf

Mental Health
2015-16 Service Plan



Supporting Community Health and Social Care Departments vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for the council, the health board and the Joint Integration Strategy. This Service Plan provides an overview of the Mental Health Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Mental Health Service is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".*

That means we will work in partnership with each other to make Shetland a community that:

- is free from stigma and disadvantage in relation to mental health issues;
- promotes positive mental health and increases our resilience as individuals, families and communities to live positively and free from mental illness wherever possible;
- deals sensitively and effectively with mental illness when it does occur;
- uses a recovery approach to work with people living with mental illness.

Drivers for Change

Government Policy and Legislation

The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in October 2005. This Act contains much more than simply legislation for new forms of compulsory powers and safeguards. Its underpinning principles herald a new era of rights-based care for people who use mental health services. As well as providing care and treatment, services are now required to promote social inclusion and a wider citizenship agenda.

A number of policy documents have shaped the development of local mental health services: Delivering for Mental Health (2006) set out national policy for the development of Mental Health services and the improvement of mental health in Scotland. This was followed by Better Health Better Care (2007) which established additional improvement objectives and National Targets/Standards.
In 2009, Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 outlined the roles and responsibilities of government, local public agencies and third partner agencies in promoting positive mental health.

In August 2012, the Scottish Government published a new Mental Health Strategy for Scotland with a renewed emphasis on "prevention, anticipation and supported self management". This focus is central to mental health policy in Scotland and the strategy emphasises a range of improvements and interventions that are in accordance with the best evidence for return against investment over time, including:

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;

Early detection and treatment of psychosis.

In addition to the above interventions the strategy focuses on actions that people can take for themselves and with their communities to maintain and improve their own mental health.

There are two further areas of health and care that are closely associated with the strategy and delivery of mental health services; Dementia and Substance Misuse.

Dementia

Dementia is the name given to a group of organic psychiatric/mental illnesses that affect the normal working of the brain. These illnesses interfere with memory and the ability to think and reason. It is recognised that dementia has profound consequences for those affected and their families.

A 2005 review of staffing and dependency levels in Shetland's care centres discovered that approximately 40% of older residents (aged 65 +) had a mental health problem which was assessed as medium or high in severity. The majority of these people would have a dementia. A more recent review showed the proportion of these residents with a mental health problem had risen to almost 60%. There are also a small

number of adults with learning disabilities who have early onset of dementia. The number of people in Shetland with dementia is expected to continue to increase as the population ages.

The main national drivers for change in this area arise from the 17 commitments outlined by the Scottish Government in Scotland's National Dementia Strategy 2013-2016. These build upon a number of earlier improvement ambitions including; increased levels of diagnosis, Standards of Care for Dementia in Scotland (2011) and more recently the Scottish Government response to the Mental Welfare Commission Report "Dignity and Respect: dementia and continuing care visits" (August 2014). At a local level, many of the identified change and improvement drivers are being addressed as part of Shetland's response to the dementia "Deep Dive" assessment conducted in 2013.

Substance Misuse

Substance Misuse affects people in all walks of life. It can impact on individuals, families and communities. A number of local service providers exist to offer treatment and support to both individuals with their own issues and people who are affected by others misuse.

Two overarching Government strategies underpin all the work undertaken in Shetland; The Road to Recovery (2008) and Changing Scotland's Relationship with Alcohol; a framework for action (2009).

In Shetland, Alcohol and Drug Services are commissioned through Shetland Alcohol and Drug Partnership (SADP). SADP is a multi agency strategic partnership that meets bi-monthly to oversee the design and development of services.

In addition to SADP the Shetland Alcohol and Drug Forum, a multi agency operational group, also meets bi-monthly. Its aim is to provide SADP with information on operational issues and assist with the planning process.

In recent years the main services in Shetland providing help and support to a) people with their own substance misuse issues and b) people affected by those who are misusing substances, have been delivered by three distinct agencies; namely NHS Shetland, Shetland Islands Council and Community Alcohol and Drug Services Shetland (CADSS). The services provided by these organisations are currently part of a comprehensive redesign of Shetland's drug and alcohol services. The new Substance Misuse and Recovery Service will be part of the Community Health and Social Care directorate and it is anticipated that the new integrated service will commence in April 2015.

Feedback/Consultation

During 2012/13, feedback from service users, carers and staff highlighted a range of issues that were impeding the development of Shetland's mental health services. In response to these concerns Shetland Islands Council and NHS Shetland commissioned a joint review of mental health services. Published in February 2014, the review recommended increases in staffing levels and the development of 24/7 mental health services.

Implementing the recommendations of the Mental Health Review Action Plan, with renewed focus on partnership working with service users, their carers and families, is a major driver for the changes currently taking place in Shetland's mental health services. The views of service users, carers and staff were also gathered as part of a) the "Deep Dive" review of Dementia provision conducted by Stirling University and b) the ongoing review of Substance Misuse services.

In summary, these new national and local strategies, together with a growing appreciation of the Triangle of Care model and the benefits of co-production, are shaping how we work together to redesign and develop safe, effective and person centred services.

Local Strategy and Priorities

An updated Mental Health Strategy for Shetland, written in accordance with Scottish Government's priorities was agreed by Shetland Islands Council and NHS Shetland in May 2014 and a comprehensive action plan to implement that strategy is currently in development.

The over arching aim of the Shetland Mental Health strategy is to develop a single plan that will deliver comprehensive mental health services; use the resources available to deliver services in the most effective way and avoid harmful gaps and wasteful overlaps. This will involve health, social care, housing, education, and employment, voluntary and other agencies working jointly in the provision of complementary services across the whole spectrum of mental health support and treatment.

Our vision is a 21st century mental health service for the people of Shetland. That vision, fuelled by a renewed focus on person centred partnership is, and will continue to be, a significant driver for change and improvement.

About Us

Mental Health services in Shetland have grown from a single adult Community Psychiatric Nurse (CPN) in 1986 to the current provision which encompasses a range of responsibilities and services, all of which can be accessed via a GP by means of 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.

Mental Health services became part of the Community Health and Social Care Directorate following the decision by the Council and Health Board to jointly appoint a director of Community health and Social Care in February 2014. This was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

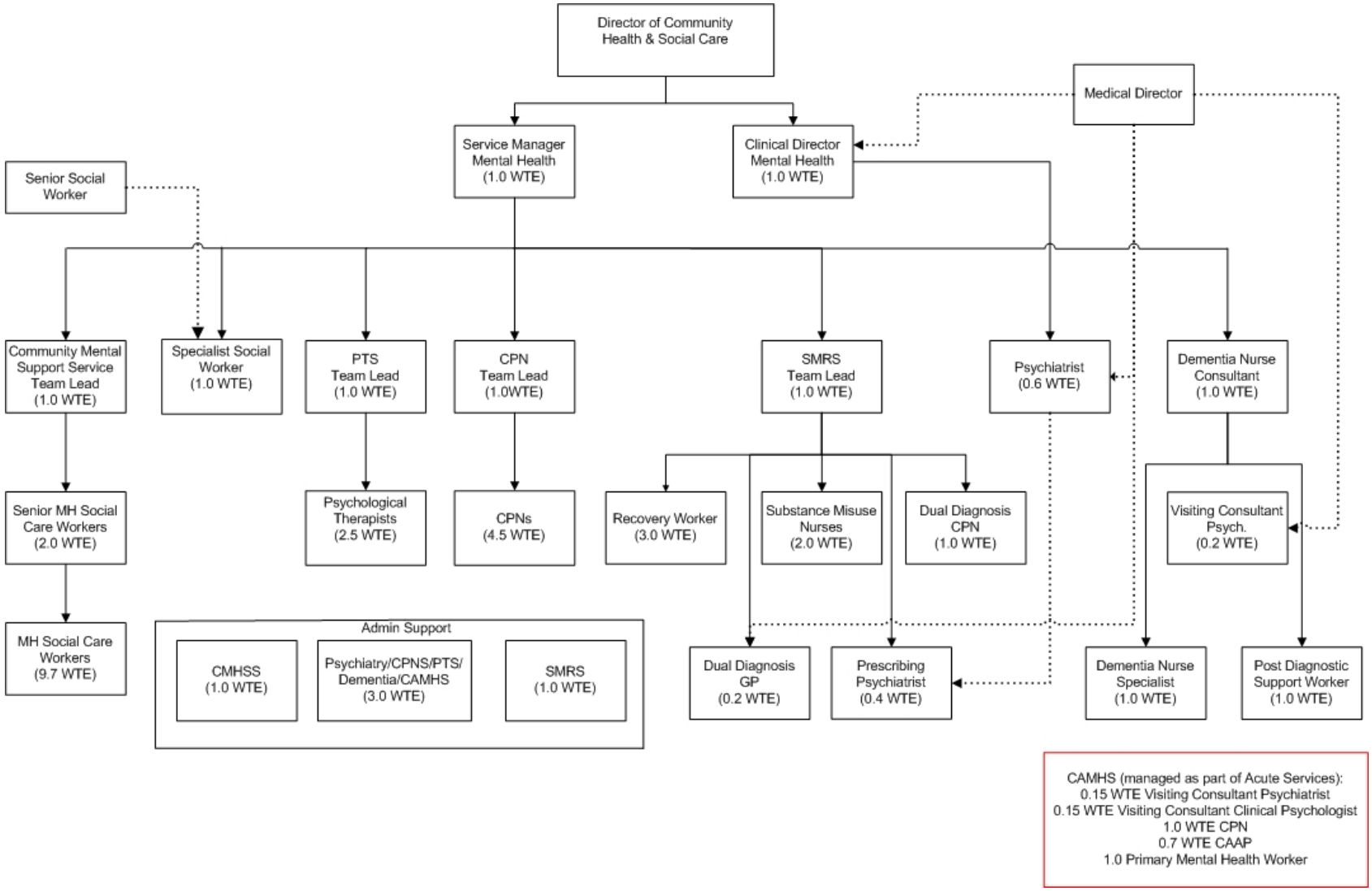
The Service comprises a number of regulatory and front-line services and has specific responsibilities in respect of *The Mental Health (Care and Treatment) (Scotland) Act 2003* and associated legislation and policy.

Who We Are

The Mental Health Service is led by the Service Manager with the support of a 7 person operational team composed of a Clinical Director (vacant), 5 Clinical Leads and a Social Care Manager. The seven operational services that make up Shetland's Mental Health Service are:

- Community Psychiatry Services (CPS)
- Community Psychiatric Nursing Service (CPNS)
- Psychological Therapies Service (PTS)
- Substance Misuse and Recovery Service (SMRS)
- Dementia Service (DS)
- Child and Adolescent Mental Health Service (CAMHS)
- Community Mental Health Support Service (CMHSS)

Organisational Chart



Locations

The Mental Health Service covers the whole of Shetland and has specific facilities in the following locations in Lerwick:

Montfield Hospital - SMMH

Lerwick Health Centre - CPS, CPNS, PTS, SMRS, CAMHS and Medical Secretaries

Annsbrae House and King Erik House - CMHSS

Grantfield House - DS

Governance

The Mental Health Service is part of the Community Health and Social Care Directorate and reports to the Social Services Committee and Community Health Partnership Committee which meet concurrently. It will be accountable to the new Shetland Integration Body once established.

The Service's performance is reported to the Directorate Management Team monthly and 5 PIs from this plan are reported to the Social Services Committee and Community Health Partnership Committee 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

Mental Health Act

Adults With Incapacity Act

Adult Support and Protection Act

Mental Welfare Commission for Scotland

Mental Health Tribunal for Scotland

Nursing and Midwifery Council

Scottish Commission for the Regulation of Care (Care Commission)

Scottish Social Services Council

Health Professions Council

Health Improvement Scotland

What We Do

Community Psychiatric Services

These services are provided by:

Consultant Psychiatrist
Community Psychiatric Nurses (CPNs)
Specialist Social Worker/MHO

The services provided are General Adult Psychiatry, Old Age Psychiatry (excluding Dementia), Emergency/Liaison Psychiatry.

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

1. 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.

2. 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.

3. To assess patients in police custody on request of a police surgeon (Consultant Psychiatrist).

4. Fulfil the duties associated with the Mental Health (Care and Treatment) (Scotland) Act, 2003.

5. To contribute to the teaching and training of students, trainees and multidisciplinary staff groups as appropriate.

Psychological Therapies Service

These services are provided by:

Psychological Therapists
Health Improvement Practitioners
NHS24 Telephone Service for Guided Self Support and Cognitive Behaviour Therapy
Telehealth Technologies (e.g. Computerised Cognitive Behavioural Therapy)

The service provides a range of psychological interventions for adults (16/18-65+) who have moderate to severe mental disorder (e.g. depression, anxiety, personality disorder) and/or distress as a consequence of life events or health conditions (e.g., suicidal ideation, trauma, diabetes). Where appropriate, psychological therapies are used to complement more traditional psychiatric interventions.

Referrals to the service are received from GPs, Community Psychiatric Services and Hospital Consultants. The duties of the service are:

1. To provide access to specialist "talking therapies" for adults and older people with including; assessment and treatment of patients in the community and a range of care settings.

2. To provide assessments and advice on patients in the care of medical and surgical colleagues.

3. To contribute to the teaching and training of students, trainees and multidisciplinary staff groups as appropriate

Child and Adolescent Mental Health Services

These services are provided by:

Specialist Psychiatric Nurse
Primary Mental Health Worker
Clinical Associate in Applied Psychology
Consultant Psychologist (monthly visiting service)
Consultant Psychiatrist (monthly visiting service)

Referrals to the service are received from across the spectrum of services and agencies that work with young people and includes GPs, Schools, Social Work and Health Visitors. The duties of the service are:

To provide consultation, assessment and interventions for children and young people up to the age of 16 (or 18 if they remain in full-time education). Interventions can include different types of individual therapy including: behavioural; cognitive; systemic; psychodynamic, family work of various kinds and, where needed, prescribed medication. The kinds of problems the service get referrals for include:

- psychosis
- depressive disorders
- attention deficit hyperactivity disorder (ADHD)
- autistic spectrum disorders (as part of the pathway to diagnosis only)
- tourette's syndrome and complex tic disorders
- self-harm and suicide attempts
- eating disorders
- obsessive compulsive disorder (OCD)
- phobias and anxiety disorders
- mental health problems secondary to abusive experiences

Community Mental Health Support Services

These services are provided by:

- Service Manager
- Senior Social Care Workers
- Social Care Workers

The service is based at Annsbrae House and delivers a range of community support services for people who have mental health and/or complex dementia needs and is proactive in seeking and promoting the views of all those who access the service.

Referrals to the service are primarily received from GPs, Social Work and the Community Mental Health Team. The services provided include:

1. Supported Accommodation
2. Short break/respite service
3. Outreach service
4. Skills Centre
5. Duty Service
6. On call Service

There are 8 individual supported tenancies at Annsbrae and 1 shared supported tenancy at King Erik House for people living with severe and enduring mental health and/or complex dementia conditions.

The Outreach Service provides support to people with mental health conditions in their own homes. This service is tailored to individual needs supporting people to live as independently as possible. Support may be provided with a variety of life and social skills, such as cooking, shopping, budgeting and working towards self support and recovery in daily life.

The Skills Centre offers service users the opportunity to participate in and lead meaningful activities, covering a variety of educational and recreational subjects.

A short break/respite service is available to provide family or carers' breaks for those who support individuals living in their own homes with a mental health condition and/or complex dementia.

Annsbrae House, Duty Service offers access to advice or support on any aspect of social care for those with mental health/dementia needs. This is provided by telephone, face-to-face, and where feasible, outreach contact.

Where physical frailty is the main presenting problem, a person with dementia is more likely to receive care from one of the care services in their locality (e.g. Edward Thomason House, Overtonlea etc).

Substance Misuse and Recovery Service

There are a range of services in Shetland that provide help and support to people with their own substance misuse issues or have been affected by another persons substance misuse. Historically, these services have been delivered by a number of providers including NHS Shetland and Shetland Islands Council.

NHS Shetland provides specialist treatment and support through a Substance Misuse Service (Prescribing Clinic) and a Dual Diagnosis service. The Substance Misuse Service offers medicated detox for both alcohol and drugs. The Dual Diagnosis service currently offers support for clients with both alcohol and mental health issues.
These services are provided by:

- Medical Prescriber (Consultant Psychiatrist)
- GP with Specialist Interest (GPwSI)
- Substance Misuse Nurses
- Substance Misuse Support Workers

Referrals to the service are via GP. In addition to the above, Generic treatment and support for people experiencing difficulties with their use of alcohol and drugs can be accessed through A&E, the Mental Health Department and GP surgeries.

Shetland Islands Council employs a Specialist Substance Misuse Social Worker who provides support for people who are not currently accessing treatment or support for their substance misuse. This post holder also undertakes work to support access to residential rehabilitation services on the basis of the person's assessed needs. In addition, the Local Authority Criminal Justice service works in partnership with CADSS to provide support for those subject to Drug Treatment and Testing Orders (DTTOs) imposed by the Courts.

The statutory services also work in partnership with the following local Voluntary Sector services:

CADSS who provide early intervention, treatment, support and aftercare of those who misuse drugs and alcohol; young person's services including input into the Schools programme; working both with individuals who have substance misuse issues and those who are affected by others misuse. Their adult services focus on the psychosocial aspects of substance misuse and work very closely with

the Substance Misuse Social Worker. The CADDS Aftercare Service supports clients with alternative ways of spending leisure time and avoiding relapses.

SCBP (Shetland Community Bike Project) is an employment based project where all clients must be substance free to participate. A programme of approximately 6 months in length is developed with each individual with the ultimate outcome being further employment. SCBP has a 60% success rate with securing future employment for its participants.

DAD (Dogs Against Drugs) is a small charitable organisation that is involved in early intervention and enforcement. DAD is involved in the input to the Schools programme. It also works closely with Northern Constabulary on the detection of illegal substances in Shetland.

There are a number of other statutory and voluntary sector organisations which, although not established specifically to work with substance misuse, also work with many people who are affected by this issue.

An example of this is the “Drink Better” initiative led by SADP and supported by the NHS Shetland Health Improvement Service. Its aim is to achieve culture change over the next 10/15 years. Relevant messages are communicated at different times of the year to different audiences with a focus on the positive side of healthy and responsible drinking.

Dementia Assessment Service

The Dementia Assessment Service (DAS) has been developed as a partnership initiative between NHS Shetland and Alzheimer Scotland. The service is led by the Dementia Service Manager who also fulfils the function of the Alzheimer Scotland Dementia Nurse Consultant and has links with the National Nurse and AHP Consultant Group. The nurse led DAS is delivered by the following staff:

- Dementia Services Manager (DSM)
- Dementia Clinical Nurse Specialist (DCNS) (Alzheimer Scotland funded)
- Consultant Psychiatrist (weekly video conference service)
- Dementia Advisor and Activities Coordinator (DAAC) (Alzheimer Scotland funded)

Referrals to the service for those suspected of having a dementia are received from GPs, the Community Mental Health Team and Gilbert Bain Hospital Consultants. The following services are provided:

1. Specialist dementia assessment. This is delivered with the support of two sessions weekly of Old Age Psychiatry input from NHS Grampian. People suspected of having dementia meet with the psychiatrist, via videoconference. They are then assessed, usually in their own home, by one of the nurses. The referral is discussed in the weekly VC clinic and, where appropriate, a diagnosis can be made.
2. Support to staff in the Gilbert Bain Hospital and Care Centres to assist in the assessment and management of people with dementia
3. Support to the Dementia Services Partnership (DSP). The partnership brings together a wide range of individuals from statutory and third sector providers who work with people with dementia and their carers. The group meets fortnightly and provides a Single Point of Referral for all people with a diagnosis of dementia. The aim is to ensure that people are in receipt of appropriate services and that they continue to be followed up as necessary.
4. Dementia Advisor and Activities Coordinator (DAAC). In partnership with NHS and SIC staff the DAAC provides access to a wide range of specialist support, advice, activities and raises awareness of dementia issues.
5. Support to the Directorate's learning disabilities services as part of an ongoing commitment to provide care and support to people with learning disabilities who subsequently develop a dementia (NB some learning disability diagnoses are linked to early on-set dementia).

Our Patients

We work on the presumption that every resident is registered with a GP practice. For most of our services, people will only access these and become known to a service when there is a need e.g. an episode of depressive illness. It is therefore vital that the work on integration includes the appropriate sharing of information through With You For You, so that people only have to tell their story once, and services can be put around the individual in a more comprehensive way.

For local authority provided services, National Eligibility Criteria for older people are applied. These can be found at the following link: http://www.scotland.gov.uk/Resource/0039/00399040.pdf

For more information please see the eligibility criteria for each of the individual services detailed above.

Our Costs and Income

The Service has 66.21 full time equivalent staff and annual net expenditure of £ 2,930,417. As detailed below:

Health & Social Care – Mental Health Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Mental Health Service Management (inc. medical secretarial/admin staff)	4.00			200,303	Nil
Community Psychiatry Services (CPS)	2.00			252,926	Nil
Community Psychiatric Nursing Service (CPNS)	5.50			238,671	Nil
Psychological Therapies Service (PTS)	3.5			242,673	Nil
Substance Misuse and Recovery Service (SMRS)	2.82			160,204	Nil
Off-Island Rehabilitation Placements	-	54,500	0	54,500	Nil
Substance Misuse Specialist Social Worker	1	47,985	46,480	1,505	Nil
Community Alcohol & Drugs Services SLA	-	467,400	346,200	121,200	Nil
Dementia Service (DS)	2.00			53,830	Nil
Child and Adolescent Mental Health Service (CAMHS)	2.5			132,046	Nil
Mental Health Officers (including Preventative)	2.72	148,159	-	148,159	Nil
Community Mental Health Support Service (CMHSS +DSP)	39.17	1,367,061	42,661	1,324,400	Nil
Mental Health Service Total	**65.21**			**2,930,417**	

Funding and resources

The service receives “ring fenced” funding from a number of sources including Shetland Alcohol and Drugs Partnership, NHS Education Scotland. The Mental Health Service is currently experiencing a number of cost pressures. These pressures are associated with a) the need to deliver a wider range of services and b) an increase in demand for those services. At the same time the service is required to make effective and efficient use of its resources and where ever possible contribute to the Directorate’s overall savings target. The main cost pressure is in respect of the additional staffing required to deliver a sustainable Out of Hours service.

Aims and Objectives

Directorate Plan Aims	Action
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	There will be no need for a customer’s needs to be assessed for eligibility for services by more than one relevantly qualified member of staff. Where possible, a customer will have allocated to them a named individual who looks after their service needs so that they need only have to “tell their story once”
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.	Financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions. Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system Resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need. Services are delivered to the best possible standard and quality, at the best possible price.The Directorate will have a single planning and design process with clarity in what they are trying to achieve in the short, medium and longer term.Services will be planned and designed in partnership with customers and the general public.

Service Aims/Priorities	Objectives/Actions
Ensure that people can access information to maintain their own mental health	Work in partnership with Health Improvement Department to provide easy access to up-to-date, evidence-based information to help people maintain their own mental health.
Promote resilience and mental wellbeing to prevent and reduce mental illness and distress	Promote the in-service development of existing clinicians, and use opportunistic recruitment of suitably experienced clinicians to build a team of staff who combine a broad range of additional skills and special interests.
Early recognition and treatment of mental illness and disorder	Establish a programme of mental health education and support for GPs and Hospital Doctors. Redesign and develop services to improve the range of, and speed of access to, evidence-based interventions.
Provide person centred care through well integrated services that focus on individual need including the needs of carers and families	Review internal processes to ensure that staff and resources are deployed in a manner that supports person-centred rather than service-centred activity.
Ensure service users are at the centre of care and treatment	The “Triangle of Care” approach will underpin and inform how staff and services engage with patients, carers and families.
Effective engagement of families and carers to support care and treatment	Develop a “Communication and Engagement Framework” that facilitates improved communication between services, families and carers to ensure that their views are at the heart of development and redesign decisions.
Embed recovery approaches within services	Undertake a “baseline audit” of services using the Scottish Recovery Indicator (SRI) tools.
Redesign of mental health services in line with service review/best practice	Review the clinical workforce with a view to building a stable and sustainable service structure together. Establish the timetable and funding to achieve this.

New Planned Actions Due to Start in 2015/16

Title/Heading	Start	End	Outcome	Expected Outcome/Supported Aims/Objectives
Review the clinical workforce with a view to building a stable and sustainable service structure	June 2015	December 2015	Better patient outcomes. Improved team-working. More staff with additional skills.	A highly skilled and experienced workforce through in-service development of existing clinicians and recruitment of staff with additional skills.
Access to a range of patient education and information resources	June 2015	October 2015	Up-to-date patient information and education resources. Development of a “locally branded” Mental Health website.	Improved patient understanding of Mental Health Services and how they function. Increased patient knowledge, reduction in complaints, improved patient/carer/staff partnership working.
Service capacity issues and areas of unmet need	June 2015	March 2017	Improve the ability of services to provide a timely response to patient need.	Improved patient/carer experience and a reduction in unscheduled care presentations.
CMHT response to OOH Psychiatric Emergencies	April 2015	October 2015	Extend the current CMHT Duty Service to GBH from 5 to 7 days.	Improved patient/carer experience and reduction in GBH bed pressures due to timely assessment and discharge (where safe and appropriate).

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

- Recruitment
- Capacity
- Ability to Redesign Services

Key Service Indicators

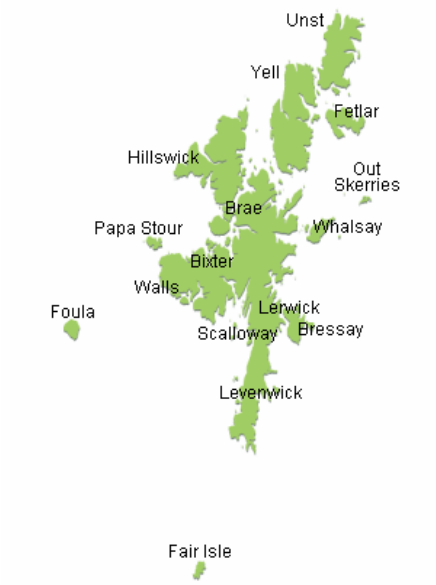
With the exception of the 'Unscheduled Care Presentations to GBH', the performance measures detailed below are set by Scottish Government. In future years we plan to introduce measure that will also reflect service user experience and satisfaction.

Performance Measure	Performance 2014/15	Target 2015/16
Psychological Therapies HEAT Target (By December 2014 all patients will start treatment within 18 weeks of referral)	Target not being met	100%
CAMHS HEAT Target (By December 2014 all patients will start treatment within 18 weeks of referral)	On Target	100%
Unscheduled Care Presentations (mental health) to GBH	Not Set	To Be Determined
Dementia Diagnosis Standard (No. Diagnoses to exceed 50% of prevalence)	On Target	> 50%
Dementia Post Diagnostic Support (By 15/16 all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support)	On Target	100%

Contact Details

Service Manager - Mental Health Mental Health Manager Montfield – Upper Floor Burgh Road Lerwick ZE1 0LA (01595) 743363 david.morgan3@nhs.net	Community Mental Health Team Health Centre South Road Lerwick ZE1 0RB (01595) 743006	Annsbrae House Knab Road Lerwick ZE1 OPB (01595) 744345 Muriel.forbes@shetland.gov.uk	King Eric House St Olaf Street Lerwick ZE1 0EU (01595) 745025	Dementia Service Grantfield Lerwick ZE1 0NT (01595) 744322 Alan.murdoch@nhs.net

Oral Health
2015-16 Public Dental Service Plan



Supporting Community Health and Social Care Departments vision:

"To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community"

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for both the Council and the Health Board, and to the Joint Integration Strategy. This Service Plan provides an overview of the Oral Health Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Public Dental Service is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".*

Drivers for Change

In 2013/14 the Scottish Government introduced changes to salaried dentistry, combining Community Dental Services and Salaried General Dental Services into the Public Dental Service (PDS).

The remit of the Public Dental Service, set by Scottish Government, is to:

- provide care for people with special needs, including people who would have difficulties accessing general dental practices
- complement the current General Dental Service and specialist services, especially in remote and rural areas **
- have a public health role, and oral health promotion targeted both at populations and individuals
- assess and treat people referred for specialised and specialist services, including the use of sedation and general anaesthesia
- make greater use of professionals complementary to dentistry both clinically and for the public health role, i.e. NDIP.

** Currently there are no independent dental practices in Shetland providing NHS dentistry, and the PDS is therefore providing routine dental care for the whole population in addition to its special needs remit.

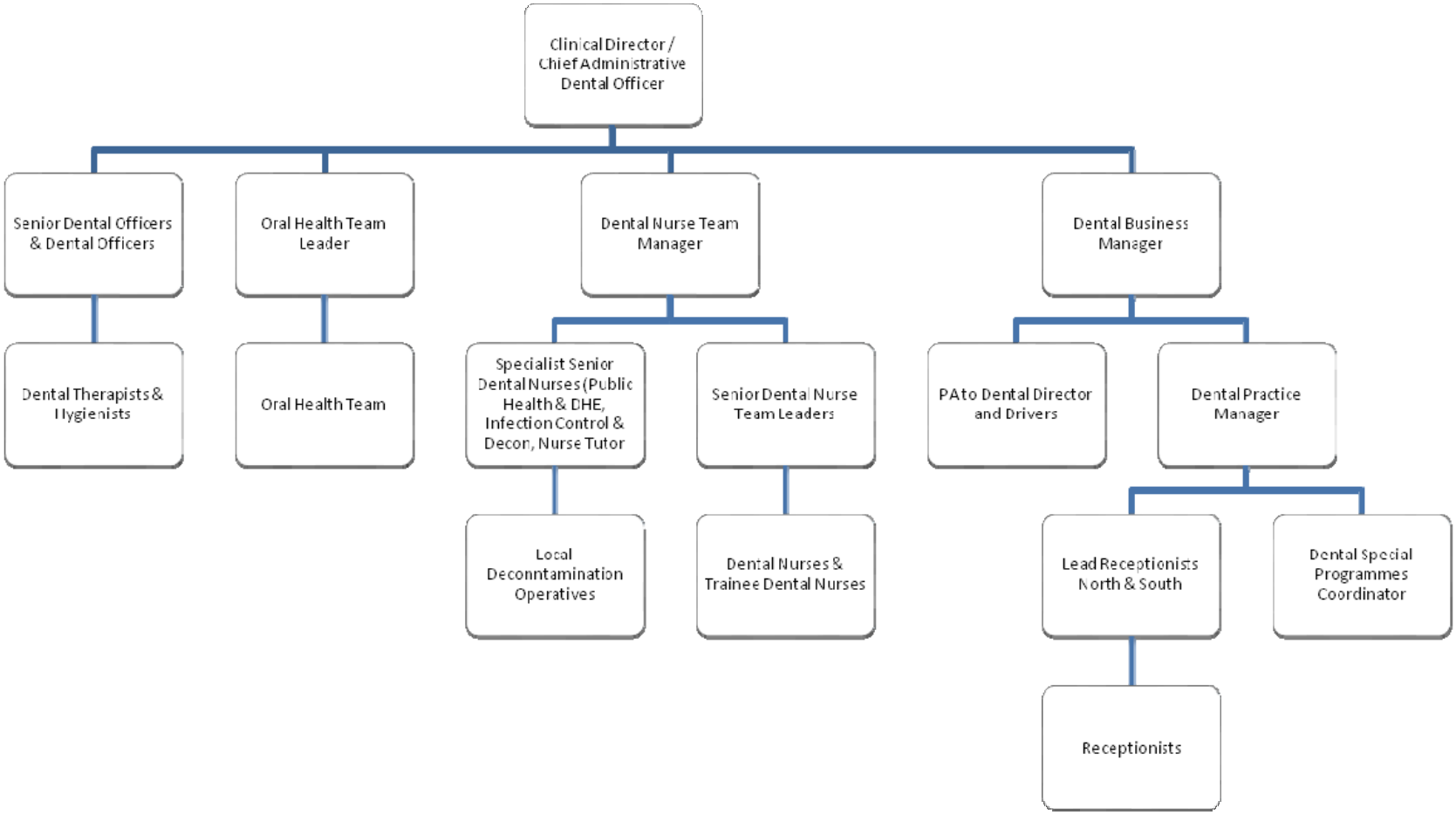
Who We Are

The Public Dental Service employs Dentists, Dental Hygienists &Therapists, Dental Nurses, Dental Receptionists, Trainee Dental Nurses and receptionists, Managers and Administrators, Oral Health Promotion staff, Local Decontamination Unit Operatives and Drivers.

The range of staff is employed specifically to provide:

- Routine clinical primary dental care for people who are registered with the PDS
- Emergency clinical primary care dental services for the whole population, irrespective of whether they are registered or not
- Secondary care oral health services for the whole population – for orthodontics and oral & maxillo-facial surgery in particular
- Dental Public health activities for the whole population of Shetland – through Childsmile, the National Dental Inspection Programme, Oral Health Education and Promotion, Caring for Smiles etc.

Organisational Chart



Locations

The Public Dental Service provides clinical care at three locations in Lerwick - Montfield Clinic, Gilbert Bain Hospital Dental Suite and St Olaf Street Clinic – and three other locations - in Brae, Mid Yell and Whalsay Health Centres. The administrative hub is located at Montfield. Annual dental camps are also held on Fair Isle, Foula and Skerries.

Governance

The Public Dental Service is part of the Community Health and Social Care Directorate and reports to the Joint Integrated Board.

Regulation and Compliance

The role and remit of the Public Dental Service is determined by the Scottish Government, and the Service is expected to fulfil all requirements placed upon it by the Government.

Dentists and Dental Care Professionals (Therapists, Hygienists and Dental Nurses) are registered with the General Dental Council, and practise to the expected Standards set by the GDC. In addition, Dental Care Professionals practise within the Scope of Practice set agreed by the General Dental Council.

The provision and range of clinical dentistry available in the PDS is determined by the Scottish Statement of Dental Remuneration (SDR). This limits what oral health care can be provided through NHS funding, both by NHS-employed dental staff and also by independently-run NHS dental practices. Additional treatments are available from consultant-led secondary care services, or on a private basis from non-NHS dentists.

What We Do

Senior Dental Officers and Dental Officers are responsible for:

- Providing routine clinical primary care dental services for people who are registered for dental care with the PDS
- Providing emergency clinical primary care dental services for the whole population, irrespective of whether they are registered or not
- Providing the Dental input required for the National Dental Inspection Programme
- Providing Dental Screening in Care Homes, Schools and other institutions as determined by the Scottish government

Visiting Consultants from NHS Grampian provide secondary care oral health services for the whole population – for orthodontics and oral & maxillo-facial surgery in particular.

Dental Therapists and Dental Hygienists:

-Provide clinical primary care dentistry for people who are registered with the PDS within the Scope of Practice for their particular GDC registration

Dental Nurses and Trainee Dental Nurses:

-Assist Dentists, Dental Therapists and Dental Hygienists to fulfil their clinical duties. The Scope of Practice for Dental Nurses includes a limited clinical remit enabling them to apply Fluoride varnish, provide oral health education etc.

Dental Receptionists and Trainee Receptionists

-Provide the front-line, extra-surgery administrative support for the clinical dental team

Oral Health Promotion team:

- Provide a range of dental public health activities for the whole population
- Carry out Childsmile activities in clinics, schools, and other community settings
- Provide Oral Health education to groups and individuals
- Support the National Dental Inspection Programme, Caring for Smiles etc.

Local Decontamination Operatives and Drivers:

-Ensure sterile equipment is always available at all clinic sites

The Managers and Administrative Team:

-Ensure the Service runs efficiently and effectively to maximise the quality and quantity of care provided for the people of Shetland within the available budget.

Our Patients

NHS Shetland has the responsibility to ensure that appropriate oral health care and advice is available for the entire population of Shetland, irrespective of whether they are registered for routine dental care at one of the six sites run by the PDS.

Over 19,600 people are registered for ongoing routine dental care, and another 1,100 local residents wishing to register have placed their names on waiting lists.

The so-called Emergency Dental Service operates daily to accommodate unregistered people needing urgent dental care. The majority of these people will be local residents.

Staff on the on-call rota for out-of-hours care see people with true emergencies who cannot wait until the next normal working day, i.e:

- People with trauma including facial/oral laceration and/or dento-alveolar bone injuries
- Oro-facial swelling that is significant and worsening
- Post-extraction bleeding that the patient is not able to control with local measures
- Dental infections that have resulted in acute systemic illness and raised temperature

This service is available to all people irrespective of whether they are residents, visitors or workers on short-term contracts.
Activities such as the national Childsmile programme reach to every child in Shetland and their parents/carers.

Funding and resources

The current funding and resources reflect that the PDS is currently providing routine General Dental Services care to Shetland in addition to the PDS's own remit. As such, these are liable to change as and when local independent NHS dental practices open.

Our Costs and Income

Health & Social Care – Oral Health Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Public Dental Service activites	57.54			2,549,897	Nil
C.A.D.O HQ activities	3			186,781	Nil
Other Oral Health activities	7.52			806,416	Nil
Oral Health Service Total	**68.06**			**3,543,094**	**Nil**

Aims and Objectives

The Aims of the NHS Shetland Public Dental Service are:

Service Aims/Priorities	**Objectives/Actions**
Increase patient access by increasing primary dental capacity	1. Encourage new independent NHS dental practice/s to open 2. Develop a business plan for extended opening in the PDS 3. Free up capacity by streamlining domiciliary care 4. Free up capacity by additional use of NICE guidelines on intervals between dental examinations
Develop a team of clinicians with a range of knowledge and skills suitable for the Public Dental Service remit	Promote the in-service development of existing clinicians, and use opportunistic recruitment of suitably experienced clinicians to build a team of staff who combine a broad range of additional skills and special interests.

Detailed Actions/Plan for Change

Ongoing Actions/Projects Started prior April 2015					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Encourage/facilitate at least one new independent NHS dental practice to open in Shetland	CADO & DBM	2015	3/2016	An increase in dental capacity outside the management of the PDS	Will relieve PDS access difficulties by re-registering existing PDS patients, and also take unregistered people from the PDS registration waiting list.
Develop a staff handbook to include information and protocols for various aspects of the PDS, incorporating much of what is currently unwritten 'custom & practice.'	PDS	9/2014	12/2015	A staff information handbook	Staff able to work in a more coordinated and consistent way across the whole clinical network. Greater staff confidence.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Assess the feasibility of developing a Business Plan to increase PDS capacity by extending opening hours.	PDS		3/2016	Increased capacity.	Possibly more efficient use of resources. Increased patient choice. Increased opportunities for flexible working
Strengthen the use of NICE Guidelines for varying dental examination intervals according to patient need	PDS		3/2016	Releases clinical time to enable better care for people with greater needs	Patients helped to make informed choices. Improve care for those with greater needs using the additional capacity
Introduce a revised protocol for domiciliary visits to meet increasing need and maximise cost-efficiency	PDS		3/2015	More cost-effective use of clinical time, and increased capacity	Use dedicated session(s) and clinical team for Lerwick/South mainland residents, freeing whole-session surgery capacity.
Review clinical workforce recruitment to build a stable and sustainable service structure suitable for a PDS remit	PDS		3/2016	Better patient outcomes. Improved team-working. More staff who have additional skills.	A more highly skilled and experienced workforce through in-service development of existing clinicians, and also recruitment of staff who can bring additional skills.
Provide all patients with a costed treatment plan for each episode of care	PDS		6/2015	Each patient will have a treatment plan and cost estimate for each	To meet Scottish NHS dental requirements, and to inform and empower patients.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
				episode of care	
Develop a fresh Oral Health Strategy for Shetland to drive developments over the next 3 years	PDS	4/2015	8/2015	Refreshed strategic direction for PDS and the provision of local GDS practices	Greater patient understanding of the PDS and how it functions, and of mutual expectations.
Increase the range of Patient Information Leaflets to increase patient knowledge, reduce complaints, and improve patient-staff relations	PDS	4/2015	12/2015	A series of up to date patient information leaflets. A decrease in the number of DNAs.	Greater patient understanding of the PDS and how it functions, and of mutual expectations.

Risks to Delivery

The shortfall in primary dental care capacity – both the infrastructure (dental surgeries) and the staff - dentists/ other dental care professionals.

The geographical isolation of remote, rural and island communities, challenges the cost-efficient provision of oral health care.

The increasing number of elderly people requiring domiciliary visits for high-maintenance dental care of their own teeth.

The ability to recruit suitably experienced dentists to build sustainable, long-term dental services for Shetland residents.

The difficulty in providing post-graduate training opportunities for existing dentists, coupled by a lack of resources for post-qualification opportunities for other Dental Care Professionals

Performance Indicators

Performance Measure	Performance 2013/14	Performance 2014/15	Target 2015/16
The ratio of the wte of primary care dentists providing NHS oral health care to the total resident population of Shetland at the end of the year	1:3013	1:2500	Less than 1:2500
The percentage of the adult and child populations who are registered with Shetland dentists for NHS dental care	-	88.06%	Over 88.06%
Level of unmet capacity: Numbers of people on waiting lists to register for NHS dentistry		1120	Less than 1120
Decay experience of children in P1: The mean dmft (decayed, missing or filled teeth per child) of children aged 5-6 years in P1 attending SIC primary schools.	dmft 0.64 (Scottish average dmft 1.27)		dmft less than 0.64
HEAT target on Fluoride applications: Percentage of 3 and 4 year olds in worst performing SIMD quintile receiving 2 fluoride varnish applications in a year	75% (Scottish average 19.64%)		More than 75%
Episodes of Care: The numbers of individual clinical contacts made by dentists and dental care professionals working within NHS Shetland over a 1 year period		7044 (6mths figure)	14088

Contact Details

Montfield Clinic Burgh Road Lerwick ZE1 0LA Tel: 01595 743160	Dental Clinic St Olaf Street Lerwick ZE1 0ES Tel: 01595 745769	Dental Suite Gilbert Bain Hospital Lerwick ZE1 0TB Tel: 01595 743681	Dental Clinic Brae Health Centre Brae ZE2 9QJ Tel: 01806 522098	Dental Clinic Whalsay Health Centre Symbister Whalsay ZE2 9AE Tel: 01806 566469	Dental Clinic Yell Health Centre Mid Yell Yell ZE2 9BX Tel: 01957 702031

Palliative Care Services
2015-16 Service Plan

Supporting Community Health and Social Care Departments vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for both the council, the health board and the Joint Integration Strategy. This Service Plan provides an overview of the Palliative Care Services for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The provision of Palliative Care services across Shetland supports the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community" for as long as possible.

Drivers for Change

Following on from work completed as part of Living and Dying Well, Palliative and End of life care Indicators (Health Improvement Scotland March 2013) are in the process of being implemented during 2014 -2015 as measures to demonstrate delivery of person – centred, safe and effective palliative and end of life care. Performance against these will be measured in 2015-2016.

Following negative publicity raised in England regarding the use of the Liverpool Care Pathway, the Scottish Government issued a position statement which noted the desire to move away from the routine use of the Liverpool Care Pathway to the delivery of patient care at the end of life based on the following 4 principles:

1. Informative, timely and sensitive communication is an essential component of each individual patient's care.
2. Significant decisions about a patient's care, including diagnosing dying, are made on the basis of multi-disciplinary discussion.
3. Each individual patient's physical, psychological, social and spiritual needs are recognised and addressed as far as is possible.
4. Consideration is given to the wellbeing of relatives or carers attending the patient.

A local integrated care pathway to support care of the dying was implemented in February 2014.

During 2013 a new local Palliative and End of Life Care Strategy was developed. The content of the strategy is based on contributions from patients, healthcare professionals working in a number of settings, cancer and palliative care specialists, community care services, public health, voluntary services and members of the public. In summary, the feedback from both the public and professionals alike, noted the importance of supporting choice for people with palliative and end of life care needs.

Work continues to progress implementation of the action plan.

About Us

Palliative care is the active total care of an individual whose disease is not responsive to curative treatment and who is in the end stage of life. This can apply to people of any age including children. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life for individuals, their families and carers.

Palliative Care services will:

- focus on the quality of life;
- respect autonomy and choice;
- provide good pain and symptom control;
- respond to psychological, social and spiritual needs;
- communicate openly among individuals, families, carers and staff;
- support individuals to help them have a full and active life for as long as possible;
- support families and carers to help them cope during an individual's illness and in their own bereavement.

Palliative care services are delivered by staff who work in the Acute and Specialist Services Directorate as well as staff who work in the Directorate of Community Health and Social Care. The Macmillan team and Specialist Nurse Team are line managed through the Acute Services Structure with the District Nursing and Community Care services being line managed in the Directorate of Community Health and Social Care.

Through the restructuring of the Acute Services in October 2013, the Macmillan and Specialist Nurse team were placed in the Acute and Specialist Services Directorate. The District Nursing service was placed in the Directorate of Community Health and Social Care following the

decision by the Council and Health Board to jointly appoint a Director of Community Health and Social Care in February 2014. This was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

The Service provides palliative care services for individuals at the end of life, supporting them to die in their preferred place of choice. District Nurses in conjunction with Community Care support staff, support individuals to die within a community based setting. The Macmillan and Specialist Nurse team (Cardiac Nurse Specialist, Diabetes Specialist Nurse, Stroke Nurse and MS Nurse) provide expert advice and contribute to the care of patients with palliative care needs in both hospital and community settings.

Additional expertise can be sourced, as necessary, from the Specialist Palliative care resources available through Roxburghe House in Aberdeen.

Who We Are

The Macmillan and Specialist Nurse teams sit within the Acute and Specialist Services Directorate and is led by the Director of Nursing and Acute/Specialist Services.

The District Nursing Service and Community Care support services sits within the Community Health and Social Care Directorate and is led by the Director of the Community Health and Social Care.

The following Services are also in the Community Health and Social Care Directorate - Adult Services, Community Care Resources, Social Work (including Criminal Justice), Mental Health services, Occupational Therapy services, Dental Services and Pharmacy services.

Organisational Chart

Locations

The Macmillan and Specialist Nurse teams are both based in the Gilbert Bain Hospital and provide an outreach service to patients on a Shetland wide basis. The Macmillan team are 3 WTE and the Specialist Nurses comprise 2.9wte.

The District Nursing Service is located at each of the Health Centres throughout Shetland. In addition the District Nursing service provides 24hour cover, on a 7 day a week basis, 365 days a year across Shetland. This service is provided either via a shift based system or an on call service in the out of hours period thus enabling provision of care in a home or community setting on a 24hour basis. The District Nursing service comprises 26.93 WTE, excluding the resident nurses on the Non-Doctor Islands.

The Community Care staff are based in localities throughout Shetland and provide a range of support services to individuals within that geographical area, whether in a residential or home setting. Health and care staff work closely together in order to support the delivery of a comprehensive palliative care service within the community setting.

Governance

The Community Nursing Service is part of the Community Health and Social Care Directorate and reports to the Social Services Committee and Community Health Partnership Committee which meet concurrently.
The Service's performance is reported to the Directorate Management Team monthly and PIs from this plan is reported to the Social Services Committee and Community Health Partnership Committee 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

All nursing staff working within the area of Palliative and End of Life Care are required to have current active registration with the Nursing and Midwifery Council (NMC).

Other professional groups will also hold the appropriate Registration with their respective regulatory bodies eg General Medical Council (GMC), Scottish Social Services Council (SSSC).

What We Do

The District Nursing Team, provide a generalist nursing service for individuals with a range of healthcare conditions. This service is provided predominantly to patients who are housebound. This includes individuals in the palliative and end stage of life.

The Macmillan Nursing team aim to provide an integrated oncology and palliative care service across hospital and community services, for individuals with both cancer and non-cancer conditions.

Specialist support and advice is available from the Macmillan nursing team and other specialist Long Term Conditions nurses e.g. cardiac, stroke, continence , dementia and MS nurses. Systems are in place to meet the palliative needs of individuals with all Long Term Conditions.

Our Customers

There are on average between 200 and 230 deaths each year in Shetland. We now know that only a quarter of people die a sudden death and three quarters die from conditions such as organ failure (such as respiratory or heart disease), frailty, dementia and cancer. This means that up to 170 people in Shetland each year may need access to some type of palliative or supportive care at the end of their life to meet their needs.

Previously palliative care focused on the needs of people with cancer, however, services are increasingly working to ensure the needs of all people requiring palliative care are addressed.

People living at home or in residential care will be supported by their GP, community nursing service, specialist nurses, psychological support services and social care services.

Support is provided through:

- Anticipatory Care Plans,
- Electronic Palliative Care Summaries (ePCS), and electronic Key Information Summaries (eKIS)
- Do Not Resuscitate Policy,
- Integrated care pathway ,
- Just in Case boxes, and
- 24/7 Community based Nursing

Tele-conferencing facilities are also used to help with the management of health care needs across all geographical settings.

All agencies work together to provide a flexible, rapid response for palliative care cases where patients have reached the end stage of life.

Community care services include:

- residential care,
- day care,
- personal care at home,

- help with domestic tasks,
- occupational therapy,
- specialist equipment, adaptations and Telecare.

Respite care and short breaks at home for people with Palliative care needs are provided by the local Crossroads Care Attendant Scheme.

Shaping Bereavement Care (2011) set out a framework for the development and delivery of quality bereavement care services. Work has been progressed locally to develop action plans to meet the needs of families.

The importance of providing training in order to support people, their families and carers is recognised. Joint training plans are developed between Health and Social Care and the Voluntary sector which includes palliative care and bereavement.

Our Costs and Income

As Palliative Care services are provided via various staff teams across Acute services and the Directorate of Community Health and Social Care it is not possible to identify separately the costs attributed to the provision of a Palliative care service. The table outlines the total Registered Nursing service who may support individuals with palliative needs within a community setting.

Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management					Nil
Team 1 – District Nursing service	26.93				Nil
Team 2 – Macmillan Nursing service	3				
Team 3 – Specialist Nurses	2.9				
Service Total	32.83				

NB No staff member dedicated to the provision of Palliative Care services only

Funding and resources

Funding for all the services listed is provided by core NHS funding.

Aims and Objectives

The Palliative Care Services aim

- To provide appropriate, high quality palliative care in all care settings that is person- centred, safe and effective.
- To provide a comprehensive rapid response service for palliative care.

Directorate Plan Aims	Action
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so.
People who use health and social care services have positive experiences of those services, and have their dignity respected	There will be more flexible services and more choice for our customers, within available resources.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	Where possible a customer will have allocated to them a named individual who looks after their service needs so that they only need to “tell their story once”.

Service Aims/Priorities	Objectives/Actions
The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so.	Community based health and care staff, supported by local and NHS Grampian based specialist resources, will support the delivery of a comprehensive palliative and end of life care service in a community setting.
There will be more flexible services and more choice for our customers, within available resources	Working within localities, health and care staff will endeavour to provide as flexible a palliative and end of life care service to meet individuals specific needs, as resources allow
Where possible a customer will have allocated to them a named individual who looks after their service needs so that they only need to "tell their story once".	Community health staff will take a lead role in the co-ordination of services for individuals with complex palliative and end of life care needs.

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15		
Description	**Delivered Early/on-time/late**	**Achieved original intention?**
Implementation of "Just in Case" boxes across Shetland	Delivered	Achieved original intention of providing an anticipatory approach to planning for end of life care.

Review of "Liverpool Care Pathway" and revision to locally agreed "principles of care" and Integrated care pathway to support end of life care	Delivered	Continues to support a structured approach to end of life care whilst also providing appropriate reassurance for patients/families/carers/public on the management of end of life care.
Support for General Practices to move from electronic Palliative Care Summaries (ePCS) to use of electronic Key Information Summary (eKIS)	Delivered/Ongoing	The eKIS provides a greater range of information about an individual and their personal circumstances than the ePCS and therefore increases the ability of services to respond more appropriately to individual's needs.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Implement system to monitor KPIs as outlined in Healthcare Improvement Scotland's (HIS) Palliative and End of Life Care Indicators	Chief Nurses Acute & Community Health & care with respective teams	April 2015		Data to demonstrate local performance against national benchmark standards	Service wide understanding of local performance in relation to Palliative and end of life care. Ability to work to improve performance once baseline position known.
Implement Managed Clinical Network approach for Palliative and	Director of Community	December		Focus given to enhancing services	Opportunity to review and enhance care and service provided for patients

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
End of Life Care	Health & Social Care Chief Nurse DCH&SC	2014		provided for palliative and end of life care	and families who require palliative and end of life care services
Implement action plan from revised Palliative and End of Life Care Strategy	DCH&SC Chief Nurse DCH&SC	February 2015		Enhanced palliative and end of life care	Palliative and end of life care services meet the needs of individual patients and families.

Risks to Delivery

Workforce planning within the Specialist Nursing workforce has been fairly static over the last year, however, significant challenges have been faced within the Community Nursing services, in particular the District Nursing service. The District Nursing service has experienced significant difficulty with recruitment in the service, the effects of this in terms of service provision being further compounded by the number of staff whom have had long term sickness absence whilst awaiting / recovering from surgical interventions. Service developments have been limited in 2014-2015 as staff have had to focus on meeting the clinical needs of patients on the current caseload. It is anticipated that these issues will be resolved before we enter 2015-2016.

Palliative Care Services Plan 2015/16

Key Service Indicators

Performance Measure	Performance 2014/15	Target 2015/16
Proportion of people with cancer who are on a palliative care register		
Proportion of people with a long-term condition other than cancer who are on a palliative care register		
Proportion of people with cancer who have an electronic palliative care summary		
Proportion of people with a long-term condition other than cancer who have an electronic palliative care summary		
Proportion of people who have had their electronic palliative care summaries accessed		
Proportion of people who die in hospital		
Proportion of people who die in their usual place of residence		

Contact Details

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Pharmacy and Prescribing

2015-16 Service Plan

Supporting Community Health and Social Care Departments vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for both the council, the health board and the Joint Integration Strategy. This Service Plan provides an overview of the Pharmacy and Prescribing Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Pharmacy and Prescribing Service is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".* The Pharmacy Vision statement which facilitates this is drawn from the Scottish Government *Prescription for Excellence* states " That everyone should receive the same standard of pharmaceutical care, regardless of where they live"

Drivers for Change

Prescription for Excellence builds on the Government's 2020 Vision Route Map and Quality Strategy Ambitions. It recognises pharmacists as experts in the therapeutic use of medicines and highlights their potential contribution through integration into health and social care teams.

Over the next few years significant changes will occur in medicine and therapeutics. These changes necessitate the development of new and innovative models of care to enable patients to obtain the maximum benefit. Pharmacists will have a key role in this. Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and reduce the likelihood of adverse events.

Patients, regardless of their setting or where they live should receive high quality pharmaceutical care. This is particularly important for patients with complex health issues including multimorbidities and those living in care homes. Going forward, pharmaceutical care provision should

complement and support dispensing doctors' services and their patients, with a shifting emphasis towards enhancing safety and pharmaceutical care.

These aspirations will result in clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners

An essential role of the clinical pharmacist working within the team will be to initially assess the patient for potential issues to help inform the choice of medication. In addition they will be responsible for the continual monitoring of the effects and side effects and making adjustments to dose.

The NHS continues to face increasing workforce pressures. The inclusion of NHS accredited clinical pharmacists into the primary care team is intended to increase the clinical capacity and assist in addressing the growing demands in primary care, particularly as our population in Shetland ages, and the complexity of their care increases.

About Us

The department has been in place since 1998 it has steadily grown since then and for the first time in 2012 has sufficient staffing to provide a service rather than an input. The service is now within the Health and Social Care directorate following the decision by the council and Health Board to jointly appoint a director of Community health and Social Care in February 2014. This was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

Pharmacy services include:

- Supporting General Practices in demonstrating safe and effective prescribing
- Providing a modern pharmacy service for the Gilbert Bain Hospital in line with standards laid down by the Royal Pharmaceutical Society, which includes: procurement and dispensing, teaching junior doctors, medicine reconciliation, providing safety and clinical checks, providing information and support to all prescribers.
- Developing and supporting the process around the current work to address health inequalities in access to high-tech medicines. Including those supplied directly to patients by Homecare companies

- Supporting dispensing practices in line with *Prescription for Excellence*
- Working within Care Homes and patients own homes so helping to ensure patients are receiving medicines safely and that waste is avoided
- Providing prescribing clinics, run by pharmacists, such as polypharmacy reviews to minimise the harm and maximise the effect of medicine regimes.
- Support for community pharmacies to ensure the continuity of contracted arrangements including: the delivery of safe and effective dispensing, patient safety programmes, a modern substance misuse service, Minor Ailments Service, Public Health Service and the Chronic Medication Services

Who We Are

This Service sits within the Community Health and Social Care Directorate and is led by the Director of the Community Health and Social Care.

The Service comprises a Director of Pharmacy, shered with NHS Orkney, the Director of Pharmacy has a role in overseeing the governance arrangements around the procurement prescribing supply pharmaceutical services and input into the clinical use of medicines in Shetland. The Director of pharmacy is the Accountable Officer for Controlled drugs in Shetland and Orkney as defined in the Health Act of 2006.

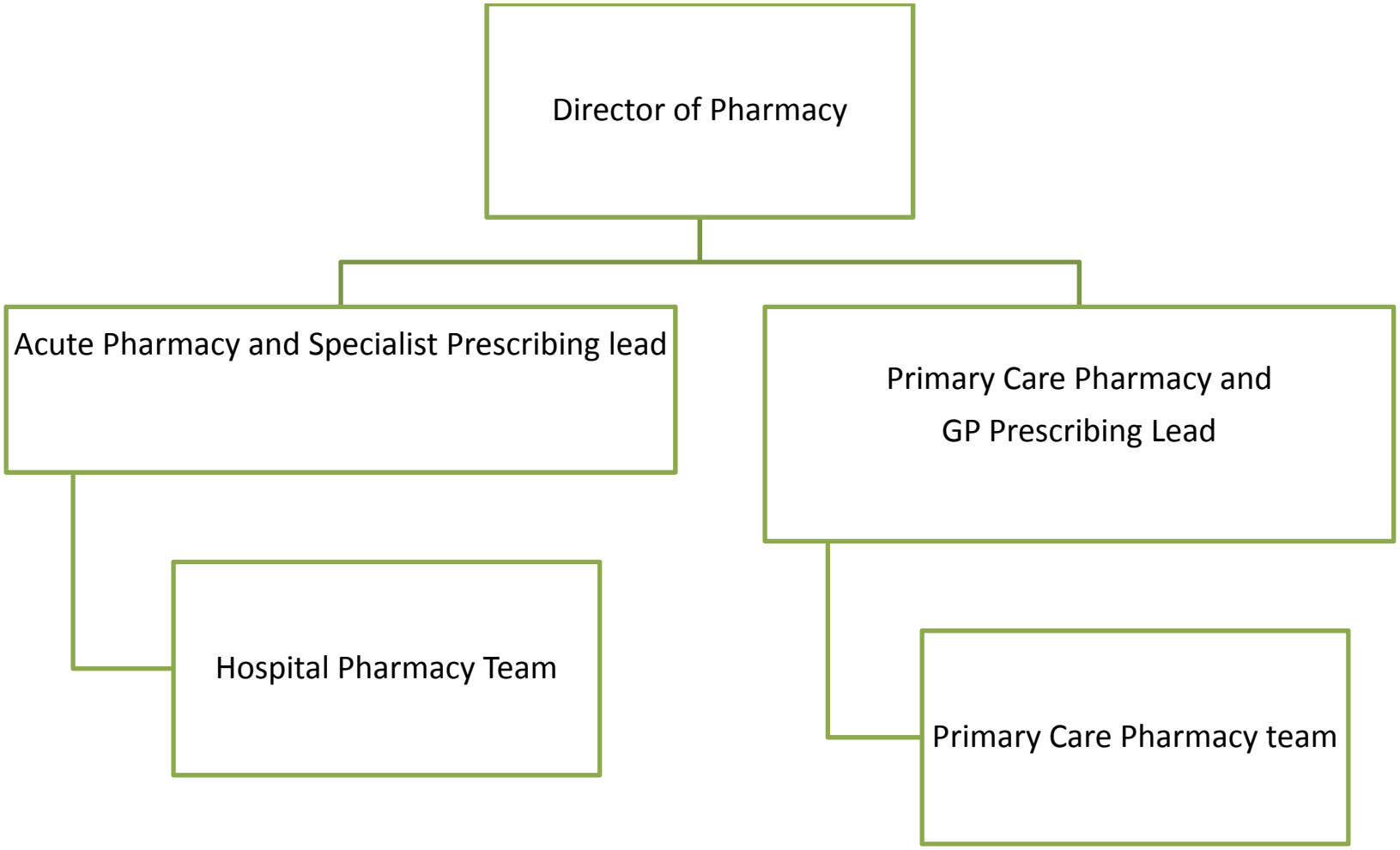
There are four full time pharmacist within the managed service, and four technicians and 1.5 WTE support staff. 6.5 of these staff are occupied within the Acute service.

Within the team, pharmacists have or are working towards a prescribing qualification and can independently prescribe in their own right.

The hospital pharmacy service is a technician led service which means the senior technician is responsible for all aspects of the procurement dispensing and checking of prescriptions. The hospital pharmacists having a ward based clinical role.

In primary care, the team worrk within health centres and care homes, with outreach into patients own homes to support patients with their medicines

Organisational Chart



Locations

The Pharmacy and Prescribing Service is based at the Gilbert Bain Hospital, the Director of Pharmacy works from Montfield, Lerwick and is based in the Health and Community Care Directorate

Governance

The Pharmacy and Prescribing Service is part of the Community Health and Social Care Directorate and reports to the Social Services Committee and Community Health Partnership Committee which meet concurrently. In due course reporting to the Integrated Joint Board. The Service's performance is reported to the Directorate Opertaional Management Team, 5 PIs from this plan is reported to the Social Services Committee and Community Health Partnership Committee 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

Pharmacists and Pharmacy Technicians are regulated by the General Pharmaceutical Council. Community pharmacy premesis are also regulated by this body. Pharmacist professionally work to standards laid down by the Royal Pharmaceutical Society. Increasingly health Improvement Scotland have a role in audits of pharmaceutical activity. There are Home office and Medicine Control Agency Regulations and compliance notices which need to be followed.

What We Do

- Hospital Pharmacy Team, responsible for:
  Activity 1 – Providing a modern pharmacy service for the Gilbert Bain Hospital in line with standards laid down by the Royal Pharmaceutical Society, which includes: procurement and dispensing, teaching junior doctors, medicine reconciliation, providing safety and clinical checks, providing information and support to all prescribers.
- Activity 2 –Developing and supporting the process around the current work to address health inequalities in access to high-tech medicines. Including those supplied directly to patients by Homecare companies

Primary Care pharmacy Team, responsible for:

Activity 1 - Supporting General Practices in demonstrating safe and effective prescribing

Activity 2- Supporting dispensing practices in line with *Prescription for Excellence*

Activity 3 - Working within Care Homes and patients own homes so helping to ensure patients are receiving medicines safely and that waste is avoided

Activity 4- Providing prescribing clinics, run by pharmacists, such as polypharmacy reviews to minimise the harm and maximise the effect of medicine regimes.

Activity 5 -Support for community pharmacies to ensure the continuity of contracted arrangements including: the delivery of safe and effective dispensing, patient safety programmes, a modern substance misuse service, Minor Ailments Service, Public Health Service and the Chronic Medication Services

Our Customers

The Pharmacy Service Provides pharmaceutical care to all patients who take medicines in Shetland.
We have identified a need to provide efficiencies in prescribing which places a further demand on prescribing support and pharmacist hours.

People in care homes and in their own homes require care cloise to where they live, with an increasing number of older people, with an increasing number of long term conditions being treated in a wide variety of location, the demands on the pharmacy service is set to increase. in the future and we anticipate this will benefit around 50 households and 10 care homes in the coming year.

Our Costs and Income

The Service has 9.48 full time equivalent staff and annual net expenditure of £5,601,110, detailed below:

Health & Social Care – Pharmacy and Prescribing Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Director of Pharmacy	1			75,134	Nil
Hospital Pharmacy	6.48			266,577	Nil
General Pharmaceutical Services	2			4,122,399	Nil
Specialist Drugs	-			346,000	Nil
Chemists	-			791,000	Nil
Pharmacy and Prescribing Service Total	**9.48**			**5,601,110**	**Nil**

Funding and resources

The income is derived from sharing the Director of Pharmacy with Orkney. Drug costs escalate each year with expensive and highly cost effective specialist medicines being made available. The cost of most medines in the GP prescribing budget does not change, but the volume of medines used increases each year with the growth of treated long term conditions among the growing number of people over 50.

Each year the pharmacy team find saviongs through prescribing efficiencies and reducing waste. Whilst a proportion of these savings are recurring they do need to be maintained. So each year a growing amontt of time is spent in maintaining the savings gained in previous years.

Pharmacy and Prescribing Service Plan 2015/16

Aims and Objectives

Service Aims/Priorities	Objectives/Actions
Reduce Prescribing Costs	Reduce wastage Improve efficiency
Improve Pharmaceutical Care	Support Professionals Patients in Carers in ensuring that medicines provide maximum benefit and minimum harm. Bring services closer to where people live providing pharmacists and technicians in health centres, care homes and making them available for home visits.

Detailed Actions/Plan for Change

Ongoing Actions/Projects Started prior April 2015					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Providing a range of Pharmacy efficiency and medicine reduction schemes	Primary Care			Started in June 2014, currently on-time to finish in April 2015	Resources are used effectively and efficiently in the provision of health and social care services

Pharmacy and Prescribing Service Plan 2015/16

Develop a strategic plan to describe and tie together the ongoing actions in rolling out Prescription for Excellence	DOP		Action plan will run until 2024	July 2015	People who have long term conditions or who are frail are able to live as far as reasonably practical, independently at home or in a homely setting in their communityesources are used effectively and efficiently in the provision of health and social care services
Provide Pharmacy and technician support to Care Homes	Primary care			Started in June 2014, This work is ongoing	People who have long term conditions or who are frail are able to live as far as reasonably practical, independently at home or in a homely setting in their community
Run polypharmacy clinics and additional clinics using tekle links between community pharmacies and remote island locations. Work will be rolled out from pilot work done in the remote islands with board employed pharmacist	Primary care			Started in April 2014, this work will be ongoing	People who have long term conditions or who are frail are able to live as far as reasonably practical, independently at home or in a homely setting in their community and people using services are kept safe from harm.
Develop Hospital technician led service	Acute			Started in June 2014, currently on-time to finish in April 2015	Resources are used effectively and efficiently in the provision of health and social care services

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Improve controlled Drug governance	Director			Plan to start work in November 2015	
Improve Management systems around vaccines	Acute			Commence work in April 2015 resource permitting	Resources are used effectively and efficiently in the provision of health and social care services
Ramp up poly pharmacy and care Home work For an ageing population that has increasing multiple delivery of NHS pharmaceutical care to all patients in all settings is essential A step change in establishing collaborative partnerships within the integrated health and social care system in order to achieve the best possible outcomes from medicines with care staff increasingly working alongside pharmacists and technicians	Health and Social care			Plan to introduce additional hours in November 2015	Resources are used effectively and efficiently in the provision of health and social care services People who have long term conditions or who are frail are able to live as far as reasonably practical, independently at home or in a homely setting in their community and people using services are kept safe from harm.

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Performance Indicators

Key Service Indicators

Performance Measure	Performance 2014/15	Target 2015/16
Cost per patient (GP Prescribing)	N/A	£125
Number of prescriptions for antibiotics per 1000 patient population	N/A	575
Number of polypharmacy reviews completed	N/A	2
Hospital Prescription time turnaround	N/A	90% dispensed within 90 minutes of receipt
Percentage of requests for non formulary medicines processed within 10 working days	N/A	100%
Percentage of patients who's medicines are reconciled by a a pharmacist within 72 hours of admission	N/A	75%
Number of discharge prescriptions dispensed out of hours by nursing staff.	N/A	Less than 5%

Other Performance indicators

These Indicators are new, once measured we will establish Improvement levels

Indicator	2014/15	Target 2015/16
Cost per patient (GP Prescribing)		
Number of prescriptions for antibiotics per 1000 patient population		
Number of polypharmacy reviews completed		
Hospital Prescription time turnaround		
Percentage of requests for non formulary medicines processed within 10 working days		
Percentage of patients who's medicines are reconciled by a a pharmacist within 72 hours of admission		
Number of discharge prescriptions dispensed out of hours by nursing staff.		

Contact Details

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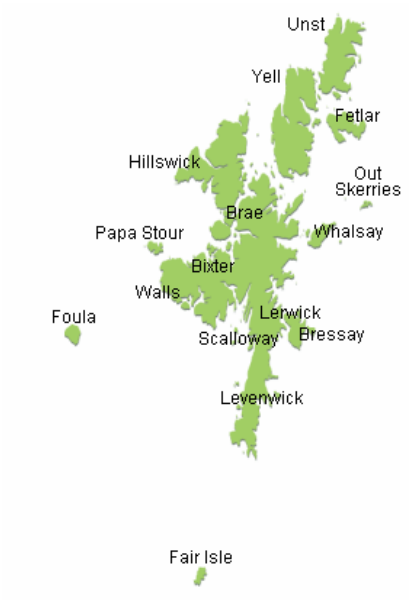
Primary Care
2015-16 Service Plan



Supporting Community Health and Social Care Departments vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for both the council, the health board and the Joint Integration Strategy. This Service Plan provides an overview of the Primary Care Service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Service plans are approved and "signed off" at Director Level as part of the Manager's Performance Appraisal and Development Review process.

Vision Statement

Primary Care across Shetland is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".*

Drivers for Change

Traditionally, health care developments have focused on the services based in acute hospital settings when the reality is that 90% of patient contact with health services is based in the community and is delivered by Primary Care Teams (GPs, Advanced Nurse Practitioners, Practice Nurses, District Nurses, Pharmacists and related Support Staff).

NHS Shetland recognises that a change in the balance of care towards treating people in as close to their homes as possible is necessary and a holistic and integrated approach to health care service delivery is more favourable for the organisation as well as the patient. At the same time, the 2012-15 CHCP Agreement states "*it is noted that budget pressures are severe and continue to have a significant impact on plans for the next 10 years. There are continuing challenges too from the demographic profile which sees a population that is ageing rapidly. It is essential that we continue to work well together to implement sustainable solutions to the problems we face*."

The NHS Shetland 2020 Vision aspires ***"****to deliver sustainable high quality, local health services, that are suited to the needs of the population; to make best use of our community strength, community spirit and involvement; for people to make healthy lifestyle choices, and to use their knowledge and own capacity to look after themselves and each other****".*** This vision is echoed in the Local Delivery Plan (April 2014), which identifies five corporate objectives for NHS Shetland:

- Improving and protecting the health of the population

- Delivering quality, effective and safe services
- Continuously redesigning our services to ensure they are modern and sustainable;
- Providing best value for the use of the (public) resources for which we are responsible; alongside
- Strengthening organisational capability, capacity and resilience.

Looking to the future, primary health care services will be required to adapt to meet the health care needs of an ageing population that has rising expectations of health care and treatments. Other factors that affect the development of services include statutory guidance on working hours, rising professional standards and a shortage of health care professionals.

The key drivers for looking at how primary care operates are:

- We want to improve the health of the people in Shetland and ensure healthcare services are meeting public expectation;.
- There is greater demand on local health services in part due to an aging population, with greater health needs;
- A Hospital setting is not always the answer; more care can be delivered in primary care and community settings than ever before and patients benefit from care provided closer to their home;
- There are workforce challenges (for example recruitment of GPs) which currently affect delivery of the best quality care and optimal patient outcomes;
- We need to adopt new models of care and best practice which can deliver better health outcomes for patients;
- We want to ensure care is safe, effective, efficient and patient centred.

Through implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 Joint Integration Boards will be responsible for ensuring that the Community Health and Social Care Partnership delivers on the Health and Wellbeing Outcomes for their local population. These outcomes include the following:

1. Healthier living

Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.

2. Independent living

People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.

3. Positive experiences and outcomes

People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.

4. Carers are supported

People who provide unpaid care to others are supported and able to maintain their own health and wellbeing.

5. Services are safe

People using health, social care and support services are safe- guarded from harm and have their dignity and human rights respected.

6. Engaged workforce

People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.

7. Effective resource use

The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.

About Us

Traditionally, the “four pillars” of Primary Care have been GP Services, Pharmacy Services, Dental Services and Ophthalmic Services. There are separate dental and pharmacy departments in Shetland.

For GP Services, there are ten Health Centres in Shetland, together with five non-doctor islands which are staffed by Community Nurses and who receive GP services from a local health centre. Of the ten GP Practices, three are directly salaried to NHS Shetland (all staff are employed by NHS Shetland) and the other seven are what is known as independent practices – this means they contract with NHS Shetland to provide core GP services to their practice population, for which they receive funding worked out through a national formula and it is the responsibility of the independent GP practice to decide how to use this funding to provide the contracted services.

GP Practices are recognised as the ‘way in’ to services by most people and as a place to go to with general concerns. Other points of access in Shetland include five Community Pharmacies, three Opticians and the Dental Service. A recent addition to direct access has been the introduction of a self referral process to physiotherapy. Out of hours services and A&E may also be the first point of access for some people.

An effective front line entry point for patients is essential to ensure that there is timely access to assessment, advice and treatment. The current structure of General Practice and Community Services gives access across Shetland, including the islands, with corresponding opportunities to develop relationships with individuals and families and for consistency and continuity of approach. However, there are a number of challenges as detailed below:

- There is variation in opening times, different appointment systems and waiting times for appointments between practices;
- There is variation in additional services provided, for example enhanced family planning and minor surgery;
- There are current difficulties with balancing the requirements to provide enough appointments to meet demand within waiting times, with the need to spend sufficient time with patients;
- There are geographical issues, which may influence ease of access;
- There are noticeably different arrangements in hours and out of hours;
- Recruitment and retention has proven to be problematic in recent years, across all Practices in Shetland. It is not unusual for there to be several rounds of advertising and it is becoming more difficult to recruit staff who wish to work in a remote and rural location;
- A changing workforce profile and changing skills set needed for new models of care;
- Changes to secondary care provision in terms of services now being offered through primary care providers rather than the hospital;
- Inequity of funding provision across Primary Care in Shetland;
- Clinical/medical innovations and improvements such as telehealth.

Yell, Unst and Whalsay are all single handed GP practices on islands and cover their own Out of Hours. It is not envisaged that this arrangement will change at any time in the near future. Hillswick is also single handed and covers their own OOH. It should be noted that these 4 practices have a part time Associate GP to cover annual leave etc; there is 1 GP on duty 24/7. The island of Yell has introduced the use of NHS24 out of hours, as a vehicle through which patients can contact their island GP. This supports the single handed GP on the island – if the GP is out on a visit, then the call will be taken by NHS24 who will give patients any immediate advice and can then contact the GP directly without the patient having to make another call. This arrangement could be put in place for the other practices that cover their out of hours as required to augment existing services. The remaining practices form part of an Out of Hours co-operative, with a rota being prepared each month by the Service Manager Primary Care. Out of hours GP services are available between 5.30pm and 8.00am on weekdays, at the weekend and on public holidays. These services provide help when General Practices are closed and the condition is too serious to wait until the next day. When patients phone practices out of hours, they will get a message explaining how to contact the local out of hours service. In Lerwick there is a walk in clinic every Saturday morning between 10am and 12 noon for those patients who have a problem which cannot wait until their surgery reopens on Monday morning. Additional GP walk in clinics are provided during the Christmas and New Year period.

The majority of the Out of Hours GPs in the co-op also provide services to the police station, following a change in process from 1st April 2014 – at this point, Health Boards became responsible for individuals requiring healthcare whilst held in police station custody. In Shetland, it was decided that rather than individuals attending A&E (which is the case in Orkney), the Out of Hours GPs would be asked to attend call outs instead. The rota for this work is undertaken by the Service Manager Primary Care, with the Medical Director being responsible for any clinical issues.

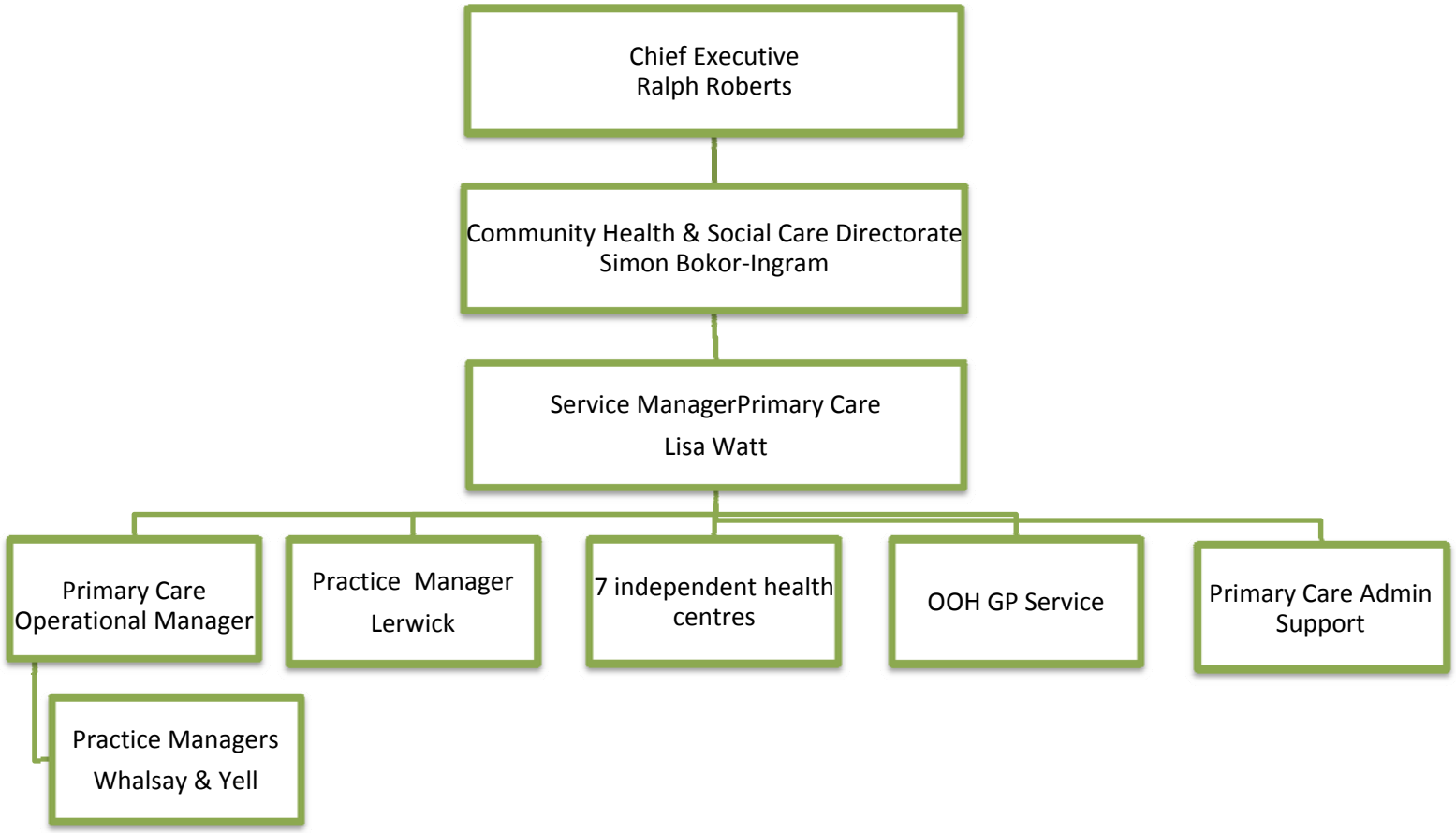
Within Ophthalmic services, there are three providers of general ophthalmic services in Lerwick, which are open to all Shetland residents. There are also visiting Ophthalmic Consultants who hold clinics in Gilbert Bain Hospital for patients referred to them with complex eye problems.

Who We Are

This Service sits within the Community Health and Social Care Directorate and is led by the Service manager Primary Care, Directorate of Community Health and Social Care. The following Services are also in the Community Health and Social Care Directorate – Community Nursing Services, Adult Services, Community Care Resources, Social Work (including Criminal Justice), Mental Health services, Occupational Therapy services, Dental Services and Pharmacy services.

The Primary Care Department consists of three individuals – Service Manager Primary Care, Primary Care Operational Manager and a PA, whose role includes sole responsibility for several IT systems including GPCD, OPCD, SCCRS (cervical cytology) and SIRS (childhood immunisations pre-school). The department has a wide remit and has a seat on the Primary Care Leads group for Scotland. The GP Appraiser for Shetland is contracted on 0.4 WTE sessions per week and the funding for this post sits within the overall Primary Care Department costs. This individuals sole responsibility is to undertake GP Appraisals and they have no other role within primary care.

Organisational Chart



Locations

The GP Practices in Shetland are in Unst, Yell, Hillswick, Brae, Whalsay, Bixter, Walls, Scalloway, Lerwick and Levenwick. Between them they care for 22,500 patients, with various sizes of practice populations. The Ophthalmic practices are in Lerwick.

Governance

The Primary Care Department is part of the Community Health and Social Care Directorate and reports to the Social Services Committee and Community Health Partnership Committee which meet concurrently. The Service's performance is reported to the Directorate Management Team monthly and PIs from this plan is reported to the Social Services Committee and Community Health Partnership Committee 4 times per year as part of the Department's quarterly performance report. There are various HEAT targets which relate to Primary Care, together with QOF (Quality Outcomes Framework) indicators which are reported on nationally.

Regulation and Compliance

All General Practitioners must be registered with the General Medical Council and have yearly appraisal. In addition, they must be registered on the GPCD system in order to work in a health board area and must take part in revalidation every 5 years

What We Do

For medical advice and treatment, or prescriptions, patients can make an appointment at a General Practice in their locality. Practices vary in size and can have a wide range of staff, including nurses and health visitors (please note that Community Nurses and Health Visitors are employed by NHS Shetland, not the GP Practice). Practices run clinics for those with long term conditions (which include asthma, diabetes, epilepsy, hypertension etc) and provide health improvement services such as smoking cessation, alcohol brief interventions etc. Weight management ('Counterweight') and 'Keep Well' health checks are also available in a number of practices. GPs provide face to face appointments, telephone advice and house calls (as appropriate) and in addition make onward referrals to other healthcare services, as well as issuing prescriptions, fit notes and other related paperwork. GPs also provide healthcare services to the care homes in their area.

There are on average 6000 GP appointments across Shetland each month; this figure does not include the "hidden" work of writing referrals, prescriptions or other paperwork. The figure also does not include the time required for undertaking anticipatory review work and with an aging population, it will become increasingly important that GPs have the time to do anticipatory review plans with patients and carers. Given the constant demand for GP appointments, this is an ongoing issue.

Our Customers

Free GP treatment is based on residence in the UK, not on nationality, the payment of UK taxes or National Insurance contributions. A person who is regarded as ordinarily resident in the UK is eligible for free treatment by a GP. A person is 'ordinarily resident' for this purpose if lawfully living in the UK for a settled purpose as part of the regular order of his or her life for the time being. Patients should register with a GP as soon as possible so that they can get medical care if needed. To register, patients will need to give their name, date of birth, address and telephone number.

Patients can make appointments (self referral) or appointments can be made at the request of another healthcare professional e.g. health visitor or community nurse. GP Practices will work flexibly with other disciplines and agencies to deliver a service that meets individual's healthcare needs and work closely with the healthcare teams in their area.

Our Costs and Income

The costs for the three directly salaried practices are straightforward and can be broken down as shown below. However, the independent practice funding is more complicated, as these practices receive what is known as a "global sum payment" based on a national formula and it is for the practices to decide how best to use this funding to provide core GP services to their patient population. There is therefore no workforce data for these independent practices, as the GPs are the owner of the business and responsible for recruitment and workforce planning. In addition, independent GP practices are eligible for enhanced service funding which is not available to salaried practices and practices which directly dispense medication also receive dispensing funding.

Funding and resources

The Primary Care budget is funded from the NHS Board core funding. Over the last 5 years savings in the region of £410,000 have been removed from the Primary Care budget, with a further removal by Government of £500,000 from the overall primary care allocation. In order to save any further monies this will be dependent upon active service redesign within the wider primary care services to support a revised service model.

The total Primary Care budget is £**4,544,654**, as shown below:

Primary Care 2015/16

Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Primary Care Department (incl. appraiser costs)	3.2	183,870			Nil
Lerwick Health Centre					
Yell Health Centre					
Whalsay Health Centre					
Unst Health Centre					
Hillswick Health Centre					
Brae Health Centre					
Scalloway Health Centre					
Bixter Health Centre					
Walls Health Centre					
Levenwick Health Centre					
Out of Hours	Bank rota	255,400			
Ophthalmic		364,700			
Pay costs					
Non-pay costs Service Total					

Aims and Objectives

Within Primary Care there are the following aims:

- To ensure any person in Shetland with primary care health needs has access to a local GP Practice.
- To develop a range of high quality primary care services in Shetland, which are sustainable in the long term.
- To enhance the services available and facilitate the shifting in the balance of care from institutional settings to the community.
- To increase the number of anticipatory care plans for patients most in need of this level of care, to ensure that healthcare needs are met and unnecessary hospital admissions prevented where possible.

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Detailed review of GP Contracts in line with national guidance (to coincide with implementation of new Scottish Contract)	Delivered	Yes – contracts met 2013/14 updates
Support development of eKIS Anticipatory Care Plans at individual practice level	On time	Work in progress but differing clinical views on implementation of Ekis and therefore variable uptake across Shetland. During 2013/14, practices were asked to use SPARRA data to undertake anticipatory care plans on the most frail patients at risk of readmission to hospital. This has continued into 14/15.

100% of Practices using electronic Palliative Care Summary by August 2013 (dependent on very small practices having patients who meet criteria)	Delivered	Yes
Detailed business case for provision of new Scalloway Health Centre	Delivered	Yes

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
GP Contracts	Primary Care Dept		March 2015	Yearly agreed GP Contracts in place	Detailed review in line with national guidance (to coincide with implementation of new Scottish Contract from 1st April 2014)
Scalloway Health Centre	Capital Projects/Primary Care Dept	2014	May 2015	Enhanced healthcare facilities for the Scalloway patients	New Scalloway Health Centre to be provided through joint project with Shetland Islands Council. The health centre will grow in capacity by an additional 600 patients and work is underway to have shared boundaries with an existing practice, with a view to equalizing patient numbers across central Shetland.
Primary Care Strategy	SMPC	2014	Ongoing	Create more sustainable primary care	Work to develop a Shetland Primary Care Strategy to commence during 14/15. The Shetland GPs have agreed key principles, with a focus on Patients First, sharing resources

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
				service	across practices and using a variety of means to aid recruitment and retention.
Introduction of DOCMAN Electronic Document Transfer into all Practices	Project Team inc IT and Primary Care	April 2014	Ongoing	Improved communication flow between secondary and primary care	Go live date of 27th October 2014
Whalsay GP recruitment Yell GP recruitment (December 14)	Primary Care & SMT	April 2014	February 2015	Clinicians in post, improving continuity and decreasing existing reliance on locums	3 rounds of recruitment for Whalsay have been unsuccessful, with different models of working being explored in conjunction with local community. Two GPs have now agreed to provide cover for 36 weeks of the year in a job share. The remaining 16 weeks, along with the Yell Associate post (17 weeks) now require recruitment. Various options including career start, GP fellows, Advanced Nurse Practitioners and long term locums are being considered.

Ongoing Actions/Projects Started prior April 2015

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
LHC Practice Manager recruitment	SMPC & HR	July 2014	February 2015	Dedicated PM in post to support practice staff and patients	PM to be recruited and in post by February 2015
Remodelling of existing clinician capacity in Lerwick Health Centre	Primary Care & SMT		March 2015	Increased access, improved satisfaction for patients and additional clinical support for staff	Owing to challenges in recruiting to 1.73 WTE GP vacancies, it was agreed to instead recruit 4 Advanced Nurse Practitioners using the funding available, to provide additional acute demand appointments. Postholders are being recruited and will commence in March 2015.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Implement Primary Care Strategy	SMPC & SMT	May 2015	March 2016	Create more sustainable primary care service	Detailed action plan based on approved primary care strategy to be agreed, with implementation dates where appropriate.
Source Emis web as a potential electronic solution to record keeping across Health & Social Care with interface to GP record, social care, secondary care	eHealth	April 2015	March 2016	Shared client communication between health & social care professionals, reducing risk and improving safety	This work is dependent on national procurement for an actual implementation date but will ultimately mean improved joint working and access to information where appropriate by professionals across health & social care.
Implement 2015/16 GP Contract and QOF amendments	Primary Care	April 2015	August 2015	Yearly agreed GP Contracts in place	All Shetland practices to have a contract based on 15/16 contract and QOF amendments once issued by Scottish Government.
Continue to support implementation of eKIS Anticipatory Care Planning across the services	Primary Care & Community Nursing	April 2015	March 2016	Shared patient communication between health professionals, reducing risk of hospital admission	Ongoing from previous years, including new polypharmacy reviews for patients at risk of readmission (as per SPARRA data)

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Roll out of EMIS ACCESS to enable patients to order prescriptions on line	Primary Care & Pharmacy	April 2015	October 2015	Increased patient safety, enhanced patient services and clinical governance	This will commence in Lerwick Health Centre and will enable patients to request repeat medications on line should they choose to do so. There is a substantial time commitment to setting up the process but it is safer for patients and saves time for staff.

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

During 2014-2015 the Primary Care service has experienced significant difficulty with recruitment in the service, particularly with regards to GPs. The practice of Whalsay is being wholly covered with locums, whilst there are 1.73 WTE GP vacancies in Lerwick and 0.3 WTE vacancy in Yell. GP recruitment overall throughout Scotland is problematic and is recognised at the highest levels. A new model of working has been proposed for Lerwick Health Centre working with Advanced Nurse Practitioners and recruitment is underway. Alternative models of care are also being considered for other areas. In addition, the salaried practices have had several maternity and sickness related absences, which has an impact on service. It is hoped that all of these issues will start to resolve but the impact of reduced numbers of staff should not be underestimated, given that the patient demand does not reduce even though staff numbers may be below optimum levels. Recruitment and retention of staff at all grades remains the greatest risk to delivery.

Performance Indicators

Indicator	2014/15	Target 2015/16
Heat Target 48 hour access to GP Practices	90%	90%
An action plan to improve access and amenities at the largest practice is in development, in conjunction with PPF partners		
QOF targets for specific disease area		
Access details including capacity and demand measured and reviewed in all practices using QuEST tools		

Contact Details

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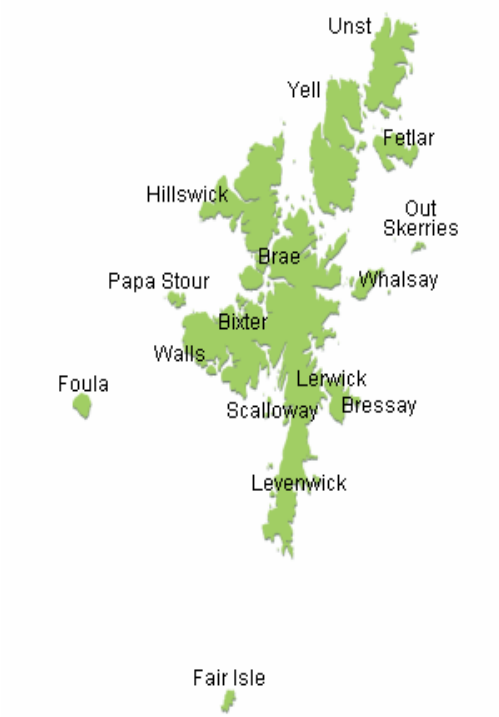
Renal Service
2015-16 Service Plan



Unmet need / Drivers for Change

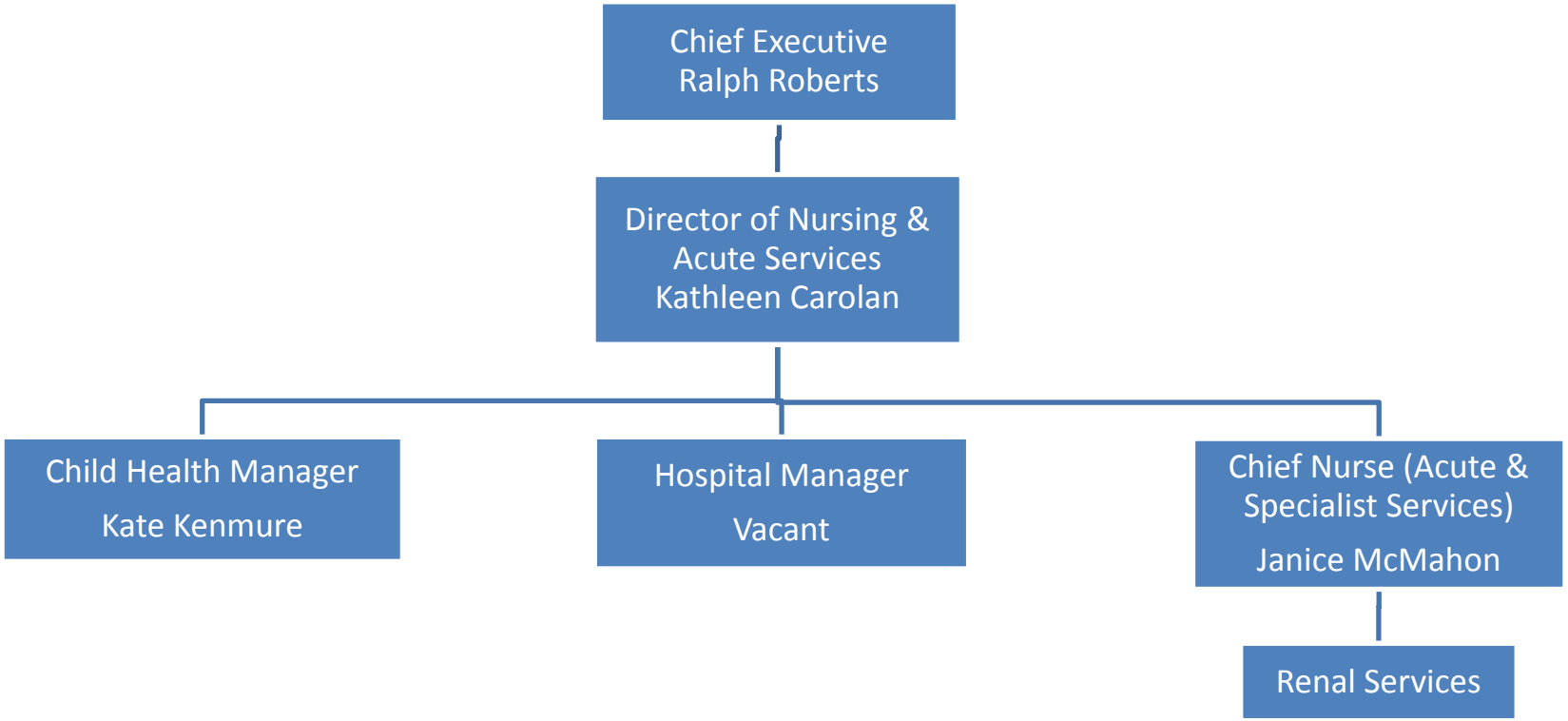
There has been an increase in demand over 2014 and moving forward into 2015 which the renal unit has responded too adjusting working times and days to support the increase in demand for the service. This increase in demand for the longer term will require a staffing review and service provision review. The savings made within the unit have been reinvested in staffing to create a more robust service, however due to increase in demand for the service a further review will be required.

About Us

Who We Are

With the increase in demand for the service financial pressure will be on pay and non pay budget for the renal service. There is currently a limited workforce previous savings plans for the renal unit have been reinvested in the department to support staffing to enable a more robust staffing facility. The unit will require a staffing review to plan future service provision to reflect the additional demands placed on to the service.

Organisational Chart



Locations

Services are delivered in Gilbert Bain Hospital and in patients' homes.

What We Do

The four-stationed Dialysis Unit is located in the Gilbert Bain Hospital.

Haemodialysis
The Haemodialysis service commenced in August 1999. It is primarily a chronic dialysis facility but palliative dialysis can be provided. This is a nurse led service providing holistic care to a diverse community. The unit has four stations and is open Monday to Friday. We also actively support home dialysis patients and their carers, offering home visits and respite dialysis. The philosophy of the unit is to think of innovative ways to provide a renal service that addresses the needs of the population in this challenging remote and rural setting.

Holiday Dialysis
Holiday Dialysis is accommodated wherever possible. However, this can sometimes depend on patients doing a direct swap.

Peritoneal Dialysis
Patients have their peritoneal catheters inserted in Aberdeen. Currently the patient trains in Aberdeen and returns to Shetland under the care of the Consultant nephrologists and the local renal team. The renal nurse carries out home visits, adequacy testing as well as reviewing the patients in clinics with the consultant nephrologists.

Pre Dialysis Education
The consultant nephrologists refer patients to the renal nurse. Home visits are offered in order to discuss treatment options in a non-threatening environment. Generic pre dialysis information is provided as well as tailoring written information to each patient's condition and geographical location. This is a highly individualized service.

Transplantation
Transplantation is undertaken at the Royal Infirmary Edinburgh. Patients would then be transferred back to Shetland for follow-up under the care of the Consultant nephrologist and the renal team. Live Related / Unrelated Transplantation is discussed with patients, family and/or significant others. If suitable, initial work up is undertaken in Shetland before being referred to the surgeons in Edinburgh.

Our Clients

All patients in Shetland who would require dialysis this figure is currently:

- 4 patients on haemodialysis + 1 on peritoneal dialysis
- 1 patient pending peritoneal dialysis within 1 month
- 4 patients pending haemodialysis within next 3 months

Holiday dialysis - intermittent demand usually in the summer months 2014-2015 1 patient.

Eligibility Criteria

Patients are referred into the service they are seen by the consultant nephrologists and the renal nursing team. Through discussion, options/ choices are given to the patient which reflect their individual need and reviewed with the patient and the renal team.

Funding and resources

Budget 2014-2015: £107391.00

Savings Targets

Not agreed for 2015-2016

Aims and Objectives

The renal unit at NHS Shetland is a satellite site of NHS Grampian. The overall aim of the renal unit within NHS Shetland is to provide safe, effective and person centered care for patients who require dialysis. In addition the unit provides ongoing support for patients / families and carers approaching dialysis, supporting them to make informed decisions /choices with regard to their future dialysis replacement care. The philosophy of the renal unit is to enable patient, families and careers to understand their individual renal failure through education, discussion and involvement. To promote and to encourage independence whilst acknowledging the limitations of their condition. To foster a culture of mutual respect between patient and staff.

Risks to Delivery

Key risks:

- **Water quality** – water testing/ monitoring and result analysis, testing criteria and plan in place.
- **Water failure** – Estates monitoring, adjustment to service provision, transportation of patient to NHS Grampian for dialysis if required in major water failure.
- **Dialysis machine failure** - secure of loan of dialysis machine as a safe guard and plans in place to purchase spare machine following procurement from NHS Grampian. Servicing of current machine undertaken by NHS Grampian. Major failures would instigate transfer of patients to other units.
- **Weather related risks** due to outer island, remote travel for dialysis – rapid response by nursing team to support change of dialysis days if required and further extension to working day. Transportation of patient to NHS Grampian if able and required.
- **Limited staffing** - staff work flexibly, hours extended where possible, additional staff member trained and used flexibly to support patient demand
- **Increase in demand for service** - change of working pattern hours and days if required to reach capacity creates impact on other local services in terms of staffing. Consideration to be given to further expansion of the service in terms of equipment, staffing.

Key Service Indicators

There are a number of standards that specifically relate to quality for adult renal service:

- Annual audit is carried out using the Quality Improvement Scotland (QIS).
- Standards for Adult Renal Services.
- Renal Association clinical standards.

Monitoring of effectives takes place with data submissions to NHS Grampian.

Contact Details

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Further reading

Useful Links:
Renal WEB: http://www.renalweb.com/
National Kidney Foundation: https://www.kidney.org/
UK National Kidney Foundation: http://www.kidney.org.uk/
The Nephron Information Centre: http://www.nephron.com/
Kidney patient guide - For kidney patients and those who care for them: http://www.kidneypatientguide.org.uk/contents.php
Royal Infirmary of Edinburgh: http://www.edren.org/

Sexual Health and BBV 2015-16 Service Plan

Introduction

Every year, each Service within the Council is required to produce a Service Plan for the following year. However Sexual Health services in Shetland are delivered by a number of organisations and departments, primarily within NHS Shetland, but also the Voluntary Sector and Shetland Islands Council, which are overseen through the Shetland Sexual Health and Blood borne Virus Strategy Group.
This Service Plan provides an overview of the work of the Strategy Group for 2015/16. The group reports to the Health Action Team which reports through to the CHCP and Community Planning Board. Individual; services within this framework have their own reporting structure.
This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Sexual Health Strategy group and associated services are committed to contributing to the 'Healthier' Outcome in the Shetland Community Plan and Single Outcome Agreement: We live longer healthier lives

Drivers for Change

Policy context

The national Framework for Sexual Health and Blood Borne Viruses (2011) builds on previous Scottish Government policy in these areas, including *Respect and Responsibility (2005)* and the *Hepatitis C Action Plan* (2006). It also incorporates the *HIV Action Plan for Scotland (2009)* and work on hepatitis B.

Unmet needs/Drivers for change

- As we there is more local and national activity on awareness raising and health promotion, then more people are coming forward to access services
- Demand for the sexual health clinic is increasing; including more people presenting who are at risk but currently asymptomatic; more men attending; and potentially people now coming to the local clinic who previously went to clinics on the mainland (although this is hard to quantify)
- There is also increase demand for long acting reversible contraception as this is being actively promoted: insertion of coils and implants requires specific additional training for staff.
- It is recognised that access to the Sexual Health and Wellbeing Clinic is limited, especially for people who live outwith Lerwick and those that cannot get there in the evening.

- There is scope for more work on understanding and addressing the needs of the local LGBT (lesbian, gay, bisexual, transgender) community, and specifically MSM ('men who have sex with men').
- There is scope for more work on understanding and addressing the needs of people locally who may be affected by Gender Based Violence (including rape and sexual assault; childhood sexual abuse; human trafficking & sexual exploitation): this links with the work on Domestic Abuse

About Us

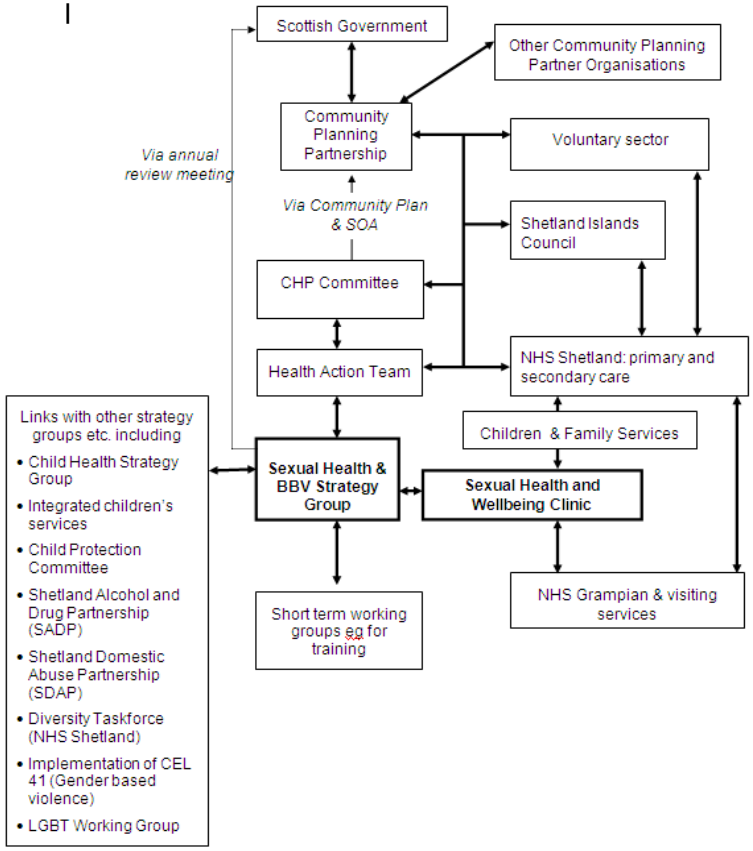
In Shetland sexual health is now combined with the blood born virus (BBV) work programme, and will be led through the Shetland Sexual Health and BBV Strategy 2014-24 (currently being finalised). This brings together local work on sexual health, Human Immuno-deficiency Virus (HIV), hepatitis C and hepatitis B into a single integrated strategy. This is in line with the Scottish Government's single national Framework incorporating both sexual health and BBV policy that was published in August 2011. The local Strategy echos the framework by linking different strands of the agenda, and strengthening links with other major health issues. It also has addressing health inequalities as a key theme throughout.

Who We Are

The Sexual Health Strategy Group includes representation from:

- Public Health, NHS Shetland
- Education, SIC
- Health Improvement, NHS Shetland
- Youth Development ,SIC
- Short breaks for Children, SIC
- Our Peer Education Network
- Environmental Health Services, SIC
- Community Nursing, NHS Shetland
- School Nursing, NHS Shetland
- Occupational Health, NHS Shetland
- GPs / Sexual Health Clinic doctors
- Maternity / Sexual health clinic
- Community Alcohol and Drugs Support Shetland
- Substance Misuse Services, NHS Shetland
- Substance Misuse Social worker, SIC

Organisational Chart



Locations

The Sexual Health and Wellbeing Clinic is located in the Outpatient Department of the Gilbert Bain Hospital on a Monday evening from 6.30-8.30pm. All other services are based at various locations throughout Shetland: refer to individual service plans.

Governance

The Sexual Health and BBV Strategy Group reports to the Health Action Team as required and to the Scottish Government on an Annual basis. All the individual departments and teams have their own Governance structures (refer to individual service plans).

Regulation and Compliance

Refer to the service pans of individual departments

What We Do

Strategic planning and co-ordination of services is led by a local multi-agency Sexual Health and Blood Borne Virus Strategy group. It oversees the co-ordination of this area of work in Shetland, including developing the Strategy and workplans and monitoring progress. The BBV element includes both sexual health work and

Sexual Health and Wellbeing (SHWB) Clinic runs once a week (on a Monday evening) in the out-patients department of the Gilbert Bain Hospital and provides both family planning and genitourinary medicine services with health promotion as a key element. It is managed through the Children and Families Service, with the team being led by a midwife with responsibility for sexual health, early pregnancy and gynaecology. Services include:

- Information, advice and counselling on family planning and contraception.
- Full range of contraceptive services including barrier methods, intra-uterine device / system (IUD/S) fitting and removal, contraceptive implants and removal, oral contraceptives and emergency contraception.
- Information and advice on sexual health and sexually transmitted infections, both prevention and treatment.
- Testing for blood borne viruses (HIV, Hepatitis B &C) and Hepatitis B vaccination when indicated
- Information on other relevant services and referral in certain circumstances.

The clinic is staffed on a rota basis by GPs (every other week) and nurses (every week) from a range of backgrounds (both primary and secondary care).

Primary Care

- There are ten general practices in Shetland. Each offers access to some contraceptive services for their patients and a number also see non-registered patients for contraceptive services.

- Not all practices currently offer long acting reversible contraception (LARC) but those that do not have arrangements with other practices to ensure the service is provided.
- All the practices can offer screening for STIs via the local laboratory services and those in Grampian.
- Partner notification may be undertaken by the practice nurse or GP, but this is limited in practice. GPs can request the SHWB clinic or the specialist GUM services in Aberdeen to undertake partner notification.
- Emergency contraception is available out of hours: five of the GP practices provide their own out of hours services, the other practices use NHS24. There is also a walk-in primary care service at weekends in the Gilbert Bain Hospital.
- The five Community Pharmacies in Shetland can all provide emergency hormonal contraception free of charge to the patient.

Health Visiting and School Nursing

Health visitors and public health nurses provide a universal service for families, especially those with young children and also provide input to schools as part of the school nursing service. There is one dedicated full time school nurse who provides a school nursing service to all the schools in Shetland. Sexual health is one part of their overall health remit and activities include:

- Support for schools including delivering some of the Sexual Health and Relationships Education (SRE) curriculum (the core programme is known as SHARE).
- Delivery of the SHARE programme to specific groups such as the Bridges Project, for young people who are not in mainstream education, training or employment.
- Provision of drop in services in schools, although this is currently patchy across Shetland
- Input to SHARE training.
- Health visitors advise new mothers about contraception after the birth.

Secondary Care / Hospital services

There are some secondary care sexual health and BBV services provided in the Gilbert Bain Hospital in Lerwick, but most specialist services, particularly for the management of BBVs, are provided in Grampian. However there is scope to share the management of patients with BBVs between Grampian and Shetland

- Specialist services for the management of hepatitis C and HIV are provided by mainland NHS Boards; usually NHS Grampian, but occasionally NHS Lothian and other Boards. Management plans for individual patients include input from primary care locally in Shetland, and there may be scope to develop this further.

- Currently visiting consultants from Grampian hold a gynaecology outpatient clinics in Shetland with support from a local GP with a Special Interest (GPwSI) in Gynaecology
- In 2013 a new Shetland based Consultant in Obstetrician and Gynaecology post was developed, however the post has not been filled.
- Patients are referred to NHS Grampian for sexual health services not available in Shetland such as termination of pregnancy and psycho-sexual counselling.
- Emergency contraception is available through the Accident and Emergency Department 24 hours a day.
- Antenatal testing for BBVs is carried out in the midwife led antenatal clinics (in the maternity unit and in primary care).

Health Improvement / Public Health

In addition to delivering health promotion / health improvement activities in educational, workplace and community settings ,the Health Improvement and Public Health teams led on the development of the new clinical service. This has resulted in a strong health promotion emphasis within the SHWB Clinic.

Health Improvement activities include:

- Provision of resources, including patient information leaflets and training materials, from the Health Improvement Resource Centre.
- *Help Yourself to Health* which is a joint project with local Library services to increase access to health information resources including sexual health information.
- Distribution of free condoms and lubricant in the community, usually at appropriate events and for specific projects
- Organisation and delivery of training programmes, including specific training for youth workers and multi-agency training
- Work with youth services on projects such as World Aids Day (WAD) activities
- Awareness raising, particularly using national campaigns
- Audit of Sexual Health and Relationship Education (SRE) in schools

Public Health activities include:

- Leadership and strategic planning for sexual health and BBVs
- Surveillance of BBV, STIs, teenage pregnancy and other sexual health indicators.

Services for Children and Young People (up to age 25)

- **'OPEN' (Our Peer Education Network)** is a third sector project set up in 2011 to train young people as peer educators in sexual health and alcohol. Trained peer educators deliver workshops in schools and other settings across Shetland. The project won the Shetland Youth Volunteering Award in 2012, and received the Volunteer Friendly Award in 2013.
- **Shetland Islands Council Youth Services** have in the past undertaken a range of activities through youth clubs, schools and other settings. These have included provision of information and publicity around sexual health issues in settings such as youth clubs; educational session and workshops in schools (e.g. LGBT workshop); events for World Aids Day including in the past Battle of the Bands; Disco and workshops; awareness raising, often working in partnership with health and other services. However, as resources for Youth Services have been reduced, it is likely that there will be less formally organised activities on a Shetland wide basis, but potentially more local based activities in Youth Clubs. Youth Club workers are offered training by the Health Improvement Team.
- **Shetland Islands Council Children's Services / Schools:** all schools deliver some Sexual and Relationships Education, although it does vary particularly in the primary schools. The junior high and high schools mostly use SHARE as the basis for their teaching and there are teachers from nearly every school trained in SHARE. There has been ad hoc training for staff involved with Looked After Children in the past; this is being further developed. There has also been some limited training for staff working with children and adults with learning disabilities.

Drug and alcohol services also deliver services concerned with reducing BBVs, early diagnosis and supporting people with BBVs.

Our Patients

Shetland experiences the same sorts of sexual health issues as the rest of Scotland, although we do tend to have very small numbers and generally lower rates of sexually transmitted infections (STIs) and blood borne viruses (BBVs) and also teenage pregnancy. Much of sexual health work is about prevention across the whole population. There are some groups that are more at risk such as young people at risk of Chlamydia and teenage pregnancy; Men who have sex with men and intravenous drug users are more at risk of blood borne viruses. People who are particularly vulnerable due to learning difficulties, poverty or social exclusion for example, may be more at risk of sexual exploitation.

- We continue to have a low level of teenage (girls under 16) pregnancies.
- There are small numbers of people with HIV and hepatitis C, although probably comparable with other remote and rural areas
- The number of people diagnosed with HIV has remained relatively stable: the number with diagnosed hepatitis C is increasing probably as a result of increased awareness and testing.
- The number of chlamydia infections has been rising, probably in part due to increased testing.

- There have been small number of cases of herpes simplex each year; and after several years of no cases of gonorrhoea, there were a small number diagnosed in 2013.
- In recent years there have been no patients diagnosed with syphilis

STIs

Figures collected by Health Protection Scotland and reported in the weekly surveillance report gives us an indication of the incidence and prevalence of genital chlamydia, gonorrhoea and genital herpes simplex virus (HSV1&2) in Shetland. The 2013 data is the most recent published data. Very small numbers are now reported as less than ten.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Genital chlamydia	8	24	<5	41	50	53	37	23	26	52*	42	69	60	62
Gonorrhoea	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Genital Herpes Simplex (HSV)	2	0	0	2	0	3	6	4	1	<10	<10	<10	<10	<10

Source: Health Protection Scotland, ***Genital herpes simplex, genital chlamydia and gonorrhoea infection in Scotland: laboratory diagnoses 2003 - 2013*** available at: www.hps.scot.nhs.uk/ewr/article.aspx#images

For HSV figures upto 2008: Health Protection Scotland Weekly Report 25.03.2009: www.documents.hps.scot.nhs.uk/ewr/pdf2009/0912.pdf

* information obtained directly from Aberdeen Royal Infirmary Microbiology Laboratory as the figure reported by HPS was zero

Unintended pregnancy

It is difficult to know the true rate of unintended pregnancy because many women will go on to have their baby even if their pregnancy had not been planned. There are a small number of women who have terminations of pregnancy, but for the purposes of national reporting the figures are included in with the other island boards because they are so small. Below are the figures for the three island Boards combined (Orkney, Shetland and Western Isles):

	2002	2003	2004	2005	2006	2007[r]	2008[r]	2009[r]	2010[r]	2011	2012	2013
Islands - number	91	87	82	66	73	73	67	81	50	63	68	64
Islands – rate per 1000 women aged 15-44	7.5	7.3	6.8	5.5	6.1	6.2	5.7	6.6	40	5.1	5.6	5.2
Scotland - rate per 1000 women aged 15-44	**11.1**	**11.6**	**11.8**	**12.0**	**12.5**	**13.1**	**13.3**	**12.4**	**12.2**	**11.9**	**11.9**	**11.2**

r =revised

Source: Information Services Division. *Abortion Statistics Year Ending 31st December 2013* available at: https://isdscotland.scot.nhs.uk/Health-Topics/Sexual-Health/Publications/2014-05-27/2014-05-27-Abortions2013-Report.pdf?86370486022

As can been seen from the table above, the rate of terminations of pregnancy is much lower in the islands compare to the rest of Scotland. A number of women will also choose to take emergency contraception (emergency hormonal contraception or intra-uterine methods) after unprotected sex to prevent an unplanned pregnancy. Emergency contraception is available from a number of services in Shetland including the community pharmacies; GP practices; Sexual Health and Wellbeing Clinic and A&E. At present we do not collect figures on the usage of emergency contraception in Shetland, however we are investigating if this information can be collated to allow us to monitor patterns of usage.

Teenage pregnancy

The number of teenage pregnancies amongst 13-15 year olds in Shetland is very low with often none or one each year and occasionally higher numbers. There is sensitivity around publishing data relating to teenage pregnancies because the numbers are so small – and in recent years figures have only been reported nationally if there are 10 or more pregnancies in a particular population (e.g. Shetland). We do have some

data from previous years, which shows that there was a total of 14 pregnancies in the ten year period 1996-2006, and average of 1.4 each year with the rate per 1000 girls aged 13-15 fluctuating between 0.0 and 8.0. The figures are reported as a three year rolling average to smooth out the large changes in rate caused by just one or two more or less pregnancies each year. However, this does mean that there is always a time lag in the reporting.

Pregnancies in girls aged 13-15 (3 year rolling average)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Shetland - number in 3 year period	<10	0	<10	<10	<10	<10	<10	0	<10	<10
Shetland –rate per 1000 girls aged 13-15	2.8	0.7	3.3	3.3	4.1	2.2	2.1	1.5	1.5	2.2
Scotland–rate per 1000 girls aged 13-15	6.9	7.3	7.0	8.0	7.8	7.7	7.0	6.9	5.6	5.6

Source NHS Shetland Performance Monitoring Reports

Blood Borne Viruses (BBVs)

BBVs can be transmitted by a number of routes including sexual activity, intravenous drug use, from mother to baby, ‘sharps’ injuries and blood transfusions. I the context of sexual health we are concerned with HIV, and hepatitis B and C.

The latest available figures show there have been a total of ten people in Shetland who are or were known to have HIV. Two people have died of AIDS, both over ten years ago.

Because the figures for Shetland are so small, it is very difficult to interpret any information about trends including how the HIV has been transmitted, which is important to understand for future prevention work. However, we can see that for the people in Shetland, half of them acquired HIV through heterosexual contact, whereas the figure nationally is about a third. Half the people in Shetland with HIV are female and half are male, and the majority are aged over 35.

Latest available figures show that in Shetland approximately 60 people have been diagnosed with Hepatitis C. This is an increase from 11 in 1997, with 2-3 new diagnoses each year.

Although the rate of new cases is much lower than the national rate for Scotland, it is comparable to other remote and rural areas, for example Highland.

It is relevant to note for prevention services that within these small numbers there is anecdotal evidence that co-infection with HIV and Hepatitis C may exist.

There are very few new diagnoses of acute hepatitis B each year in Shetland, none or one or two. There are an unknown number of people with chronic hepatitis B in Shetland, although there do appear to be a number of cases picked up through the routine testing at the Sexual Health Clinic. Further work needs to be done on understanding the epidemiology of hepatitis B in Shetland.

Our Costs and Income

It is not currently possible to identify the total costs for Sexual Health Services. There is dedicated income, but this does not cover all the costs. The budget specifically for the Sexual Health and Wellbeing Clinic is outlined below. The funding and resources in other services and organisations that are used to provide sexual health services can not currently be separated out from their overall budget allocations and work force

The Sexual Health and Wellbeing Clinic has an annual budget of £40,000. The team of staff who work at the clinic do so on a sessional basis. There are two nurses and one administrative assistant at each clinic session, once a week. In addition, there is a GP and a healthcare support worker at the clinic every other week.

Funding and resources

Some specific funding for sexual health and BBV work is provided through an allocation from the Scottish Government as part of the Health Improvement Bundle for NHS Shetland. There are three elements to this: Sexual Health Service; Hepatitis C and BBV prevention.
The Sexual Health Services funding is used directly towards funding the clinic. The other finding elements are included in the general budgets for a number of areas including Health Improvement and Public Health. It should be noted that the Sexual health and BBV funding allocations to Boards are currently being reviewed and may change in 2015.

Work programme	**Funded services**	**Allocation (2014-15)**
BBV prevention	This allocation is effectively split between the following departments and services: Public Health Department (including public health professionals and admin staff) Health Improvement; Primary / Community Care; School Nursing: (including advisors, admin staff, resources, delivery of training, community provision of condoms.) Pharmacy: Needlestick injury packs	£55,000
Sexual Health	Sexual Health Clinic (staffing includes two GPs, nurses, HCSWs and admin staff on a sessional basis; managerial support)	£40,000
Hepatitis C treatment	Hepatitis C treatment at NHS Grampian (parts funds the total cost)	£32,139
	Total	**£127,139**

For all other services, the sexual health element is part of their overall service provision and the specific budget / funding cannot currently be separated out.

Aims and Objectives

Strategy Aims	Supporting Service Objectives
The overall aim of the local Strategy is to ensure that all people in Shetland irrespective of age, gender, sexual orientation, lifestyle, ethnicity, faith, disability and BBV status have the right to positive sexual health and relationships, free of coercion and harm.	• To ensure that the promotion and protection of sexual health and risk of BBVs is coordinated and comprehensive
	• To support development of a culture which supports long-term improvements in Shetland's sexual health; including reducing the risk of acquiring BBVs and maximising the health of those with BBVs
	• To provide accurate, relevant and accessible information about sexual health and BBVs.
	• To support provision of effective sexual health promotion and relationships education
	• To target health promotion messages which meet the needs of the most vulnerable and disadvantaged individuals and communities
	• To support provision of a range of accessible services to meet the needs of the population, run by appropriately trained staff
	• To work with partners to tackle issues of general risk taking in a coordinated way, and the underlying determinants of risk-taking behaviour in all ages.

Detailed Actions/Plan for Change

There are five national outcomes:

Outcome 1: Fewer newly acquired BBVs and STIs; fewer unintended pregnancies
Outcome 2: A reduction in the health inequalities gap in sexual health and BBVs.
Outcome 3: People affected by blood borne viruses lead longer, healthier lives.
Outcome 4: Sexual relationships are free from coercion and harm.
Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive.

There is a two-yearly Sexual Health and BBV Work Plan (currently 2013-15) which is reviewed on a quarterly basis.
Specific areas of work include:

- Ongoing local awareness raising and support for national campaigns

Develop needs led approach to delivering targeted messages to specific groups who may be vulnerable / not access 'mainstream' initiatives. Including looked after children and people with learning disabilities.

- Further work to explore further ways of engaging with LGBT, and MSM communities
- Improving access to sexual health services for disadvantaged communities , particularly in north Shetland
- Continued development of a training programme for a range of staff including sexual health clinic team; other health professionals; care staff; teachers and youth workers.
- Further development within the sexual health clinic including increasing the capacity to be nurse led, implementation of electronic patient record system (NaSH)
- Look at improving termination pathway to reach 9 weeks target including looking at what elements of the service could be carried out on Shetland.
- All pregnant women to have antenatal discussion re contraception, and be discharged from maternity services postnatal with an effective method of contraception, with an emphasis on LARC
- Development of managed clinical networks and patient pathways for sexual health and BBVs with Grampian and Orkney.

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
SHARE Training	On time	Yes
World Aids Day campaign	On time	Yes
One hit kits in pharmacy needle exchange	Slipped	Yes

Ongoing Actions/Projects Started prior to 2015/16

(Summarised from Sexual Health and BBV Work Plan 2013-15)

Description	Start date/ Comments	Expected Outcome
Ongoing local awareness raising and support for national campaigns	Ongoing	Fewer newly acquired BBVs and STIs; fewer unintended pregnancies A society where the attitudes of individuals, public, professionals & the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive
Develop needs led approach to delivering targeted messages to specific groups who may be vulnerable / not access 'mainstream' initiatives. Including looked after children and people with learning disabilities.	Ongoing	Fewer newly acquired BBVs and STIs; fewer unintended pregnancies. A reduction in the health inequalities gap in sexual health and BBVs.
Further work to explore further ways of engaging with LGBT, and MSM communities	Ongoing	Fewer newly acquired BBVs and STIs; People affected by blood borne viruses lead longer, healthier lives.
Improving access to sexual health services for disadvantaged communities , particularly in north Shetland	2013	Fewer newly acquired BBVs and STIs; fewer unintended pregnancies People affected by blood borne viruses lead longer, healthier lives

Continued development of a training programme for a range of staff including sexual health clinic team; other health professionals; care staff; teachers and youth workers	Ongoing	Fewer newly acquired BBVs and STIs; fewer unintended pregnancies
Further development within the sexual health clinic including increasing the capacity to be nurse led, implementation of electronic patient record system (NaSH)	Ongoing	Fewer newly acquired BBVs and STIs; fewer unintended pregnancies
Look at improving termination pathway to reach 9 weeks target including looking at what elements of the service could be carried out on Shetland.	Ongoing	A reduction in the health inequalities gap in sexual health and BBVs
All pregnant women to have antenatal discussion re contraception, and be discharged from maternity services postnatal with an effective method of contraception, with an emphasis on LARC	Ongoing	Fewer unintended pregnancies
Development of managed clinical networks and patient pathways for sexual health and BBVs with Grampian and Orkney	Ongoing	People affected by blood borne viruses lead longer, healthier lives

New Planned Actions Due to Start in 2015/16

Description	Start date/Comments	Expected Outcome
Implementation of new NES BBV training toolkit	April 2015	Fewer newly acquired BBVs and STIs; fewer unintended pregnancies
Local implementation of NaSH patient record system	April 2015	Fewer newly acquired BBVs and STIs; fewer unintended pregnancies People affected by blood borne viruses lead longer, healthier lives

Risks to Delivery

The main changes and risks for delivery are:

Training for staff and maintaining competencies

Accessing training for staff can be particularly difficult in a remote and rural area. Whilst many courses can be accessed on-line, there is still the need for clinical training and experience which can require time spent 'off island'. The expense of travelling to mainland Scotland and often needing to spend one or more nights away from Shetland can be prohibitive. Similarly the time away from work and home is far greater than for our colleagues on the mainland, and particularly affects those who work part-time, who are in small departments (possibly single handed) and who have family commitments. This is also particularly difficult for nurses in the sexual health clinic who might only work two sessions a month. Where possible, we endeavour to bring trainers to Shetland where this is more cost effective and practical, although sometimes this is not possible because of the relatively small number of people here who require the particular training being offered.

Small teams and competing priorities

It can be difficult to maintain sexual health and wellbeing as a priority amongst organisations and service providers in Shetland. The small number of people who are able to champion BBV and sexual health also have other areas of responsibility which compete with their time and commitment.

Sustainability of the sexual health clinic

There have been previous attempts at running a clinic in the past, which had been unsustainable largely due to lack of funding, trained staff and managerial support. However, we now have a good structure in place with the clinic being managed through maternity services, as part of Child and Families. We also have a team of sessional staff who have undergone training. However, there is a lack of specialist clinical (medical) leadership, which was to have been picked up through the new Obstetrician and Gynaecologist post, but that was not filled and is being reviewed. We also now have dedicated funding through the Prevention Bundle from the Scottish Government, however, if we were to lose that core funding following the review of allocations, then it is unlikely to be able to fund the clinic.

Performance Indicators

Outcome 1: Fewer newly acquired BBVs and STIs; fewer unintended pregnancies.
Outcome 2: A reduction in the health inequalities gap in sexual health and BBVs.
Outcome 3: People affected by blood borne viruses lead longer, healthier lives.
Outcome 4: Sexual relationships are free from coercion and harm.

Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive.

There are a number of indicators and targets related to each outcome contained within the National Framework and our local strategy.
A number of these have been monitored over recent years as a set of Sexual Health Key Clinical Indictors for local performance management.
Some of these were included in the National Standards for Sexual Health Services self assessment, and there are other indicators within the standards that were not included in the self assessment.
It should be noted that not all these indicators can be measured locally in Shetland, because the relevant service is currently provided in Grampian (e.g. termination of pregnancy, HIV specialist services). However, there is some further work required to understand how we can monitor these indicators for our patients who are accessing the service from elsewhere.
There are currently no national HEAT targets or local SOA indicators relating specifically to sexual health and BBVs.

Other Performance indicators

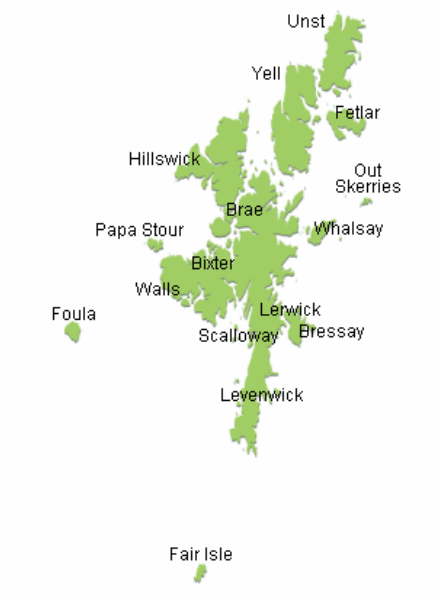
These are the national Key Performance Indicators

Indicator	2013/14	2014/15	Target 2015/16
The proportion of women of reproductive age with intrauterine and implantable contraceptives (LARC):	108.8 per 1000 women	Not yet available	60 per 1000 women
Teenage pregnancy (rate per 1000) for <16 year olds	Not yet available	Not yet available	Maintain at <2 per 1000 (Local target)
Teenage pregnancy (rate per 1000) for <20 year olds	Not yet available	Not yet available	No target
Percentage of termination of pregnancy procedures taking place at less than or equal to 9 weeks gestation per NHS Board.	60.9% (for all 3 island boards)	Not yet available	TARGET 70%
Proportion of women who have had a termination, who leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants).	Not measured	Not yet available	TARGET 60%

Contact Details

Shetland Sexual Health and Blood Borne Virus Strategy Group Chair: Dr Susan Laidlaw at NHS Shetland : susan.laidlaw@nhs.net	**NHS Child & Family Health Manager (including Sexual Health Clinic)** Kate Kenmure: kate.kenmure@nhs.net	**NHS Shetland Public Health Nurse Specialist – with remit for BBVs** Wendy Hatrick: wendy.hatrick@nhs.net	**NHS Shetland Health Improvement Advisor – with remit for sexual health, including training** Melanie Smith: melanie.smith3@nhs.net

Unscheduled Care Service
2015-16 Service Plan



Drivers for Change

Over recent years, services that provide unscheduled care have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs;
- Increasing public expectation of and access to health and social care services;
- Delays in accessing up-to-date patient information - impacting on or slowing down clinical decision making;
- Need for improved team working and better co-ordination of care between NHS partners (primary care, SAS, NHS 24, secondary care and tertiary care);
- Need for greater collaborative working to reduce delays particularly at the health and social care interface;
- Need for closer working between health and social care services to develop integrated models of anticipatory and community based care;
- Challenges in training, recruitment and retaining of staff

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies;
- Promoting personal and community level resilience and accountability for health and wellbeing;
- Developing an integrated approach for older peoples services delivery across health and social care;
- Developing robust models for dementia care and community mental health services;
- Effective health and care pathway design across primary, secondary and specialist care;
- Effective models of unscheduled care delivery;
- Strategic plans to support Living and Dying Well

About Us

Unscheduled care is an umbrella term used to describe services which provide an emergency or unplanned service response. The majority of unscheduled care takes place in the community setting and is managed by community health and social care teams.

Who We Are

The majority of healthcare functions within the wider healthcare system have an unscheduled care response or pathway, but the main ones can be defined as:

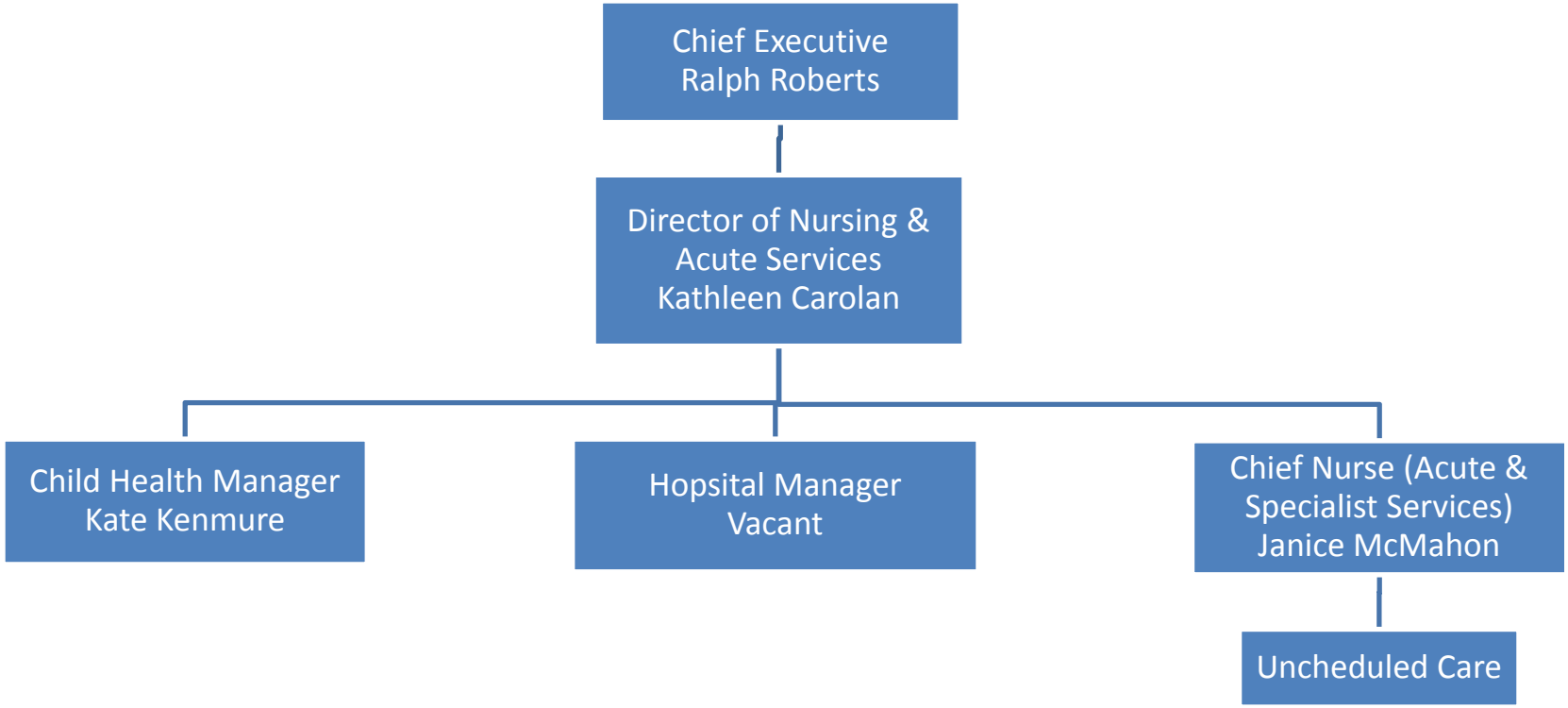
- **Out of Hospital Services – e.g. community nursing and primary care services 'out of hours'**
- **Accident and Emergency Services**
- **Acute Inpatient Medical Services**
- Acute Inpatient Surgical Services
- Critical Care Services
- Theatre Services
- Obstetric Services
- Emergency Service provision at NHS Grampian for patients requiring specialist interventions
- Diagnostic Services (e.g. Medical Imaging, Laboratory Services)

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of unscheduled care, including the provision of air transfer and critical care retrieval for adults, children accessing tertiary care centres and patients accessing specialist mental health facilities.

The services which are shown in bold are part of the integrated commissioning arrangements.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery.

Organisational Chart



Locations

Services are located in the community, at Gilbert Bain Hospital and with NHS Grampian on the mainland.

What We Do

Eligibility

Patients who present to unscheduled care services have undifferentiated health needs, ranging from self limiting conditions such as minor ailments through to serious and life threatening illness and injury. There is also an increasing trend in the number of people presenting to emergency services with psychosocial issues and secondary problems such as substance misuse.

Unscheduled care services are largely open access e.g. A&E, NHS 24 liaison with primary care services etc. Criteria are applied to prioritise patients in line with the likely severity of their clinical conditions. For instance A&E staff use a triage system to determine patient urgency (the Manchester Triage Tool is used in Shetland) and the Therapeutic Intervention Scoring System (TISS) is used by medical and critical care teams to determine if a patient has high dependency care requirements.

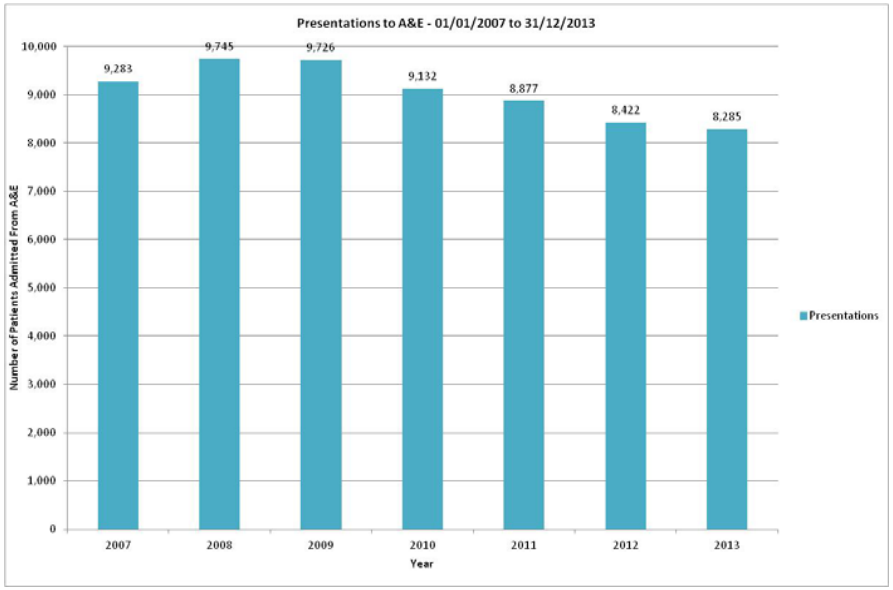
In order to ensure that we can deliver safe emergency care service provision across the whole system, we have developed the LUCAP to look at ways in which we can manage patients in the 'right place, at the right time, with the right practitioner'. This action plan along with the older people's strategy, primary care strategy and dementia strategy will help to set the direction for the shape of services, including appropriateness and eligibility for different care settings. Particularly, promoting the development of community based services to support people who do not need to access acute hospital or specialist services.

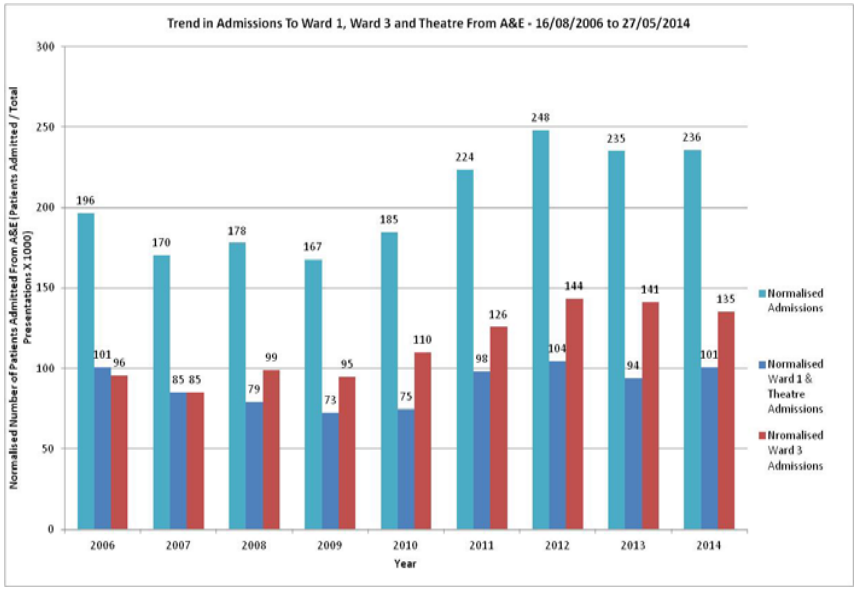
Our Clients

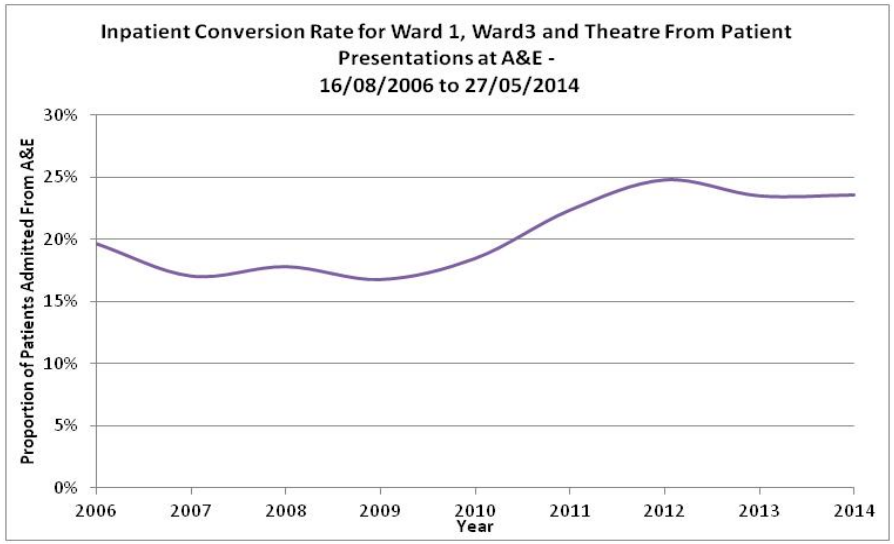
Overall the number of A&E attendances is falling and this is attributable to some extent to the development of redirection pathways back to Primary Care services and the recategorisation of patient presentations for minor ailments to Primary Care services.

Overall number of admissions has increased from 20% to 24% between 2006 and 2014, with a steep rise from 2011 onwards.

Overall numbers of patients waiting for community care packages has increased along with length of stay in 2013-14.


Presentations to A&E - 01/01/2007 to 31/12/2013
Number of Patients Admitted From A&E
Year
Presentations
9,283
9,745
9,726
9,132
8,877
8,422
8,285


Trend in Admissions To Ward 1, Ward 3 and Theatre From A&E - 16/08/2006 to 27/05/2014
Normalised Number of Patients Admitted From A&E (Patients Admitted / Total Presentations X 1000)
Year
Normalised Admissions
Normalised Ward 1 & Theatre Admissions
Nromalised Ward 3 Admissions


Inpatient Conversion Rate for Ward 1, Ward3 and Theatre From Patient Presentations at A&E -
16/08/2006 to 27/05/2014
Proportion of Patients Admitted From A&E
Year

Funding and resources

Department	Budget in 2014-15	Savings Plan for 2015-16
A&E	**£808,906**	**YES**
Ward 3 (Medical Ward)	**£884,152**	**NOT AGREED**
Surgical Services (Surgical Ward, DSU & HDU)	£1,023,466	NOT AGREED
Maternity Services	£850,484	YES
Staff Costs (Medical Doctors)	£933,289	NOT AGREED
Staff Costs (Surgical Doctors)	£951,323	NOT AGREED
Staff Costs (Anaesthetists)	£551,858	NOT AGREED
Obstetric Staffing Costs (Doctors)	£381,049	NOT AGREED
Medical Imaging	£659,229	NOT AGREED
Laboratory	£762,652	NOT AGREED

The services shown in bold provide unscheduled/unplanned care primarily and so for the purpose of determining unscheduled care costs, 100% of the budget is aligned to emergency care. All other functions, departments and services will have a proportionate cost that can be attributed to the delivery of unscheduled care services. Data analysis available at the time of writing is not sophisticated enough to be able to break these costs down further.

Aims and Objectives

The overarching aim of services aligned to unscheduled care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services 'in an emergency'.

More specific high level aims for the development of unscheduled care services are set out in the Local Action Plan for Unscheduled Care (LUCAP) and can be summarised under the following key themes:

- Making the Community the Right Place and Developing the Primary Care Response;
- Improving Flow and the Acute Hospital;
- Assuring Effective And Safe Care At The Hospital Front Door;
- Promoting Senior Decision Making and Access to Services 24/7;
- Cross Cutting Themes – e.g. Information, Technology etc

A multi-agency programme has been developed to support the delivery of these aims which is also described in the LUCAP.

Detailed Actions/Plan for Change

Our strategic priorities as set out in the Corporate Action Plan, Reshaping Older Peoples Care Plan for 2014-15 and the LUCAP 2014-15 can be summarised as follows:

- Managing patient flow - recognising the increase in admissions and demographic changes meaning patients with more complex needs are presenting through emergency care services and discharge planning models need to be revised;
- Developing a strategic approach to the delivery of older peoples care across health and social care sectors – particularly our objective to develop a locality based approach to provide more community assessment and support options;
- Focus on ensuring that we can provide appropriate care settings/resources/pathways (jointly) to ensure that clinical and care needs are met in the community, whenever it is safe to do so;
- Reducing the number of people who are delayed in hospital;
- Reviewing the current provision of Out of Hours (OOHs) services to ensure they are sustainable;
- Developing ambulatory care and day care models as a safe alternative to inpatient care;

- Role development to support unscheduled care service delivery – particularly the positioning of advanced NMAHP practitioners in Acute and Community based care settings

These priorities set out above are also relevant to deliverables in 2015-16. The LUCAP which provides more detail is available at the link below: http://www.shb.scot.nhs.uk/board/meetings/2014/201408-Boardpack.pdf

Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Unscheduled care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a 'whole system' strategic exercise with all partners working to shared objectives;
- Pace of change – developing robust community based models will take time and resources. We need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented;
- Increase in demand for acute services due to demographic changes and case complexity;

Performance Indicators

Target/Outcomes

There are a number of HEAT targets that specifically relate to quality or performance markers for effective emergency care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2014).

E.4.1S	Delayed Discharges >42 days (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0	
E.4.2S	Total Delayed Discharges (inc <42 days) (count)	M	2014 Aug	9	2014 Jul	10	R	↑	0	2015-03	0	Longest = 17 weeks Plan for longest waiter. Ongoing work on capacity and pathways. Daily scrutiny of delays.
E.9	No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0	
A.7S	A&E 4 Hour waits (percentage)	M	2014 Jul	96.8	2014 Jun	96.3	A	↑	98	2015-03	98	Recent reduction in performance is due to seasonal increase in emergency care demand and annual leave.
A.8.1S	48 hour Access - GP Practice Team (percentage)	A	2014	93.5	2013	89	G	↑	90	2015-03	90	
A.8.2S	Advance booking - GP Practice Team (percentage)	A	2014	73.2	2013	73	R	↑	90	2012-03	90	
BSC17	Level of Older People with Complex Care Needs Receiving Care at Home (percentage)	Q	2014 Apr-Jun	42	2014 Jan-Mar	42	G	→	39	2015-03	45	
T.10	Rate of attendance at A&E (rate)	M	2014 Aug	3321	2014 Jul	3198	R	↓	3061	2013-12	3061	

Contact Details

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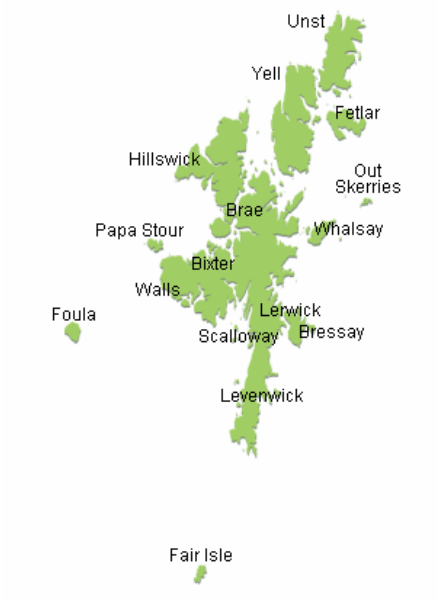
Further Reading

http://www.isdscotland.org/Health-Topics/Emergency-Care/

Planned Care Service
2015-16 Service Plan



Drivers for Change

Over recent years, services that provide planned care have been under increasing pressure. There are a number of factors which are associated with the increase in planned care activity including:

- A response to demands associated with demographic changes and patterns of ill health;
- Increased public expectation of equity of access to health and social care services;
- Advancement in technology, diagnostic capabilities and surgical techniques has made many interventions safer and less invasive resulting in an increase in the number of patients eligible for treatment;
- Progressive shift towards the delivery of day case surgery, interventions and diagnostic tests in ambulatory care units and out with the hospital setting;
- Successful delivery of services within the national waiting times treatment guarantee (TTG) and other access targets.

Another important factor impacting on planned care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways.

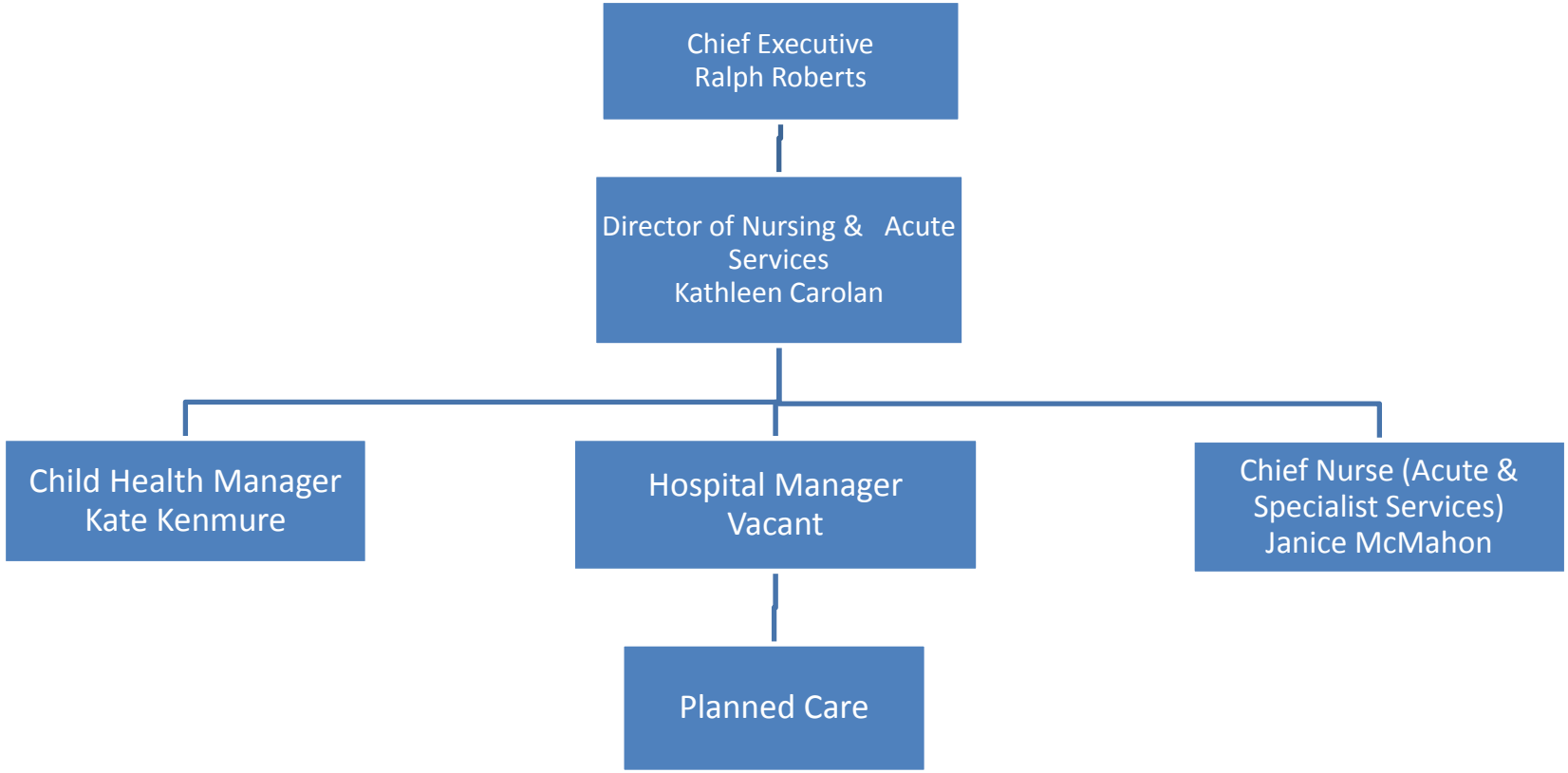
National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies;
- Managed Clinical Networks (MCNs) to support people with long term conditions e.g. diabetes, cancer, neurological conditions, sensory impairment
- Promoting personal and community level resilience and accountability for health and wellbeing;
- Effective health and care pathway design across primary, secondary and specialist care;
- Transforming outpatient services (TOPS);
- The Patients Rights Act – Treatment Time Guarantee (TTG);
- Making ambulatory care and day care services the norm;
- Effective models of unscheduled care delivery

About Us

Planned care is an umbrella term used to describe services which are scheduled and pre-booked by appointment. This includes access to elective procedures in Day Case and Ambulatory Care settings, access to diagnostic tests and outpatient consultations.

Who We Are
Organisational Chart



Locations

Our services are provided in a variety of settings including at home, in care homes, in Gilbert Bain Hospital or in other hospitals on the mainland.

What We Do

The majority of healthcare functions within the wider healthcare system have a planned care response or pathway, but the main ones can be defined as:

- Day Surgery Services
- **Out Patient Services (local and visiting)**
- Pre-Operative Assessment Services
- Chemotherapy Services
- **Renal Services**
- **Elective Inpatient Medical Services**
- Elective Inpatient Surgical Services
- **Elective Rehabilitation Services**
- Planned Critical Care Services
- Elective Theatre Services
- Elective Obstetric Services e.g. pre and post natal care, planned C-sections
- Elective Service provision at NHS Grampian for patients requiring specialist interventions
- AHPs (planned clinics are in place across all seven AHP disciplines)
- Diagnostic Services (e.g. Medical Imaging, Laboratory Services, Audiology, Physiological Measurements etc)

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of planned care, including the provision of tele-health services to support long term conditions and self-management as well as transporting patients between health and social care settings.

The services which are shown in bold are part of the integrated commissioning arrangements.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery.

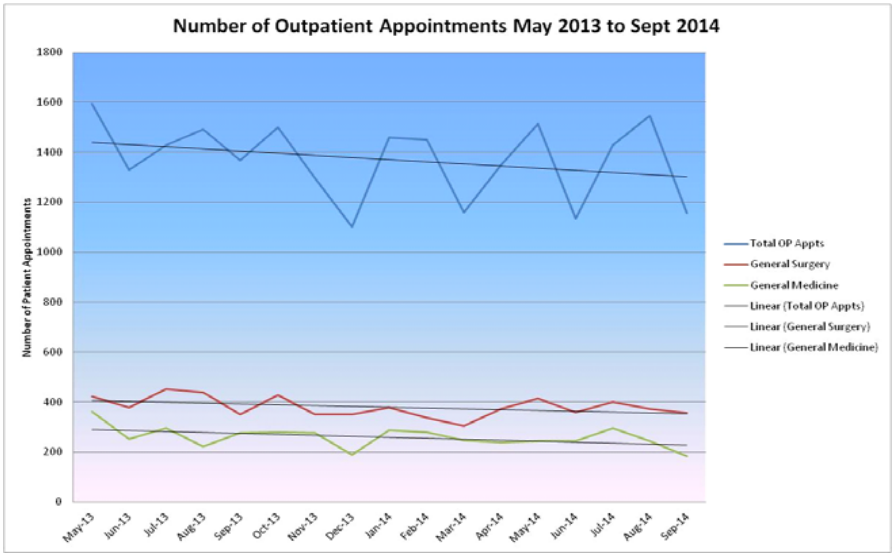
Our Clients

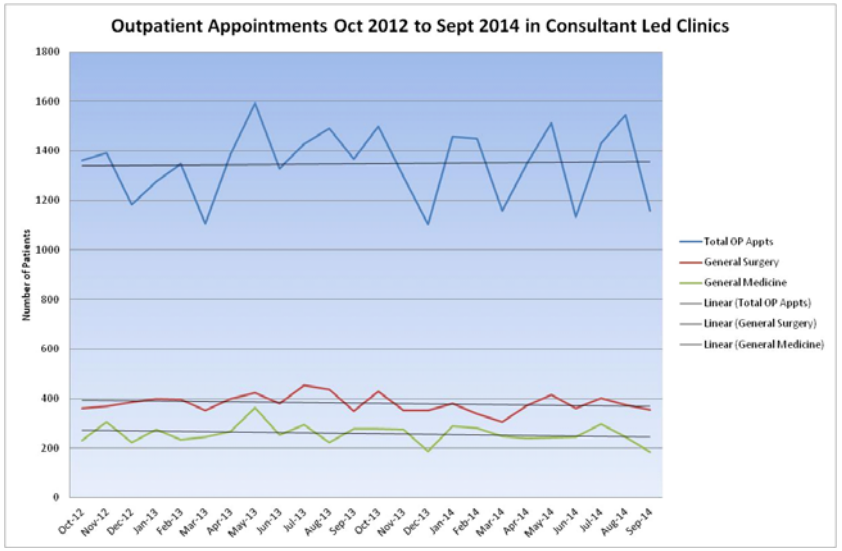
Eligibility Criteria

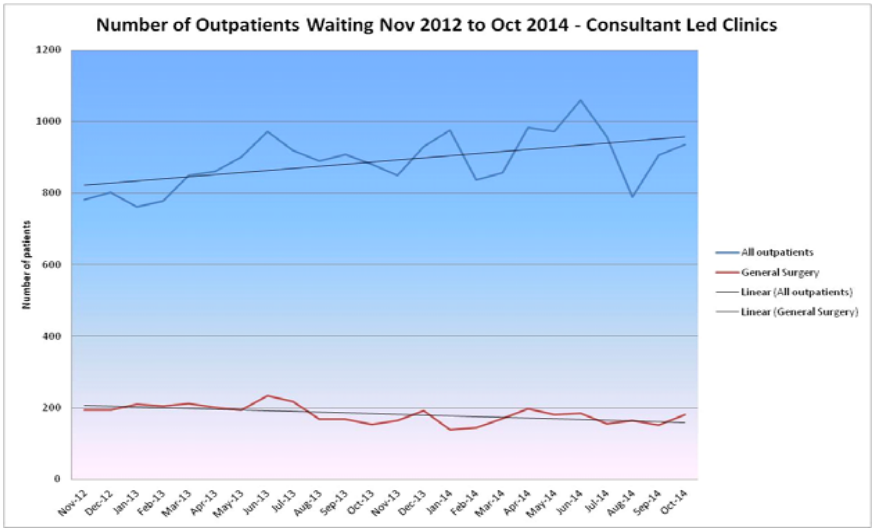
There are a variety of ways in which eligibility is applied to planned care services. These mechanisms include:

- The application of clinical standards and guidelines for referral into specialist services e.g. clinical cancer guidelines;
- The application of access targets and standards, which determine how the patient journey is organised and monitored e.g. development of 'one stop' condition specific clinics;
- The application of criteria for Out of Area Treatments for services

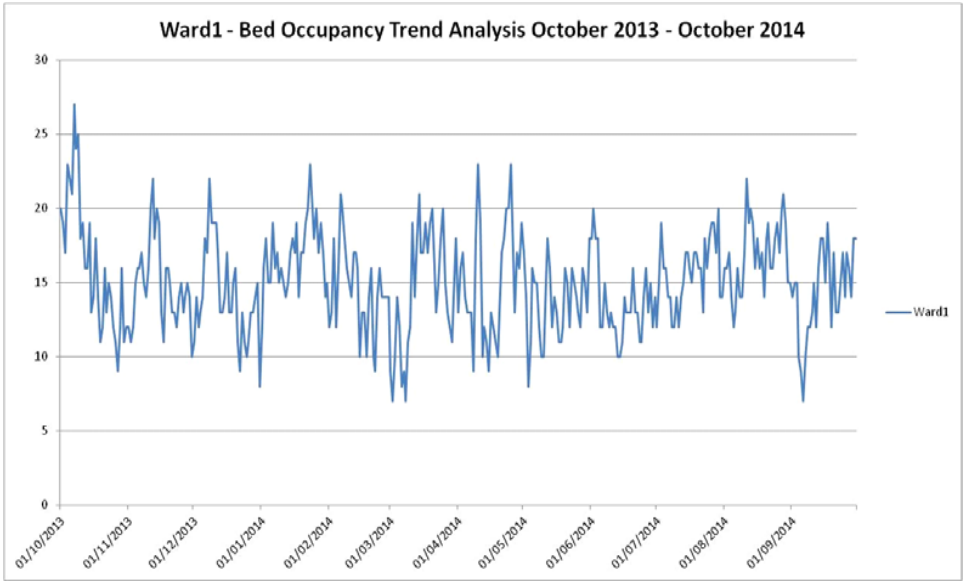
Out Patient activity



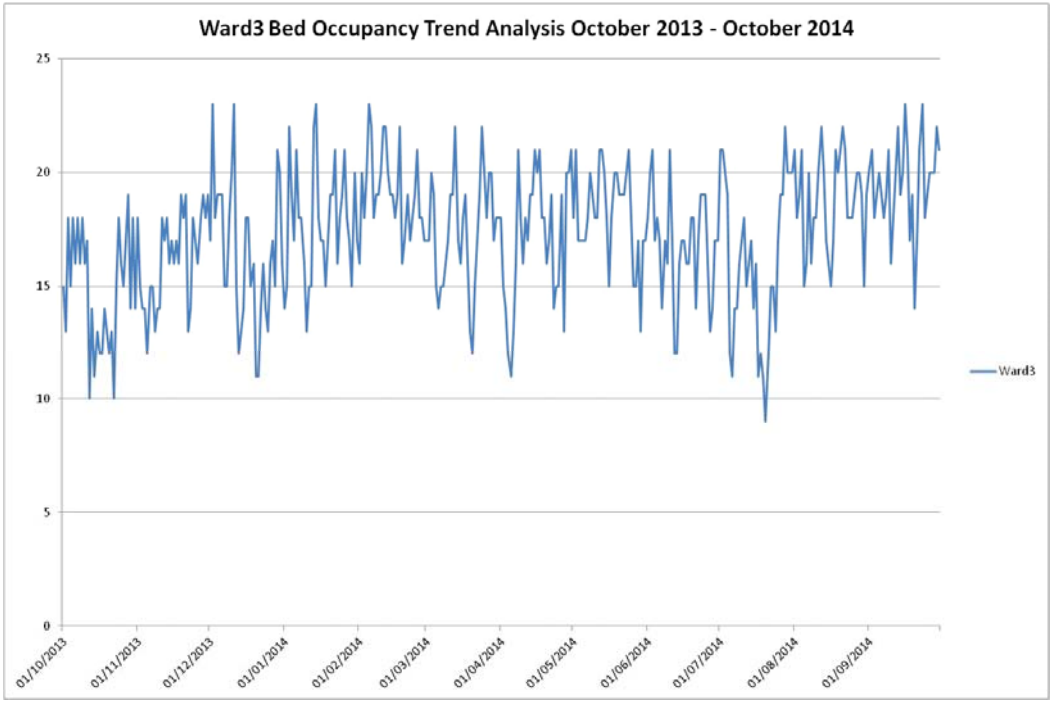




Inpatient activity

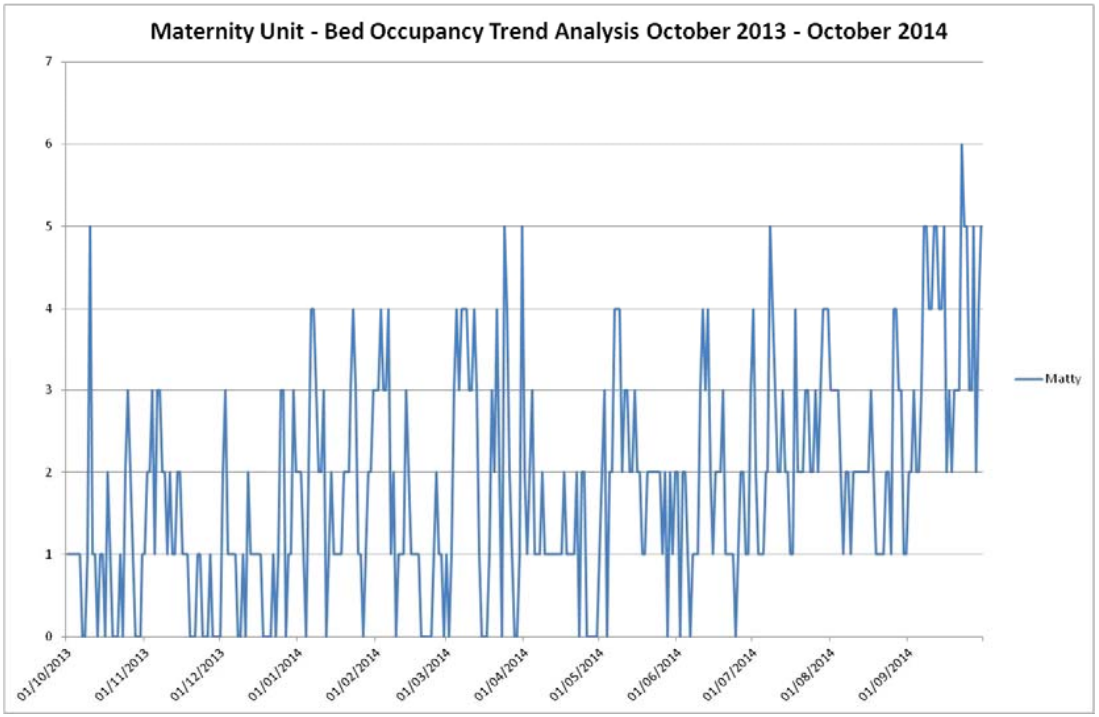


Average bed occupancy was 15 beds (at 12 midday) in this reference period with a range of 7 to 26



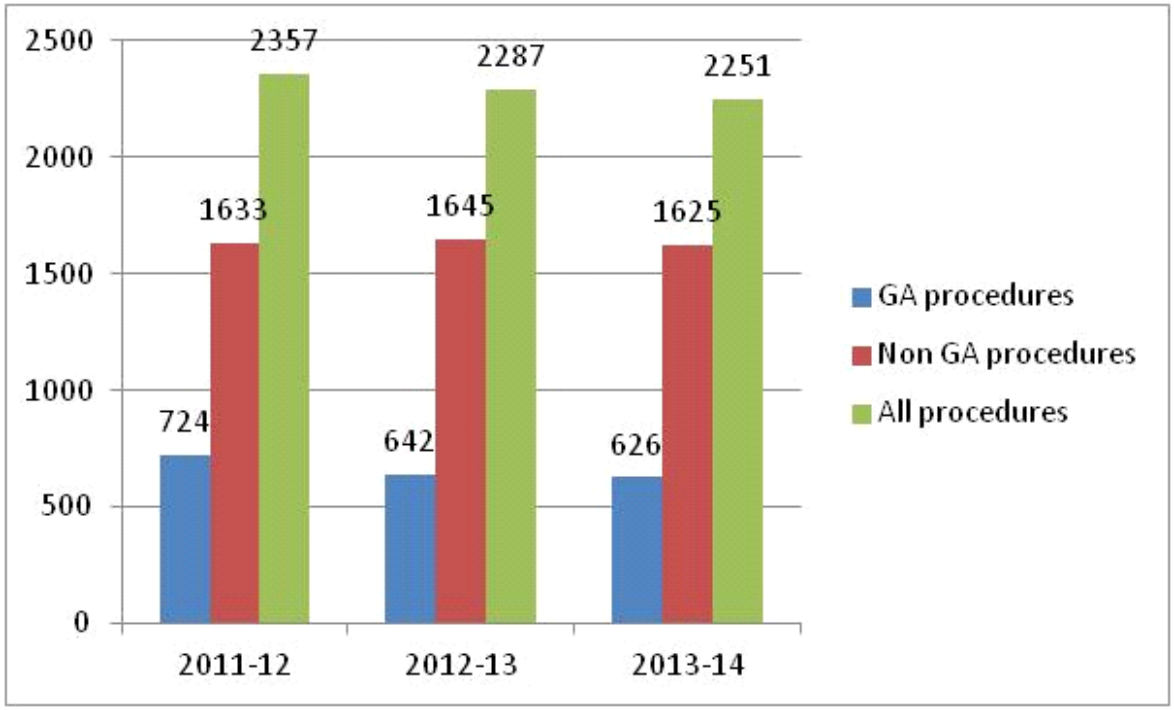
Average bed occupancy was 17 beds (at 12 midday) in this reference period with a range of 9 to 22.

Bed occupancy average of 6 beds from July 2014 (which is the maximum for this unit)

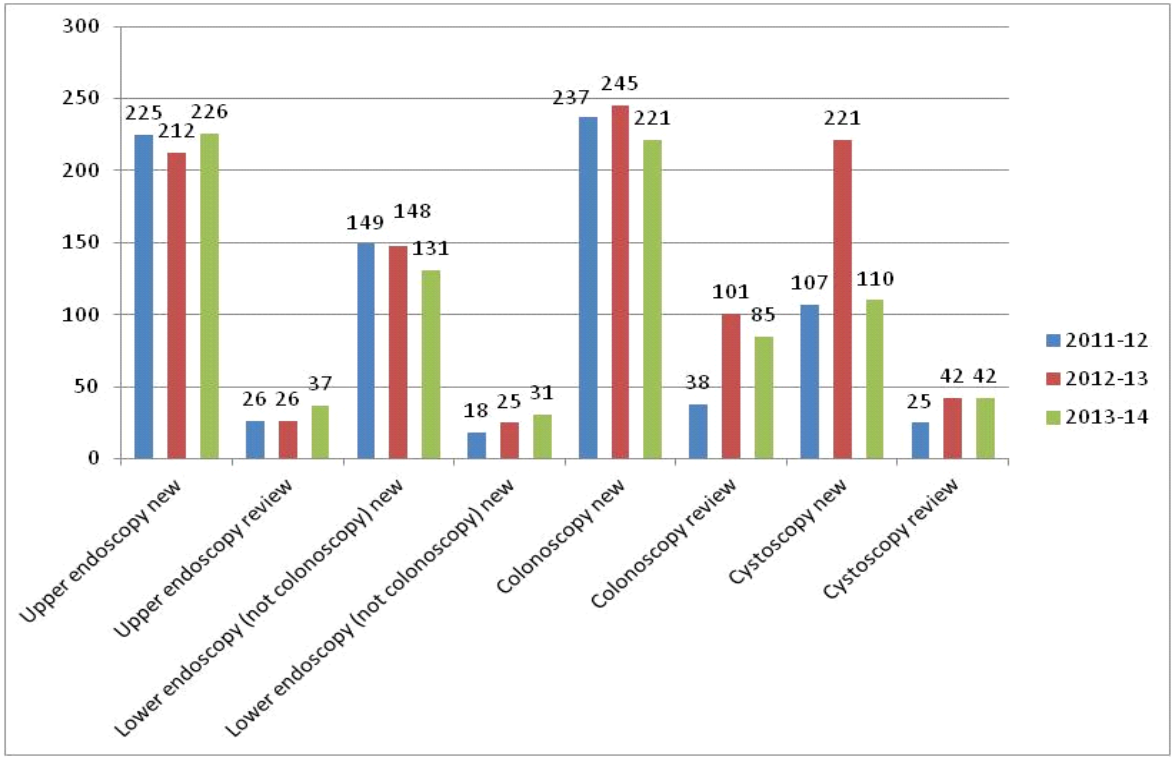


Average bed occupancy was 2, with a range of 0 to 6 beds occupied within the reference period

A Chart to Show Surgical Activity in Theatre - 2011 to 2014



A Chart to Show Endoscopy Activity - 2011 to 2014



Funding and resources

The following departments are funded in the Acute & Specialist Services Directorate

Department	Budget in 2014-15	Savings Plan for 2015-16
Ward 3 (Medical Ward)	**£884,152**	**NOT AGREED**
Surgical Services (Surgical Ward, DSU & HDU)	£1,023,466	NOT AGREED
OPD	**£291,411**	**NOT AGREED**
Pre- Assessment	£92,786	NOT AGREED
Ronas Ward	**£485,525**	**NOT AGREED**
Maternity Services	£850,484	YES
Staff Costs (Medical Doctors)	£933,289	NOT AGREED
Staff Costs (Surgical Doctors)	£951,323	NOT AGREED
Staff Costs (Anaesthetists)	£551,858	NOT AGREED
Obstetric Staffing Costs (Doctors)	£381,049	NOT AGREED
Medical Imaging	£659,229	NOT AGREED
Laboratory	£762,652	NOT AGREED
Physiological Measurements	£63,584	NOT AGREED
Oncology	£141,694	NOT AGREED
Specialist Nurses (Long Term	£131,685	NOT AGREED

Conditions)		
Theatre Services	£960,345	NOT AGREED
CDU	£168,007	NOT AGREED
Renal	**£107,381**	**NOT AGREED**

The services shown in bold provide planned care and are also included in the range of integrated services which are subject to joint commissioning arrangements through the Integrated Joint Board (IJB). Data analysis available at the time of writing is not sophisticated enough to be able to break these costs down further.

Aims and Objectives

The overarching aim of services aligned to planned care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services for pre-booked assessments, tests and procedures.

The high level improvement aims to support the delivery of planned care services include:

- Creating pathways to support day surgery and ambulatory care as the norm for planned procedures (reducing reliance/pressure on inpatient services);
- Streamlining referral and diagnostic pathways;
- Active management of admissions so that only patients who need specialist care are admitted to hospital (implementing alternative models, reducing length of stay);
- Active management and redesign of outpatient services (e.g. developing multi-disciplinary models, introducing telehealth to support remote access etc) to promote pre-admission assessment and follow up in localities

Detailed Actions/Plan for Change

Our strategic priorities as set out in the Corporate Action Plan, Reshaping Older Peoples Care Plan for 2014-15 and the LUCAP 2014-15 can be summarised as follows:

- Managing patient flow - balancing planned and emergency care and separating flows wherever it is possible to do so;
- Developing new models of supported rehabilitation and discharge to enhance recovery and reduce length of stay in hospital;
- Repatriating services where it is safe to do so – providing person centred care and maximising the efficiency of local services;
- Developing ambulatory care and day care models as a safe alternative to inpatient care and increasing activity;
- Using technology and tele-health to avoid unnecessary follow up/review in hospital;
- Role development to support planned care service delivery – particularly the positioning of advanced NMAHP practitioners in ambulatory care and outpatient settings;
- Reducing the number of people who are delayed in hospital;

Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Planned care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a 'whole system' strategic exercise with all partners working to shared objectives;
- Pace of change – e.g. developing primary care and locality based alternatives to outpatient assessment, review clinics and early supported discharge will take time. We need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented;
- Viability of alternative models – we will need to work closely with specialist services and NHS partners to ensure that pathway redesign is realistic and deliverable. There are considerable challenges ahead for succession planning generalist clinical roles and we are already starting to see the impact of this on some visiting services;
- Increase in demand for acute services due to demographic changes and case complexity;

Performance Indicators

There are a number of HEAT targets that specifically relate to quality or performance markers for effective planned care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2014).

Ref	HEAT measure	Freq	Current period	Current perf.	Previous period	Previous perf.	Traffic light	Vs prev	Traj. value	Target date	Target value
A.9aS	Urgent Referral With Suspicion of Cancer to Treatment Under 62 days (percentage)	M	2014 Aug	100	2014 Jul	100	G	→	100	2015-03	95
A.9bS	Decision to treat to first treatment for all patients diagnosed with cancer - 31 days (percentage)	M	2014 Aug	100	2014 Jul	100	G	→	100	2015-03	95
A.10.2Sa	Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (consultant led services) (count)	M	2014 Aug	26	2014 Jul	43	R	↑	0	2015-03	0
A.10.2Sb	Inpatients/Day Cases Waiting Over 9 Weeks (count)	M	2014 Aug	17	2014 Jul	28	R	↑	0	2015-03	0
A.10.2Sba	Treatment Time Guarantee - 12 weeks from being added to Inpatient waiting list to having procedure (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
A.10.2Sc	Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (Orthodontic Service) (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
A.10.3Sb	Number of patients waiting more than 9 weeks from being placed on a waiting list to inpatient treatment (Orthodontic Service) (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
A.10S	18 Weeks Referral to Treatment: Combined Performance (percentage)	M	2014 Jul	94.6	2014 Jun	96.9	G	↓	90	2015-12	90
A.13	Eligible patients will commence IVF treatment within 12 months by 31 March 2015	Q	2014 Sept	100	N/A	N/A	G		90	2015-03	90
Acc1	Number of cases where the Upper GI endoscopy waiting time was greater than 6 weeks (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
Acc2	Number of cases where the Lower endoscopy (excluding colonoscopy) waiting time was greater than 6 weeks (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0

Ref	HEAT measure	Freq	Current period	Current perf.	Previous period	Previous perf.	Traffic light	Vs prev	Traj. value	Target date	Target value
Acc3	Number of cases where the colonoscopy waiting time was greater than 6 weeks (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
Acc4	Number of cases where the cystoscopy waiting time was greater than 6 weeks (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
Acc5	Number of cases where the ultrasound scan waiting time was greater than 6 weeks (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
Acc6	Number of cases where the CT scan waiting time was greater than 6 weeks (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
Acc7	Number of cases where the Barium enema test waiting time was greater than 6 weeks (count)	M	2014 Aug	0	2014 Jul	0	G	→	0	2015-03	0
T.14	To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%. (percentage)	A	2013	16.4	2011	19.8	R	↓	22.9	2015-03	29

Contact Details

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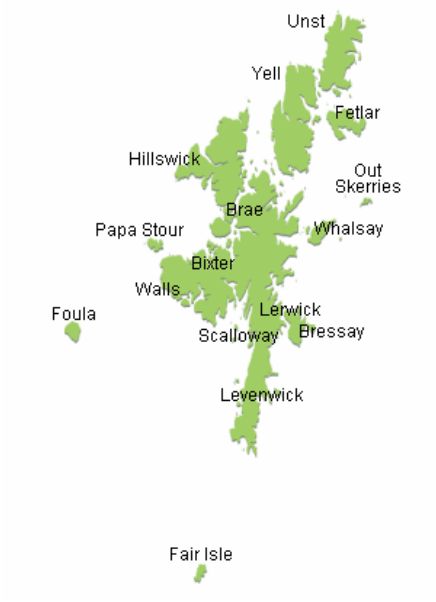
Further Reading

The LUCAP which provides more detail and is available at the link below: http://www.shb.scot.nhs.uk/board/meetings/2014/201408-Boardpack.pdf

Audiology Service
2015-16 Service Plan



Introduction

The Audiology service provides the people of Shetland of all ages with a variety of Audiological services. The main focus is on hearing aid users who make up the bulk of the service provision with diagnostic services being provided to ENT clinics and other clinicians as appropriate.

Specifically the role of the department is to provide Hearing Assessment, hearing aid provision, review and more complex, non-routine clinical services along with training and advice on ear, hearing and hearing aid related matters. We can also support people with balance and tinnitus disorders in association with the ENT clinic.

The Paediatric side of the service is provided via regular Paediatric hearing screening clinics. These clinics can be accessed via direct referral from GP's or via the ENT service and provides Audiological measurements as well as support from the Teacher for communication and hearing impairment.

We currently provide service from one treatment room which includes a built in sound proof booth for both Adult and Paediatric hearing assessment.

Vision Statement

The Audiology service is committed to supporting our service users through their care pathway and build pathways of communication with our health and social care colleagues in line with NHS Shetlands 2020 Vision. ***" to deliver sustainable high quality local health and care services that are suited to the needs of the population; to make best use of our community strength, our community spirit and involvement, for people to make healthy lifestyle choices; and use their knowledge and own capacity to look after themselves and each other."***

Drivers for Change

Sensory Impairment Strategy - http://www.scotland.gov.uk/Resource/0044/00448444.pdf
Scottish Audiology Quality standards - http://www.scotland.gov.uk/Resource/Doc/270517/0080557.pdf

Locally a recent patient survey shows that lack of deaf awareness amongst staff is an issue for patients.

- An increasing elderly population, with many having complex needs such as dementia along with hearing loss.
- Hearing loss is a progressive condition requiring regular repeat testing to support changes in hearing levels and review hearing aid provision.

As permanent hearing impairment is a progressive condition the "Scottish Audiology Standards" recommend that this group require review every 3yrs. The Audiology service has not been able to provide this for several years due to lack of capacity within the service.

This group of patients has begun to self refer for review as they notice hearing deterioration which puts them in to the 18wks pathway. Further demand comes from the general increase in the elderly population and increased demand from the ENT service for both Adults and Children. The demand for Paediatric hearing assessment has been steadily increasing for several years.
There is increasing difficulty in supporting elderly hearing aid users who are more likely to have additional complex needs such as dementia and sight loss. The number of NHS hearing aid users has increased from around 200 in 2005 to over 1,000 currently. This register is of active NHS hearing aid users and varies from week to week, but with a general upwards trend.

About Us / Who We Are

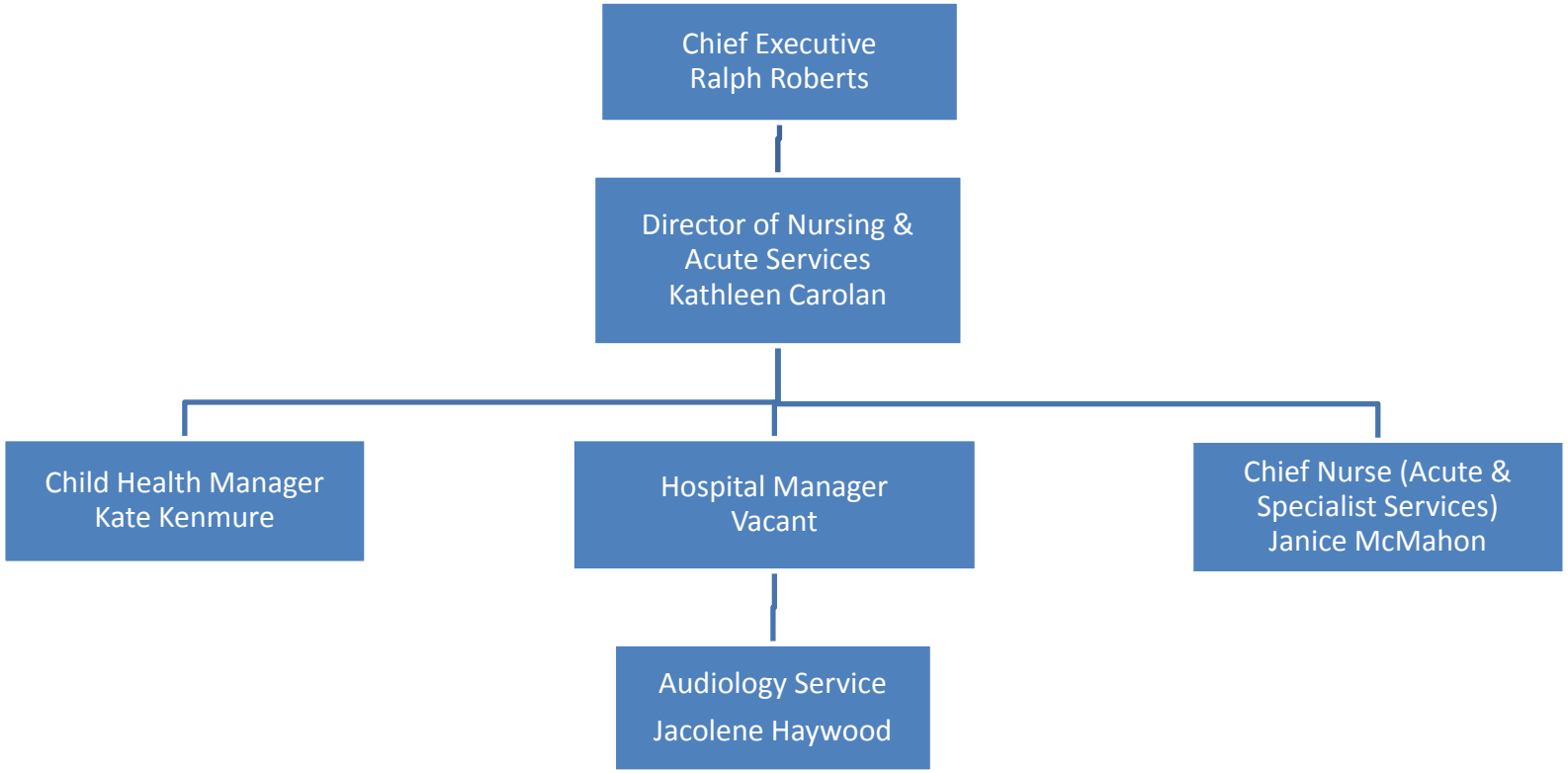
The Audiology Service was set up in early 2005 with the support of the Scottish government to modernise Audiology services and introduce computerisation and digital hearing aids. The support included ring fenced funding to provide modern soundproof facilities and equipment to supply a high level of technical support to hearing impaired people. This was closely followed by the introduction of the Scottish Audiology Quality Standards to monitor and support an improvement in standards of patient care within the Audiology services of Scotland.
In 2005 the Audiology service consisted of 1.0WTE Audiologist/Head of service.

Currently the Audiology service consists of

- 1.0WTE Audiologist/Head of service
- 0.6WTE Trainee Associate Audiologist

Patients can be seen from the treatment room which includes a soundproof booth. We have a small office to deal with the running of the department with a direct phone line for patients, staff and others to contact us on 01595 743231. We do not have a reception or receptionist to deal with unscheduled attendance at the department but hearing aids can be left at main reception along with written messages if patients are unable to use the telephone or email contact.

Organisational Chart



Locations

Audiology Department, Gilbert Bain Hospital, Lerwick, Shetland, ZE1 0TB.

Governance

The Audiology service is monitored by peer review as part of the Scottish Audiology standards and there is an appointed “National Audiology manager” for Scotland. As there is only one qualified Audiologist within the health board it is important that this person is able to access other Audiologists within the Healthcare environment to review and update current practice. This can be via email, phone and by visiting larger departments on a regular basis.

Regulation and Compliance

There is no statutory regulation of the Audiology profession and other Clinical Physiology professions.
Currently the Audiologist is on the voluntary register with the RCCP (Registration Council for Clinical Physiologists). This body has been working with others and the government to gain statutory regulation in line with other healthcare professions. The Audiologist is also a member of the BAA (British Academy of Audiology).

What We Do

We provide Audiological services for Adults and Children.

- Hearing aids – assessment, provision, follow up, maintenance and other hearing aid related services.
- NHS hearing aid repair service by appointment, post or drop box. The drop box is provided on the main reception of GBH with pre-printed envelopes to supply a description of the fault, patient details and contact information along with the faulty hearing aid. It can take up to 14 days at busy times to repair hearing aids as this is unscheduled work which needs to be fitted in between scheduled tasks. Although we try to repair hearing aids as quickly as we can it can take several days. Ideally seeing patients by booked appointment for hearing aid repairs is more effective and allows for examination of the ears and to see how the hearing aid is fitting. We try to offer several repair slots each week to allow for hearing aids to be dealt with in a timely manner.
- Supporting the visiting ENT service – support is offered during the ENT clinic and since January 2014 as part of an extended triaging of ENT referrals. The AA clinic (Audiology Assessment) provides Audiological assessment as required for GP referrals to ENT. At this clinic some patients can be dealt with as part of Audiology pathways or may be discharged under certain circumstances. If ENT consultation is still required the additional information can be used to manage the patient pathway with regard to urgency and time slot required.

- Paediatric hearing assessment clinics on a regular basis. This has been on a monthly basis but due to increasing demand this will be twice a month from January 2015. These clinics are in association with the Teacher for Communication and the Hearing Impaired.
- Paediatric hearing aid fitting when required, generally for school age children. Babies and pre-school children requiring hearing aid fitting would be seen in Aberdeen with specialist Paediatric Audiologists.
- Paediatric post grommet review in Audiology without ENT input unless required.
- Deaf Awareness – for staff and patients as required.

Our Customers

The Audiology service covers the whole of Shetland.
1 in 6 people in the UK have a hearing impairment compared with 1 in 30 with sight impairment.
The growing elderly population are living longer and requiring Audiology services for longer. The demand for Audiology services and hearing aid provision grows along with the people being seen having more complex needs. These additional needs include Dementia, sight loss, poor dexterity, tinnitus and many other age related conditions.
We do not offer an unscheduled service but patients do still turn up without prior arrangement or a scheduled appointment. This can impact on other services such as Physiotherapy and GBH reception staff if patients are no able to access a member staff from Audiology.

Eligibility

Hearing aid provision
Clinical guidelines are used to clearly show when hearing loss is outside the normal range, along with needs questionnaires to show level of disability. Referrals vetted for suitability and priority given to diagnosed dementia, mental health issues, over 90yrs old etc
Referral to Audiology or ENT service
Criteria in place to triage out ENT referrals to be seen in Audiology when appropriate OR to transfer to ENT if Audiology referral not appropriate
Paediatrics
Post grommet children are now reviewed in Audiology routinely and only referred for ENT review when required.

Funding and resources

The health board has previously funded the service to provide 1.0WTE Audiologist/Head of Service and 1.0WTE Assistant Audiological Practitioner. But 0.4WTE of the Band4 assistant post has been taken as part of the savings target.

There is great pressure on the service to meet increasing demands as described in “Drivers for change” and we have had an additional step change in referrals for hearing assessment since January 2014. This increase in monthly referral numbers has remained at the higher level every month since January along with a similar trend for the ENT clinic over a similar period.

As the clinical expertise is reliant on a single person (the Audiologist) the assistant role has been extended this year. Funding has been sourced from NES (National Education Scotland) to support a 2yr Diploma in Hearing Aid Audiology at QMU Edinburgh from the Autumn Term of 2014 to the Spring/Summer of 2016. (See the section Detailed Actions/Plan for Change)

Funding has been gained from the SIC to assist with the set up and roll out of a program to train social care staff in deaf awareness and basic hearing aid maintenance. This funding is for a 12 month period January 2015 to December 2015 and will allow the Trainee Associate Audiologist to be funded for 0.4WTE band4 ie move to full time hours over this period.

Aims and Objectives

The Audiology service aims to deal with audiological and hearing related matters for the whole of Shetland.
Assessment, Fitting and maintenance of digital hearing aids
Support to the visiting ENT service with the Audiologist working at advanced practitioner level to triage and pre-assess ENT referrals.
Deaf Awareness training to staff of all levels both NHS and SIC
Work with SIC to implement the Sensory Impairment Strategy which has come from the SEE HEAR consultation.
Maintain and improve the services for hearing impaired people both Adults and children with a growing elderly population with increasingly complex needs.

Detailed Actions/Plan for Change

Staffing/Training

Assistant Audiological practitioner

Since 12th May 2014 there has been a new support assistant in post and funding has been sourced from NES to support training to diploma level. Once completed the post holder will become an Associate Audiologist and will be able to provide the service with basic audiometric assessment of current hearing aid users and provide hearing aid fitting of routine, non-complex cases.

As the Trainee Associate Audiologist undertakes clinical training the Audiologist has reduced capacity whilst supervising and supporting the trainee until fully competent to see patients without direct supervision.

Support Deaf Awareness
To support staff with improved deaf awareness, as an action from the recent patient survey commissioned by Kathleen Caroan.

Funding
The SIC will be supporting the Trainee Associate Audiologist to take up full time hours for 12 months from January 2015. This will allow the service to support the training of social care staff in deaf awareness and basic hearing aid maintenance for those clients who are unable to do this. This will be a rolling program to keep staff up to date and in contact with the department for help and support. It is likely this will quickly be introduced for Healthcare staff as well.

NES funding for Diploma in Hearing Aid Audiology (see Staffing/Training above).

Accommodation/Equipment
A second clinical room
From January 2015 a room has been secured for 2 sessions a week (2 half days) in Outpatients GBH. Due to Audiology's heavy dependence on technology the ICT department will be needed to allow access to the Audiology database via the PC already in the room. Additional equipment has been sourced to allow for programming of hearing aids via USB connection and additional day to day consumables will be required to work from this room routinely.

A room in the Occupational Health department contains the soundproof booth previously used by the visiting Audiology service/ENT before the current local service was set up. From mid-late February the Trainee Associate Audiologist should be able to use this room 1 day per week and should be competent to see basic reassessments by then i.e. review of current hearing aid users/repeat audiometry.

While the Trainee Associate Audiologist is still training there will be periods of time spent at QMU in Edinburgh. These are usually in week long blocks.
Working down the backlog/increasing capacity
Joint hearing aid fittings

As the Trainee Associate Audiologist (TAA) is not at a stage to be able to fit hearing aids yet. In the short term clinical practice will be altered slightly to allow for a joint hearing aid fitting appointment. This will be implemented from the end of January 2015 after training has been undertaken.
Currently the Audiologists performs hearing aid fitting, verification and instructions of use in a 1hour appointment slot.
The joint hearing aid fitting will split the appointment in half allowing for the non-complex instructions part to be performed by the TAA. This will only be possible at times when we have a 2nd room available in outpatients.
1st part – Audiologist performs hearing aid fitting and verification.
2nd part – TAA will provide the instructions of use and allow the patient to practice use etc.
The patient will still be seen over the same time frame on the same day but will see 2 different people. This should allow for twice the number of hearing aid fittings in each session.

Risks to Delivery

As per “Drivers for change” the NHS as whole is dealing with **an increasing elderly population who are living longer** and requiring assistance with **more complex needs**. As most of the Audiology service users are older/elderly people this is and will continue to be a risk to delivery of Audiology services.
The service has **1.0WTE Audiologist** who works at advanced practitioner level and so this can make the **service fragile** when this person is not available. Currently demand is regularly outstripping capacity and although the TAA is training to take on more of the clinical work we **only have one permanent clinical room**.
The new TAA role is increasing the clinical role but the consequence of this is reduced clerical support for the service. We do not have a proper point of contact for patients trying to access the service for unscheduled care. This impacts on other services such as Physiotherapy and main reception.
Costs will rise with **increasing numbers of patients seen and hearing aids fitted**.

Performance Indicators

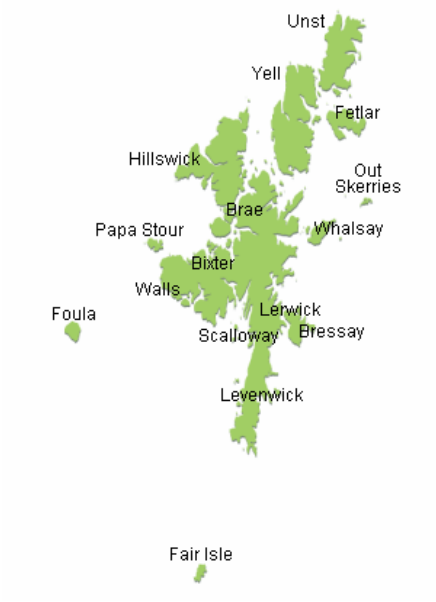
Government - 18wks RTT, Scottish Audiology quality standards, Sensory impairment strategy
Local - Patient satisfaction survey (usually annually) this is part of the quality standards

Contact Details

There is no reception or clerical staff so sometimes people need to leave a message on the answer phone. This can be very difficult for hearing impaired people to be able to use but we also have an email contact.

Audiology department, Gilbert Bain Hospital, Lerwick, Shetland, ZE1 0TB.
Telephone: 01595 743231 (Audiology office)
Fax: 01595 692184
Email: shet-hb.audiology@nhs.net

Laboratory Service
2015-16 Service Plan



Introduction

Every year, each Service is required to produce a Service Plan for the following year. This Service Plan provides an overview of the Gilbert Bain Clinical Laboratory Services for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Quality Policy

The Clinical Laboratory at the Gilbert Bain Hospital will:

- *Provide a comprehensive consultative, analytical and laboratory service to Gilbert Bain Hospital, to Health Centre, General Practitioners, local Occupational Health Service and other bodies authorized by the Medical Director.*
- *Be committed to continuing compliance with UKAS ISO 15189:2012 Ltd accreditation standards and with BSQR (2005) as amended regulations.*
- *Be committed to providing appropriate, timely cost effective and cost efficient service of the highest quality and shall be aware and take into consideration the needs and requirements of users are met.*
- *Operate a quality management system to integrate the organisation, procedures, processes and resources.*
- *Set quality objectives and plans in order to implement this quality policy to achieve continual Quality Improvement of the Quality Management System.*
- *Commit to the health, safety and welfare of its staff.*
- *Ensure visitors to the department will be treated with respect and due consideration will be given to their safety while on site.*
- *Ensure laboratory premises and environments are kept in a suitable condition providing a safe working environment in compliance with relevant environmental legislation.*
- *Conduct and uphold professional values and be committed to good professional practice.*
- *Ensure that all personnel are familiar with this quality policy the quality manual and all procedures relevant to their work.*

The Clinical laboratory is committed to:

- *Ensure that all staff are competent in all procedures used and understand the principles of GMP.*
- *Staff recruitment, training, development and retention at all levels to provide a full and effective service to its users.*
- *The proper procurement and maintenance of such equipment and other resources as are needed for the provision of the service.*
- *The collection, transport and handling of all specimens in such a way as to ensure the correct performance of laboratory examinations.*
- *The use of examination procedures that will ensure the highest achievable quality of all tests performed.*
- *Reporting results of examinations in ways, which are timely, confidential, accurate and clinically useful.*

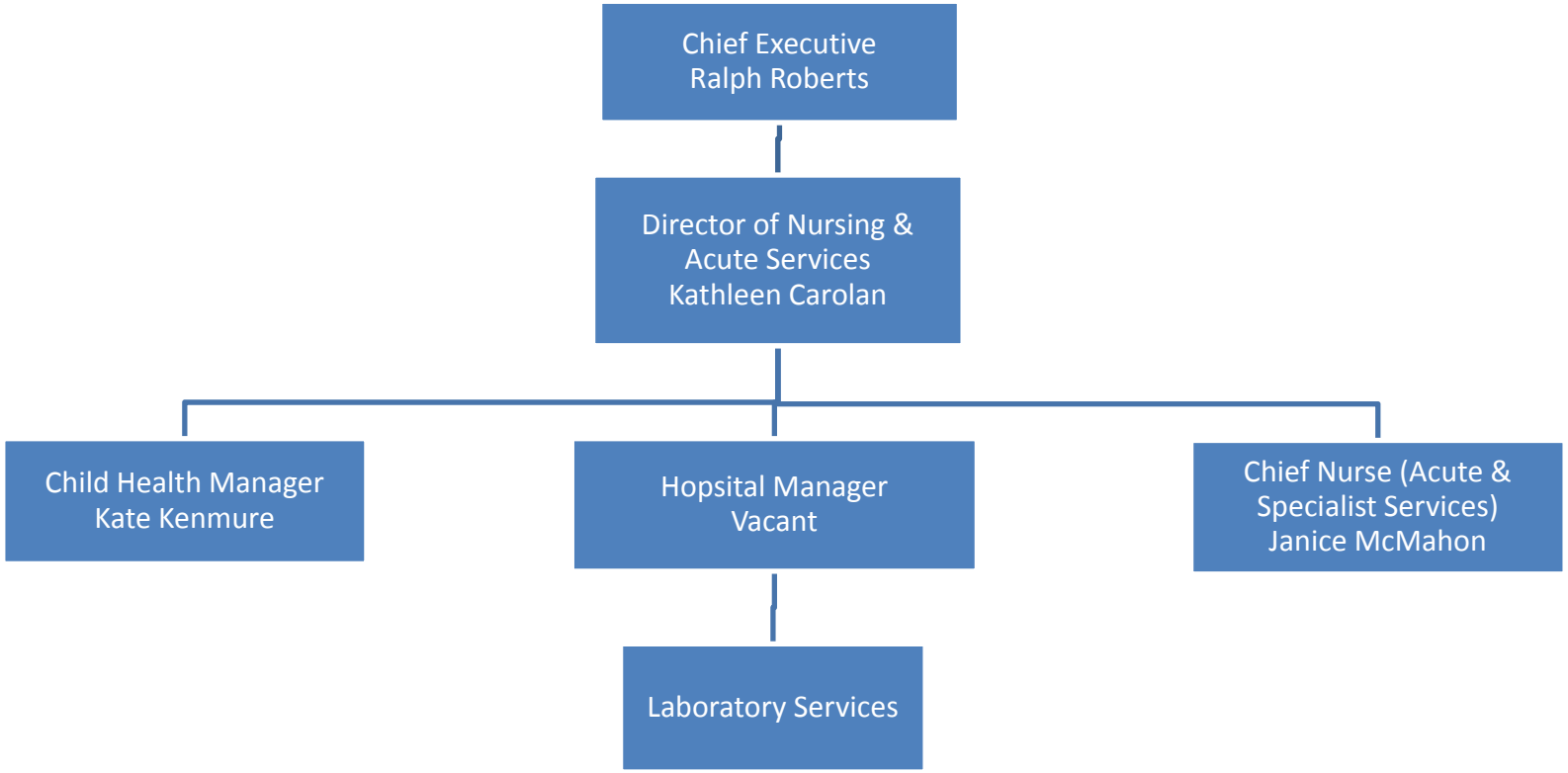
- *The assessment of user satisfaction, in addition to internal audit and external quality assessment, in order to produce continual quality improvement.*
- *Quality management being responsibility of the Quality manager with support from departmental staff in the setting up of, adhering to, and auditing quality standards.*

Drivers for Change

1. **Regulatory**: Compliance with UKAS accreditation standards means it is essential to maintain the current clinical governance relationship with NHS Grampian.
2. **Resilience**: The current obligate network arrangements with NHS Orkney have allowed shared management and quality management roles across both island sites. An extension of these arrangements permits the provision of a managed service agreement for laboratory equipment across both sites, thus providing operational resilience and efficiencies to both boards.
3. **Demand**: World-wide laboratory requests for laboratory investigations show a universal long run universal average annual increase of 7% per annum. The annual increase in NHS Shetland from calendar year 2012 to 2013 was 6.4%. This continuing increase in demand has both financial and operational implications; financial due to continuing need for adjustments to budget for laboratory consumables (test reagents) and operational, to cope with increases in demand – a combination of more labour, larger machines or faster machines is required.
4. **Plant Replacement:** Both island Boards, Orkney and Shetland, suffer from a lack of resilience in their current analyser plant. Both biochemistry analysers are beyond their economic life and are overdue for replacement, the same is true for the coagulation analysers.
5. **Clinical Pathways**: There is little to no point of care test (POCT) capability. Implementation of POCT testing can have a potentially significant impact on both patient care pathways and laboratory activity. Acquisition of POCT equipment is being addressed by the joint managed service contract (MSC) for laboratory services.

About Us / Who We Are

Organisational Chart



Locations

The Laboratory Service is located at the Gilbert Bain Hospital, South Road, Lerwick.

Governance

The laboratory operates under the direction of its Laboratory Director, a consultant clinical pathologist, currently a part time appointment from NHS Grampian. The Laboratory Director is responsible to the Medical Director NHS Shetland and the Boards Clinical Governance committee.

Regulation and Compliance

The laboratory was fully accredited by Clinical Pathology Accreditation (CPA) in September 2014. It is anticipated that CPA will be fully subsumed by UKAS before 2018.

The hospital blood bank & transfusion medicine departments are fully accredited and regulated by the Medicine & Health Regulatory Authority (MRHA)

What We Do

The Laboratory Services is by design a multi discipline service covering Haematology, Biochemistry, Microbiology and Blood Transfusion whose main services are described below. No Cellular Pathology, post mortem & mortuary services are provided in Shetland – all histology and cytology samples are referred to NHS Grampian laboratories.

Clinical Biochemistry department

The clinical biochemistry department provides an acute/routine service for both primary and secondary care throughout NHS Shetland. The bulk of the workload is carried out on a Beckman Coulter DxC600i chemistry analyser. NHS Grampian Directorate of clinical pathology laboratories undertakes more specialised testing as per a service level agreement. By having sample deliveries to Aberdeen three days a week and automated electronic reporting each day it is possible to deliver a comprehensive service to meet the needs of NHS Shetland.

Haematology and Blood Transfusion department

The haematology department provides a routine Full Blood Count (FBC), coagulation and haematinic service. The blood transfusion service in Shetland acts as a peripheral blood bank to the north east of Scotland the regional transfusion centre. The laboratory holds agreed levels of blood components required for the needs of Shetland.

Although the blood transfusion related work is a relatively small proportion of the overall clinical laboratory workload, the importance is crucial to the community of Shetland. The Hospital Transfusion Committee (HTC) plays a key role in producing effective and robust procedures for transfusion within the Gilbert Bain hospital. The minutes of HTC meetings are available within the blood transfusion laboratory.

Microbiology department

The department provides a routine microbiology service to Shetland. The laboratory carries out routine culture and antibiotic sensitivities and environmental monitoring for the Central Decontamination Unit (CDU). Isolates are generally identified to species level, if further investigations are required; they are referred to the appropriate reference laboratory. Samples and isolates that require higher than containment level two are referred to appropriate CPA/UKAS accredited laboratories usually within NHS Grampian.

Our Customers

The laboratory management will ensure that laboratory services, including appropriate advisory and interpretative services, meet the needs of patients and all those using the service.

Compliance with this standard is assessed using a variety of tools including an annual user satisfaction survey.

Funding and resources

Increasing workload, in particular for the on-call out-of-hours (OOH) service, has important financial implications. In part this increase will be covered by the POCT component of the MSC.

Aims and Objectives

To provide a resilient, high quality, accredited, efficient and responsive laboratory and blood transfusion service to NHS Shetland.

Detailed Actions/Plan for Change

Annual management, Quality and capital action plans are formulated yearly at the Annual Management Review – due 22nd Jan 2015.

Risks to Delivery

The total lack of analyser back-up is an important risk to the resilience of the service – this to be addressed by the MSC.

As with all small organisations, difficulty in the recruitment of specialist scientific staff is frequently problematic. To date, the laboratory has always eventually managed to recruit, and retain, sufficient qualified and registered staff, however there have been, in the past, significant gaps between resignation and recruitment. The option of short term locum staff to "back-fill" must always be retained.

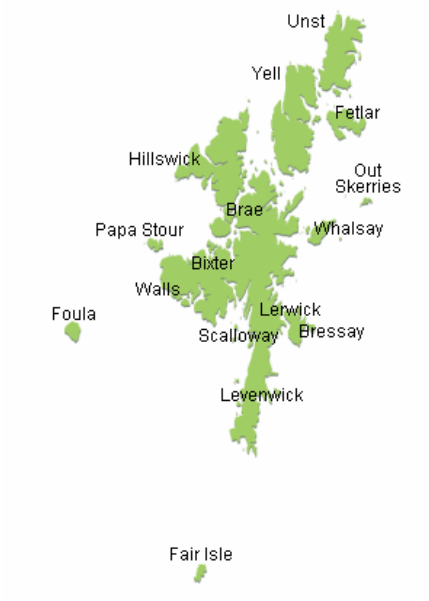
Performance Indicators

The laboratory reviews on a monthly basis a number of performance indicators e.g. Turn-around times TAT, Quality indicators – IQC & EQA, customer satisfaction, incidents etc.

Contact Details

Laboratory manager: Geoffrey Day Phone: 01595 743000 x3041	Quality manager: Carina Campos-Rio Phone: 01595 743000 x3041	Laboratory reception: Direct dial Phone 01595 743011

Medical Imaging Service
2015-16 Service Plan



Drivers for Change

- 24/7 access to diagnostics
- NDP
- Waiting Times

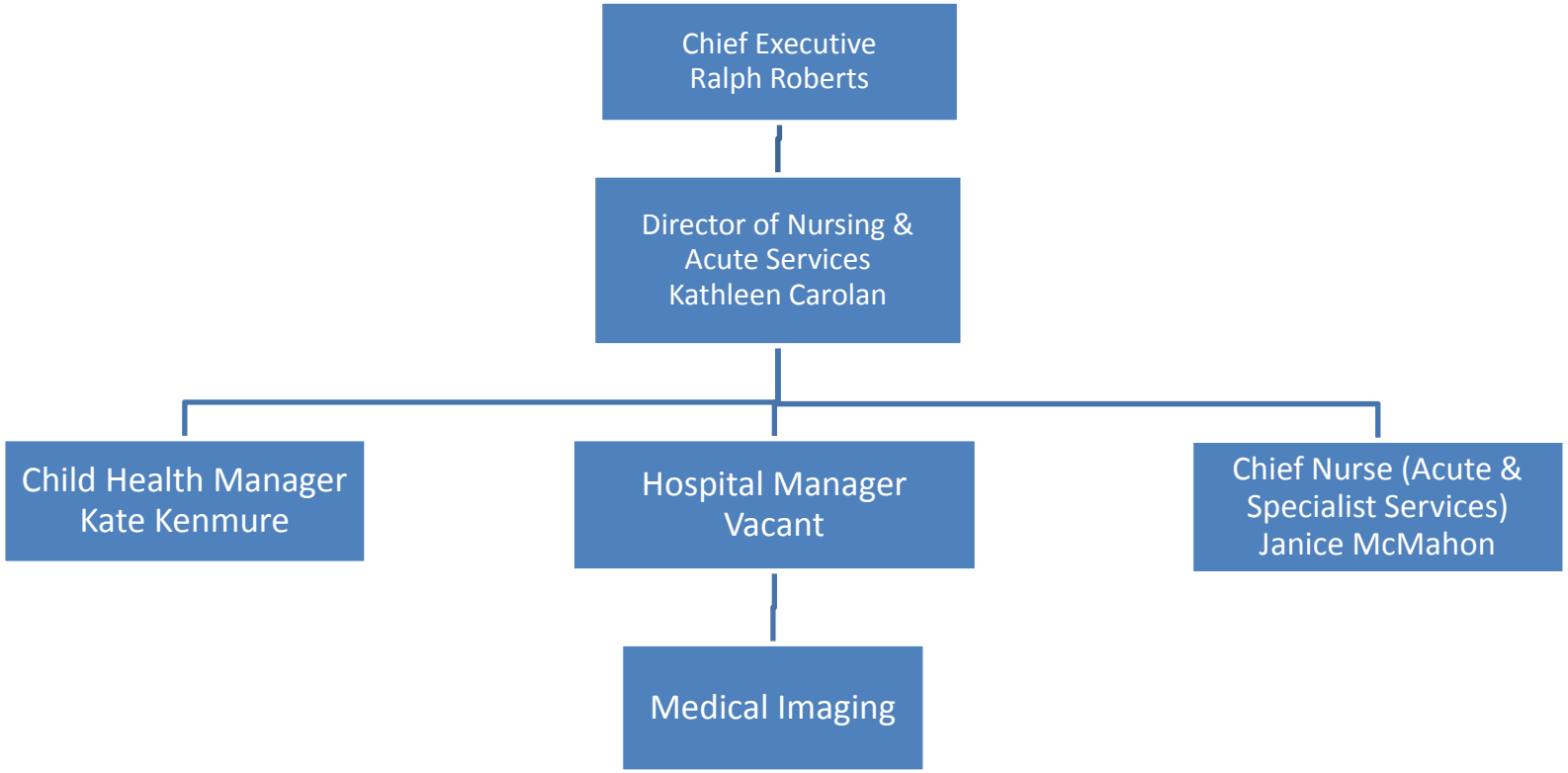
Details of any unmet needs identified, and other drivers for change including savings targets, redesign programmes.

1. Full 24/7 CT availability & clinical governance – difficult to recruit experienced CT staff. Post Grad CT Training programme in place to ensure current staff can evidence their competency to practice and to improve/guarantee quality of service. Resource to attract high calibre experienced staff.
2. Ultrasound waiting times targets – Post Grad training scheme in place to address national/worldwide shortage of Sonographers to improve the robustness of the local service and increase capacity – current trainee due to complete & qualify April 2016. Second dedicated clinical ultrasound room & machine required.

About Us / Who We Are

The Medical Imaging Department is responsible for all aspects of Medical Imaging including: General radiography and Fluoroscopy, Ultrasound Scans as well as CT. Radiographers may be called by hospital medical staff only. The requesting clinician can contact the on call radiographer through the switchboard at the Gilbert Bain Hospital. Out of hours examinations are only carried out if they are essential to the patient's management. The Medical Imaging Department is closed on public holidays when the on call service is in operation. Any queries, comments or complaints must be directed to the Radiology Services Manager during normal working hours. The on call radiographer can answer any queries outside working hours and can decide if any further action need be taken at that time.

Organisational Chart



Location

The Medical Imaging Department is located off the main corridor of the Gilbert Bain Hospital between the Accident and Emergency and Outpatient Departments. It consists of two general x-ray rooms, one ultrasound room and CT Suite. The Department is open 9:00am - 17:00pm Monday to Friday. Outside of these hours and on call service is provided.

What We Do

Description of current services provided.
Available modalities:

1. Plain general imaging, including dental , Mobile/theatre & fluoroscopy,– open access/ walk in service to Primary care/ Out Patients/ In – Patients & A&E, or booked appointments as appropriate
2. Plain general imaging 24/7 access for emergencies only from A&E/ In – Patient referrals
3. CT – by appointment. Available 24/7 for emergency stroke heads. Limited 24/7 availability for all other CT emergencies dependant on skills of on-call radiographer.
4. Visiting Radiology Clinics – 4 weekly
5. Ultrasound – booked appointments. No out of hours service. Single handed service providing general medical, obstetrics and gynecology, vascular including: Deep vein thrombosis and carotid Doppler.

Our Clients

Our service is available to all, including visitors. Limited private service examinations for Chiropractor/Physiotherapy/Chiropody & Dentists are provided.

Funding and resources

The Medical Imaging Department is responsive to demand making budgeting difficult.
Staff recruitment is challenging – the skills required for the service are often not matched and have to be acquired through training.
Successful bids for access to training funds

Aims and Objectives

To deliver best quality, responsive, appropriate and timely 24/7 imaging diagnostics to population of Shetland
Appropriate number & skill mix staffing
Recruitment & retention of appropriately skilled staff
Robust & reliable Radiology reporting services
Robust & reliable IT systems support
Equipment & clinical space

Detailed Actions/Plan for Change

Recruitment – skill mix review & potential regrading of posts to best meet service demands
Training – skills maintenance/ protected CPD time/progression& continued commitment of current post grad training programmes – both CT & Ultrasound
Review of Grampian SLA re: radiology services
Potential for collaborative networking with Orkney

Risks to Delivery

- Recruitment/retention
- Succession planning
- Changes /Service Developments
- National and worldwide shortages of radiologists and sonographers
- Satisfactory outcome of training initiatives
- Equipment failure/availability
- Sufficient funding
- Increasing demand on current service/ population demographics
- Future service expectations

Performance Indicators

Meeting waiting times targets for diagnostics

Contact Details

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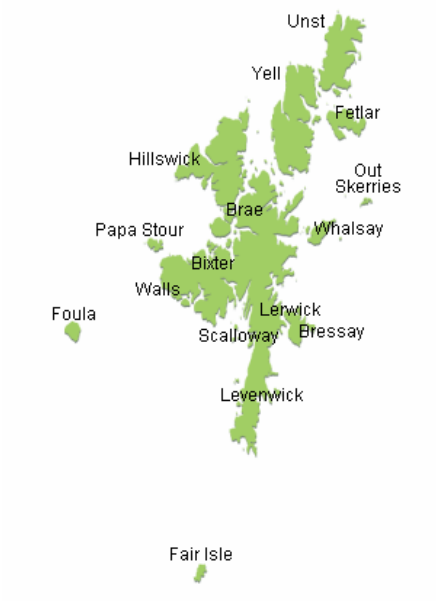
Children's Services
2015-16 Service Plan



Introduction

The Scottish Government's ambition is that Scotland should be the best place in the world for children and young people to grow up. There are a number of national policies and local strategies that we link with to help achieve this ambition and ensure that children and young people who live in Shetland will have the best possible start in life and achieve the best outcomes.

The Refreshed Maternity Framework (2011) has been designed to address all care from conception, throughout pregnancy and during the postnatal period. This document clearly outlines the strategic direction for maternity services in Scotland and NHS Shetland is delivering on this Framework. It has been well recognised that maternal health and wellbeing has a significant impact on future child development and resilience.
The Children and Young People (Scotland) Bill , which was passed by the Scottish Parliament in February 2014 combines proposals to improve the delivery of children's rights and services for children and young people. It is wide-ranging in its focus, building on the foundations of Getting it Right for Every Child (GIRFEC) particularly with the responsibilities outlined for the Named Person/Lead Professional.

GIRFEC is more than the framework supporting inter-agency assessment and planning. It provides the overarching principles and values for everything we do for our children and young people. In order to further embed these into our thinking and practice, we have formulated our practice around the GIRFEC National Practice Model SHANARRI outcomes. All our partner services have adopted this principle. The aim is to bring a common language and framework to all children and young people's services planning.
The Early Years Framework published in December 2008, signified an important milestone in encouraging partnership working to deliver a shared commitment to giving children the best start in life and to improving the life chances of children, young people and families at risk.
The objective of the Early Years Collaborative (EYC) is to accelerate the conversion of the high level principles set out in GIRFEC and the Early Years Framework into practical action. This will:

- Deliver tangible improvement in outcomes and reduce inequalities for Scotland's vulnerable children.
- Put Shetland squarely on course to shifting the balance of public services towards early intervention and prevention by 2016.
- Sustain this change to 2018 and beyond.

The EYC is premised on the fact that we know there is strong evidence about costs and outcomes of current and desired practice, but much of this is not being used in daily work. Where we have taken on board the evidence, practice does not always reliably recreate what the evidence tells us, and there is inconsistency and patchy implementation.
The EYC will help us close that gap by:

- Creating a structure in which partners can easily learn from each other and from recognised experts in areas where they want to make improvements.
- Supporting the application of improvement methodology to bridge the gap between what we know works and what we do.

The overarching stretch aims of the collaborative are:

- To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1000 births in 2010, to 4.3 per 1000 births in 2015) and infant mortality (from 3.7 per 1000 live births in 2010, to 3.1 per 1000 live births in 2015).
- To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016.
- To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.

There are key change areas identified and the Shetland EYC Group are working with individual teams to deliver improved outcomes for children as described in SOA and Integrated Children's Plan. These include addressing child poverty, family engagement and parenting skills amongst others.

Vision Statement

Shetland is the best place for children and young people to grow up.

Drivers for Change

- Due to the changes in medical training recruiting medical consultants who have the expertise to care for children may be problematic in the future.
- A national shortage of Health Visiting staff has led government-led initiative to increase the number of health visiting posts Scotland wide with a new training programme commencing in the near future.
- Modernisation of the school nursing role is at an early stage and the outcome of that consultation may have an impact on the service we provide in the future
- Advance Practice models for AHP is being discussed nationally. This has not been taken forward yet.

We work closely in the multiagency fora to support children and young people. The latest interagency plan Get It Right for Children and Young People in Shetland Integrated Children's Services Plan 2014 – 2017has recently been approved. The aims and priorities are below.

Aims:

1. Change the way we work to provide more effective early intervention to improve the wellbeing of children/young people, with a focus on the most vulnerable.
2. Create a structure with a clear understanding of local needs, planning, governance, centralised data support and service development; supporting continuous improvement in order to deliver our priorities.
3. Use GIRFEC principles when we work with children and young people.

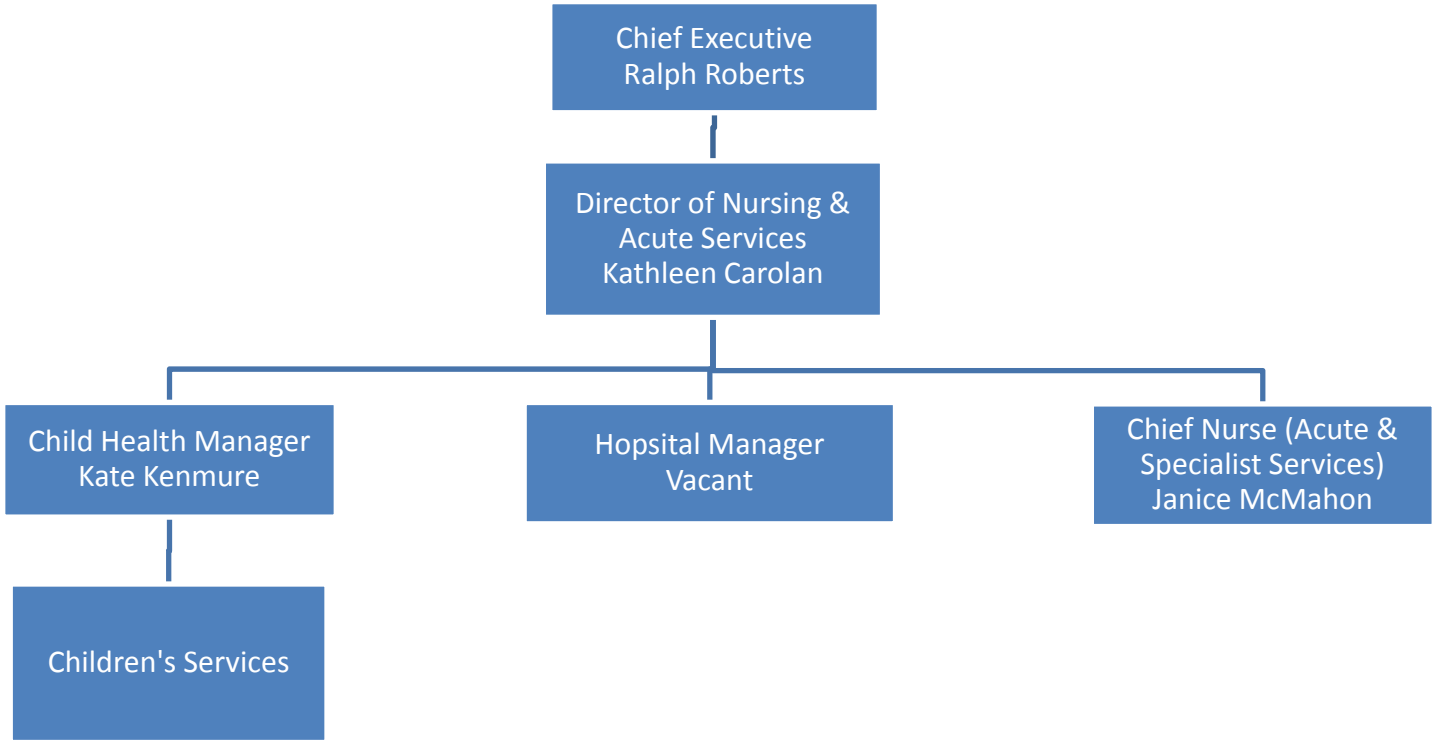
Priorities:

1. To be clear about who our most vulnerable children and young people are and to focus the work of the plan on improving the outcomes for these children and young people.
2. We will clearly hear the voices of children and young people, and show how this is changing their experiences, outcomes and service planning.
3. We will increase resilience in children, young people and families and improve their psychological well-being and self-esteem.

About Us / Who We Are

The Child Health Team was created in 2012 as a result of reorganisation within NHS Shetland. It consists of 1 team leader, 5.3 Health Visitors, 2 Children's Nurses, 1 School Nurse and a Public Health Staff Nurse who work across Shetland. They are supported by 2 support staff. This will soon include staff from the CAHMS team. This team consists of 1 WTE Psychiatric Nurse, 1 WTE Primary Mental Health Worker, 0.7 WTE Clinical Associate in Applied Psychology and two visiting specialists – a Consultant Psychologist and a Consultant Psychiatrist – who hold monthly clinics over 4 sessions.
The midwifery staff of 1 Senior charge midwife, 9.8 WTE Midwives and 4.42 Support staff.

Organisational Chart



Locations

Maternity Services are integrated with all midwives working within the maternity unit at the Gilbert Bain Hospital and also running community antenatal clinics in each Health Centre. The Health Visitors are all GP and geographically linked with some having more than one practice depending on numbers and location. The school nursing service is run on a Shetland-wide basis with the school nurse based within the child health department at the Gilbert Bain Hospital. Likewise the AHP services are all based in the Hospital with a school and home visiting service in some cases. CAHMS location at present is within the mental health base at Lerwick Health Centre but this is under review.

What We Do

Health Visitors

Health visitors support and educate families from pregnancy through to a child's fifth birthday or entering school. Health visitors are trained to recognise the risk factors, triggers of concern, and signs of abuse and neglect in children. We also maintain contact with families while formal safeguarding arrangements are in place, ensuring families receive the best possible support during this time. As we are involved in every stage of the child protection process, including serious case reviews, we are often called upon to write and present professional reports for child protection case conferences, children's hearings and court cases. They are the named person for children until they enter primary school.

Childrens' Nurses

Childrens nursing involves everything from nursing a sick newborn to an adolescent road accident victim. However, it is not all about the child, we also provide the care and support needed by the wider-family, including the parents. We have two registered children's nurses. One is based within the hospital and gives direct patient care to children who are admitted to the wards as emergencies or for routine surgery and acts as a resource and educator for adult trained nurses in the care of ill children. Our other children's nurse is based in the community

Our Children's Outpatient Department operates as required and enables children to be seen within Shetland by General Practitioner with Special Interest in Paediatrics and by visiting paediatricians and visiting specialists. Our healthcare support worker works within this department half time and in the school nursing service the rest of her time.

School Nurses

School nurses are public health nurses who work within a variety of settings but principally within schools. A child-centred public health approach enables the school nurse to work at community level with public health programmes, with whole schools, with group work within schools and with individual children, young people and their families.

Children's Physiotherapy

The paediatric physiotherapy service is based at the Gilbert Bain Hospital and served by 1.6 WTE staff (made up of 1 WTE Band 7, 0.5 Paediatric band 6, and 0.1 Outpatient Band 6). It provides a service to children and young people aged 0-16 (19 if additional needs) in a variety of settings including: inpatients, outpatients, community and schools.

The service takes referrals from health, education and also from parents and children themselves via self-referral. It provides advice, assessment and treatment in all areas of paediatric physiotherapy such as development, orthopaedics and musculoskeletal problems,

respiratory illness and neurology. It is also able to refer directly into paediatric and orthopaedic clinics for children on the caseload which minimises the impact on GP's.

Speech and Language Therapy Service
This service provides assessment, diagnosis and treatment for children and adults with speech, language and communication needs, and those with eating, drinking swallowing problems (dysphagia). Children are seen with a range of speech, language and communication needs, including language delay and disorder, difficulties with speech production, voice problems, dysfluency and social communication difficulties. There are 2.56 speech and language therapist and 0.7 support worker. There is currently 243 children on the caseload with 104 referrals in 2013.

Child and Adolescent Mental Health Service
This multi disciplinary team provides a CAMH service to the population of Shetland. The team consists of 1 WTE Psychiatric Nurse, 1 WTE Primary Mental Health Worker, 0.7 WTE Clinical Associate in Applied Psychology and two visiting specialists – a Consultant Psychologist and a Consultant Psychiatrist – who hold monthly clinics over 4 sessions. It provides consultations, assessments and interventions; treatment can include different types of individual therapy: behavioural; cognitive; systemic; psychodynamic, family work of various kinds, and where needed prescribed medication. Referral for 2014 has seen a 30% increase in numbers from the same time period in 2013.
The team will transfer their management to the wider child health team in April 2015.

Children's Occupational Therapist (OT)
This service is involved in the assessment and development of the practical skills necessary for children's everyday life. An OT will aim to enable a child to be as independent as possible by analysing the following areas functional abilities, school skills, play skills sensory abilities fine motor gross motor, movement abilities and behavioural responses during your child's day. The staff consist of a specialist children's OT (0.8) Assistant Practitioner (0.5).

Medical Care
Medical services on island are provided by a local GP with Special Interest in paediatrics and sessional paediatrician providing a community child health clinic, and joint clinics with visiting paediatricians offering a combination of general paediatric sessions and specialist clinics e.g. cardiac, respiratory. Most in-patient children's services are provided through NHS Grampian or to more specialist regional or national paediatric services.

Children who are acutely ill will present through Accident and Emergency, be assessed and given initial treatment by the medical or surgical teams, in consultation with specialist paediatric services in Grampian as appropriate. Children may stay overnight in GBH but if they need longer term inpatient care they will be transferred to a specialist Children's Hospital. There is also a paediatric retrieval service for transporting seriously ill children to specialist units off island.

Midwives

Midwives provide care and support to women from booking (before 10 weeks pregnant) until the baby is 10 days old when they pass care over to the Health Visitor. They provide an individualised programme of care based on risk and pathways in line with the Refreshed Framework for Maternity Care.

Our Clients

Child birth – 18. However following the proposals affecting looked after children detailed in the Children and Young People (Scotland) Act 2014 provide a clear definition of corporate parenting and defining the bodies to which it will apply; placing a duty on local authorities to assess a care leaver's request for assistance up to and including the age of 26; providing additional support for kinship carers in relation to their parenting role and providing families in distress with access to appropriate family counselling. This may impact on children's services.

Funding and resources

Department	Budget in 2014-15	Savings Plan for 2015-16
CHILD HEALTH	£540,406	Not agreed
PAEDIATRIC MEDICAL	£41,986	None identified
VISITING SERVICE	awaiting	None identified
AHP SERVICES	awaiting	Not agreed
CAHMS	awaiting	Not agreed

Aims and Objectives

See above.

Detailed Actions/Plan for Change

See Shetland Integrated Children and Young People Plan.

Risks to Delivery

All the issues raised in the drivers can also be seen as risks.

Performance Indicators

Key Service Indicators - HEAT and other Local Targets

ID Code	Target Description
H.9	3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year (percentage)
H.10	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours. (percentage)
BSC4	Immunisation Uptake - MMR1 at 2 yrs (percentage)
BSC7	Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter) (percentage)
HI.3	Percentage of mothers smoking during pregnancy
HI.4	Reduce the proportion of children with their Body Mass Index outwith a healthy range (>=85th centile) (percentage)
HI.6	Reduce teenage pregnancy rate (13-15 year olds) Rate per 1,000 population (3 year rolling average) (rate)

Service Performance Measures from the Shetland Single Outcome Agreement

Single Outcome Agreement objectives:

- Effective early intervention and prevention to enable all our children and young people to have the best start in live.
- Effective early intervention and prevention to get it right for every child.

Other Performance indicators

National Performance Framework strategic objectives:

- Our children have the best start in life and are ready to succeed.
- We have improved the life chances for children, young people and families at risk.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

Local outcomes (as agreed by the Integrated Children and Young Peoples Strategic Planning Group in the Multiagency Children's Plan:

- Shift from crisis intervention to prevention and early intervention.
- Promote resilience and wellbeing of children, young people, families and communities.
- Timely engagement with children and young people to ensure their views shape current and future planning.
- Continue development of our workforce in delivering the best outcomes for children and young people through their multi-agency working.

Contact Details

Kate Kenmure –
kate.kenmure@nhs.net

Further Reading

GIRFEC website: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp

EYC website: http://www.scotland.gov.uk/Topics/People/Young-People/early-years

Shetland Integrated Children and Young People Plan:
http://www.shetland.gov.uk/children_and_families/documents/ShetlandsIntegratedChildrenandYoungPeoplesServicesPlan2011to14.pdf

Public Health Department
2015-16 Service Plan

(The Fence on The Hill)

Supporting NHS Shetland's vision:

"to deliver sustainable high quality local health and care services that are suited to the needs of the population; to make best use of our community strength, our community spirit and involvement; for people to make healthy lifestyle choices; and use their knowledge and own capacity to look after themselves and each other."

Introduction

This Service Plan provides an overview of the NHS Shetland Public Health service for 2015/16. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Public Heath Team is committed to supporting NHS Shetland's 2020 Vision: ***to deliver sustainable high quality local health and care services that are suited to the needs of the population; to make best use of our community strength, our community spirit and involvement; for people to make healthy lifestyle choices; and use their knowledge and own capacity to look after themselves and each other.***

Drivers for Change

External and national drivers for taking a new approach to public health and health improvement include:

- Increasingly challenging national targets (e.g. HEAT target for smoking cessation which is now focussing on the hardest to reach groups)
- Increasing emphasis on doing things 'with' people rather than 'for' them, including using co-production, enablement, and asset based approaches
- Fewer public sector resources to meet increased demand due to factors such as changing demographics (the aging population) and global economics.
- Changes in lifestyle and culture (for example more sedentary work and leisure pursuits, and the use of games consoles and portable devices)
- Changes in diet (for example increased consumption of processed and convenience food, and larger portion sizes)
- A persisting, and possibly worsening, inequality gap between the most advantaged and the most disadvantaged in our society
- New developments on prevention and early intervention including the implementation of new immunisation programmes and screening programmes.
- Changing climate and increased travel abroad are leading to increased spread of communicable diseases
- Global climate change will also have direct effects on health; as well as on food production; the environment; migration patterns and sustainability of communities.

About Us

Policy context

The Board's 2020 Vision describes the context for public health in Shetland. The Public Health etc (Scotland) Act 2008 sets out the responsibilities of NHS Boards and Local Authorities to protect and improve the health of their populations. In 2012 the Board agreed the Public Health Strategy, known as the 10 year plan, which sets out our ambitions in line with government policy on health improvement and addressing inequalities. We are also looking to make the most of the opportunities provided by public sector reform such as the Public Bodies (Joint Working) (Scotland) Act 2014 and the forthcoming Communities Empowerment Bill, to make sure that we use our resources to best effect to protect and improve the health of the people of Shetland.

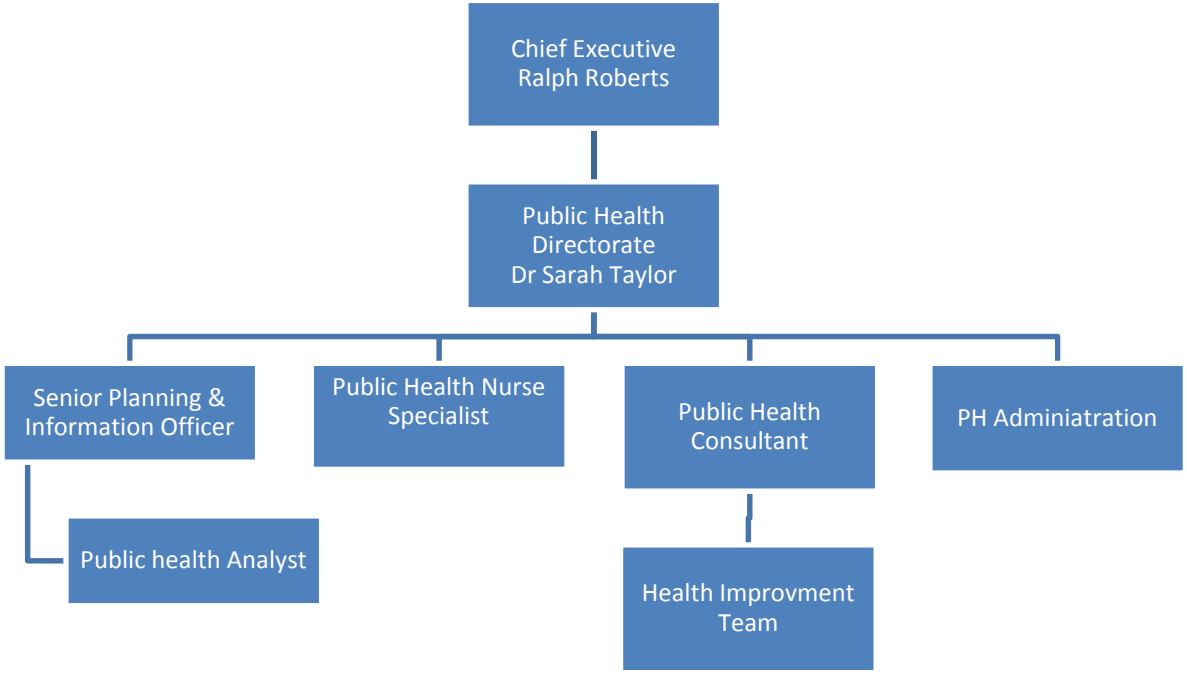
Who We Are

The Public Health Department is led by the Director of Public Health and includes both the Public Health Team and Health Improvement Team (refer to separate service plan).

Public Health Workforce:

Director of Public Health & Planning 1.0 WTE
Consultant in Public Health Medicine 0.6 WTE
Public Health Nurse Specialist 0.5 WTE
Senior Planning & Information Officer 1.0 WTE
Public Health Analyst 0.9 WTE
Public Health Secretary 1.0 WTE

Organisational Chart



Locations

The Public Health Team is located at NHS Shetland Board Headquarters, Upper Floor Montfield.
The Health Improvement Team is based at Grantfield, with outreach to other localities.

Governance

The Public Health Team is part of the Public Health Directorate and reports to the NHS Shetland Board on an annual basis (through the Public Health Annual Report and annual update on the Public Health 10 year Strategy) and more frequently as required; and also as required for specific areas of work and strategies. A number of indicators relating to both the Public Health and the Health Improvement Teams' performance are included in the NHS Shetland Board Performance Report that is reported to the Health Board every two months. Professional

members of the team are regulated by their professional bodies (GMC and GN&MC) and participate in clinical governance arrangements including appraisal and audit.

Regulation and Compliance

We have to comply with the Public Health etc (Scotland) Act 2008.

Healthcare Improvement Scotland has a programme of inspection and monitoring of standards for various elements of the Public Health work programme. These include self assessment and unannounced inspections to monitor infection prevention and control practices within the hospital (the Public Health Team is responsible for certain elements of this including surveillance and outbreak management). There are standards for all the screening programmes and a number of other work areas that public health contribute to including blood-borne viruses, mental health, child protection.

What We Do

There are three main areas of Public Health work:

- **Health Improvement** services and plans are detailed in the Board's Public Health Ten Year Strategy. They include a specialist health improvement service delivering a range of programme and locality based services to the public and local communities; and to staff and professionals working in the NHS, Local Authority, voluntary sector organisations and other Community Planning partners in Shetland. Delivery through Integrated services is detailed in the relevant section of the Joint Commissioning Strategy. Delivery in NHS delivered services is focussed on hospital based Health Promoting Health Service work, the Healthy Working Lives programme, health improvement within Children's Services (detailed in the Shetland Children's Plan) and contributions to a number of areas of strategic planning on prevention and early intervention.
- **Health protection:** summarised in Shetland's Joint Health Protection Plan, the Public Health Team provide a 24/7 health protection service for communicable disease and environmental hazards. This includes surveillance (detection, monitoring and investigation of risks to health); prevention and control through management of situations of increased risks and incidents along with proactive infection prevention and control advice and routine vaccination programmes; and communication to the public and professionals. This is done in collaboration with relevant local authority service, specifically Environmental Health Services and Emergency Planning and Resilience, and delivered in partnership with regional and national networks and specialist services including arrangements with the North of Scotland Public Health Network and the national Health Protection Network and Health Protection Scotland.

- **Public health contribution to service delivery**: the public health team contribute to improving services through its population approach. This includes assessing the health of the population using skills and tools such as collating and analysing information (health intelligence), epidemiology (the study of patterns of disease), health needs assessment and health impact assessment; and assessing the effectiveness of healthcare interventions, programmes and services.

In addition to preventative work, public health also has a specific responsibility for early detection of disease through the co-ordination of screening programmes.

We also have a specific role in addressing health inequalities across all areas of our work and with a range of partners; linked in with the wider inequalities, deprivation and social exclusion agenda that is a key element of community planning and the Single Outcome Agreement.

Our Population

Public Health is a population based service; we are responsible for protecting and improving the health of the whole population of Shetland and those who visit the islands.

Our Costs and Income

The budget specifically for the Public Health Department (which covers public health; planning and performance monitoring functions) is £183K. (excluding the costs of the Director's post which are included in the Chief Executive's Board costs)

The budget and workforce for the Health Improvement Team is shown separately in the Health Improvement service plan.

Funding and resources

We have a savings target for the Public Health Directorate (including the Public Health Team and Health Improvement Team) of £18,000 for 2015-6, which we have identified through planned change to staffing and resources primarily within the health improvement budget.

Aims and Objectives

Our aims are to:

- reduce key risk factors for poor health outcomes: substance misuse (smoking, alcohol, drugs) and obesity

- 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 that are most in need
- support people to reach their full potential at all life-stages – from birth and early years through working lives to old age
- protect the health of the local population against communicable diseases and environmental threats through an effective health protection function
- to contribute population health skills and expertise to the planning, commissioning, delivery and evaluation of health services.

Directorate Plan Aims	Supporting Service Objectives
• reduce key risk factors for poor health outcomes: substance misuse (smoking, alcohol, drugs) and obesity	• Increase proportion of adults in Shetland aged who exercise at recommended levels through improving access to physical activity at a local community level. • Reduce number of people admitted to hospital with alcohol related conditions through Drink Better Campaign and redesign of substance misuse services. • Reduce percentage of adults who smoke through targeted smoking cessation, smoking prevention and tobacco control work • Reduce prevalence of mental health problems and suicides through Choose Life Action Plan and implementation of Mental Health Strategy • Reduce obesity through preventative work; childhood healthy weight interventions and counterweight.
• 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 that are most in need • support people to reach their full potential at all life-stages – from birth and early years through working lives to old age	• Continue to roll out implementation of Keep Well inequalities - targeted health checks to vulnerable, socially excluded and disadvantaged groups. • Implementation of outcomes Focussed Action Plan to mitigate against effects of Welfare Reform. • Contribute to Fairer Shetland work including Life Project • Contribute to Early years Collaborative work

	• Implementation of Older People's Strategy
• protect the health of the local population against communicable diseases and environmental threats through an effective health protection function	
• to contribute population health skills and expertise to the planning, commissioning, delivery and evaluation of health services.	

Detailed Actions/Plan for Change

Refer to the Public Health Ten Year Strategy and individual work plans / programmes:

- Control of Infection Committee Work Plan
- Immunisation Work Plan
- Sexual Health and BBV Strategy Group Work Plan
- NHS Shetland Corporate Action Plan
- Choose Life Action Plan
- Integrated Children and Young People's Service Plan
- Mental Health Strategy Action Plan
- Fairer Shetland Framework Action Plan

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Publication of Public Health Annual Report 2014	On time	Yes
Finalise Major Emergency Procedure (with updated counter-terrorism annex)	On time	Yes
Programme of multi-agency emergency planning exercises	On time	Yes
COIC Work plan including Norovirus table top exercise; updated MRSA and C diff procedures; TB Plan	On time	Yes
Immunisation work plan: including implementation of extension to Childhood Seasonal Flu immunisation programme; immunisation training programme	On time	Yes
Sexual Health & BBV Work Plan: including completion of revised Sexual Health & BBV Strategy; SHARE and Traffic Light training	Late	Yes
Redesign of Substance Misuse Services	Late	Still to be determined through monitoring outcomes
Locality health profiles	On time	Yes
Outcomes Focussed Plan: Welfare Reform Impact on health	In progress	
Development of Older People's Strategy	In progress	

Ongoing Actions/Projects Started prior to 2015/16

Description	Start date/Comments	Expected Outcome
Update of Pandemic Flu Plan	2014	
Health Inequalities / Learning Disability Health Needs Assessment and communication project	2014	

New Planned Actions Due to Start in 2015/16

Description	Start date/Comments	Expected Outcome
Potentially -Changes to Childhood immunisation programme.	Dependent on national policy	

Risks to Delivery

- Reduced public sector funding and prioritisation of prevention and early intervention in the light of increasingly limited NHS budgets.
- The challenges of public sector reform in distracting from the primary prevention agenda.
- Sustainability and resilience in a small specialist team

Performance Indicators

Service Performance Measures from the Shetland Single Outcome Agreement

SOA Outcome: we live longer, healthier lives
Scottish Government Priority / Objective: Healthy and Caring: Reducing Health Inequalities and Increasing Physical Activity

Refer to Health Improvement and Health Inequalities Service Plan for all indicators relating to health Improvement including:

- Physical activity levels in population (SOA)
- Alcohol: rate of alcohol related hospital admissions (SOA) and number of alcohol brief interventions
- Smoking: population prevalence (SOA) , smoking in pregnancy and smoking cessation outcomes (HEAT)
- Suicide rate (SOA)
- Childhood weight
- Keep Well: Health Inequalities targeted health checks

Other indicators:

Indicator	2013/14	2014/15	Target 2015/16
Screening targets (national):	Not yet available AAA - not yet available Breast - not yet available Cervical 78.8%	Not yet available AAA - not yet available Breast - not yet available Cervical- not yet available	The target for bowel screening uptake is 60%; for Abdominal Aortic Aneurysm Screening (Men) and also breast cancer screening (women) it is 70%; and for cervical cancer screening (women) it is 80%.
Teenage pregnancy: 13-15 year olds	2.2	Not yet available	1.6 /1000 or less (3 year rolling average)

Public health work also contributes to the achievement of a number of other prevention and early intervention targets including:

Breastfeeding: Increase the percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) from 48.8% in 2011 to 58%. (Higher than the national target)
Early antenatal booking: Target by March 2015, at least 80% of pregnant women in each SIMD quintile are booking for antenatal care by the 12th week of gestation.
Detect Cancer Early: Target is to increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer from 19.8% in 2011 to 29% in 2015.

Contact Details

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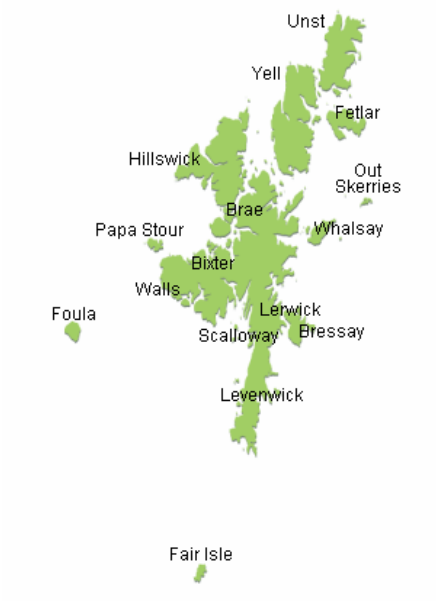
Estates & Facilities Service
2015-16 Service Plan



Introduction

This plan summarises the key issues & activities for NHS Shetland's Estates & Facilities services. This is described in significantly more detail within our Property & Asset Management Strategy (PAMS). This was presented to the Board in June 2014 and is updated on an annual basis and submitted to the Scottish Government (see link below).

(NB: The information from each Health Board's PAMS is collated into a National "State of the Estate Report" – see link below)

NHS Shetland's Estate & Facilities service provides a critical support service to all of our services and properties. As we progress with Health & Social Care Integration this will include services and properties that, in future, will be planned, managed and delivered in an integrated way.

Vision Statement

The Estate & Facilities service is designed to support the overall vision of NHS Shetland.

It therefore aspires to provide and maintain ***sustainable, high quality properties and facilities services*** that allow the effective delivery and continuous improvement of healthcare across Shetland.

Drivers for Change

The PAMS describes in more detail the current challenges in providing and maintain high quality buildings and Estates & Facilities services.

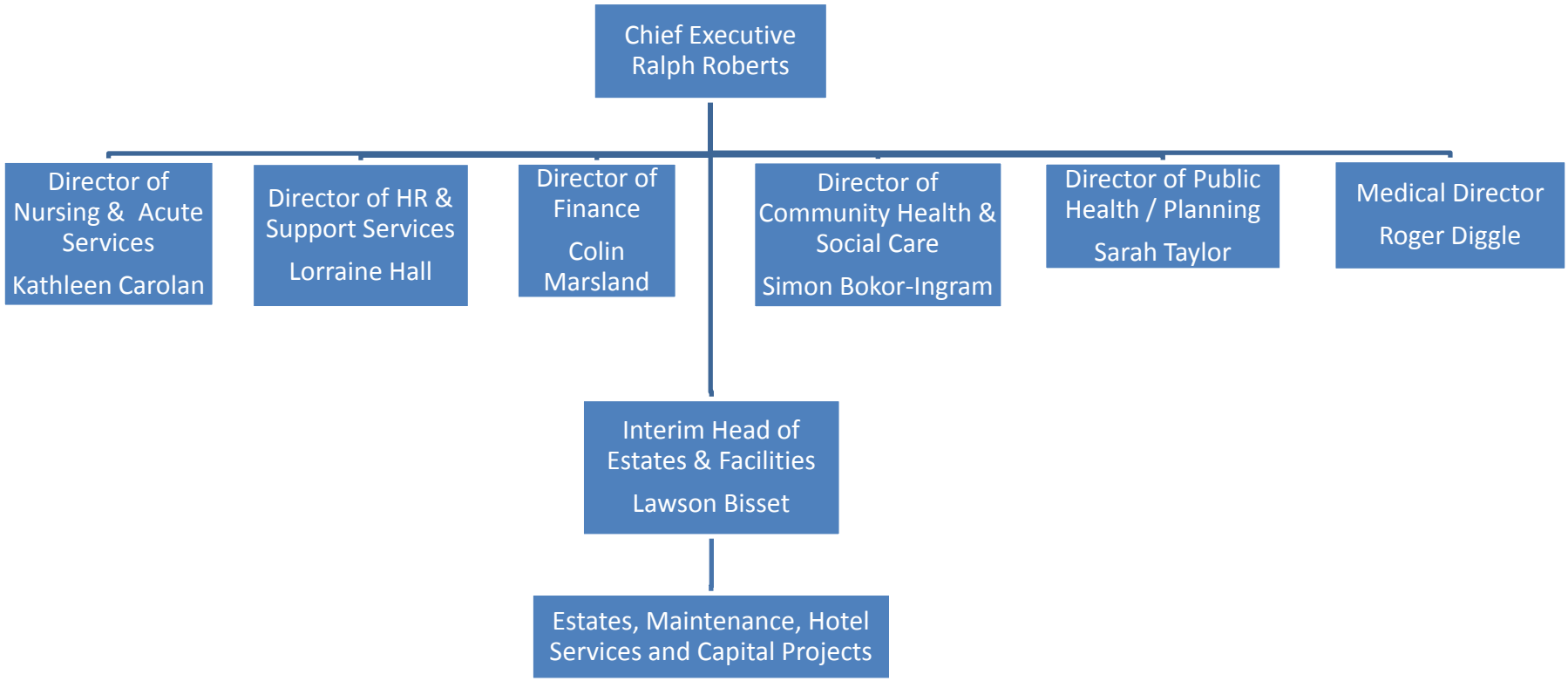
The key issues highlighted include:

- replacement of Scalloway Health Centre – currently underway through joint project with Shetland island Council
- sustaining required levels of backlog and planned preventative maintenance
- restricted revenue and capital budgets to sustain identified maintenance levels
- recruitment & retention of qualified trades and other staff, particularly because of competition from the oil, buildings and service sectors
- long term future for Gilbert Bain Hospital

Facilities services were recently brought back in house from a private contractor (Sodexho). This has resulted in a number of organisational challenges and a considerable amount of work has been carried out to align working arrangements and Terms & Conditions of employment. Current information from the PAMS and the linked NHS Scotland Annual State of the NHS Scotland Assets and Facilities Report 2013 (SAFR – see link below) also shows that NHS Shetland has a number of services that would appear to be high cost. This will, in part, link to issues associated with economies of scale, but it is recognised that a detailed review of the efficiency of these services is required. This work has commenced in 2014 and information is currently being collated to allow decisions to taken about service redesign and service provision.

About Us

Organisational Chart



Locations

The Estates & Facilities Service is located in the Gilbert Bain Hospital, South Road, Lerwick.

Governance

The Service is led and managed by the Head of Estates & Facilities. This post reports directly to the Chief Executive. The post holder also attends a number of key management groups (i.e. Heads of Department) where they interact with colleagues and departmental stakeholders.

The service is responsible for a number of HEAT targets and is also monitored against a range of Key performance indicators. These are incorporated within the PAMs and progress is also monitored through the Capital Management Group.

Specific issues are also monitored through relevant committees such as the Infection Control, Health & Safety and Fire Committees.

Regulation and Compliance

The service is obliged to maintain compliance with a range of indicators. A number of these are national KPIs and others link to legislative requirements (e.g. Legionella, Hospital Gases, Building regulations, Fire safety, etc, etc.)

What We Do

A detailed summary of the physical assets supported by the Estates department are included in the PAMS (see link). These include the Gilbert Bain Hospital, the Montfield site including Dental services, Staff development and Board HQ and 10 Health centres and 4 clinics spread across the Shetland mainland and outer isles. There are also a number of other small owned properties (i.e. St Olaf Dental practice) and privately owned premises from which NHS contractor services are provided (i.e. Pharmacies and Opticians).

All the NHS Shetland owned buildings, Health centres and Medical equipment assets are supported by an Estates function that carries out planned and reactive maintenance, capital planning, minor repairs and schemes and a Medical Physics function.

The facilities services provided by the Directorate include Domestics, Catering, Porters and Laundry and Linen services.

Our Customers

The Estates Department provides services for all of the NHS Shetland estate and GP practices. This includes our own staff, visiting staff, patients and members of the public.

Funding and resources

The total budgets and workforce for the department are:

Estates:	Revenue - £ 1.99M, Capital - £1.1M;	Staffing – 15.5 WTE
Facilities:	Revenue - £1.66M	Staffing – 71.12 WTE

The current savings target (for 2014/15) is £202k and plans have been identified to deliver this. The new target for 2015/16 is a further target of £122k and outline plans have been identified to achieve this.

This will require a further restriction on a number of non pay and contractor budgets and a redesign of staffing and service provision to also deliver pay / workforce savings.

Aims and Objectives

The overall aim for the Estates & Facilities service is to provide effective physical assets and facilities services to support the delivery of high quality clinical services to the local population.

The service is provided through the provision of a range of buildings and functions that ensure these assets are effectively maintained and serviced with support staff.

Detailed Actions/Plan for Change

The current PAMS sets out a list of key priorities over the next year, five years and longer term. This provides a clear set of objectives and plans against which the service needs to deliver.

In 2015/16 there will be a focus on:

- Improving the Physical Condition of the estate by targeting high risk backlog maintenance
- A significant improvement in the condition of Medical Equipment through the allocation of a
- significant proportion of this year's capital allocation
- Improving wireless, mobile, remote and virtual working IM&T

- a Soft FM review and implementing the outcomes
- Improving and updating EAMS data;
- implementation of the Capital Planning tool
- confirm option for the initial further redesign of the Gilbert Bain Hospital
- completing a feasibility study on the future use of Breiwick House

In the Medium Term, over the next five years;

- Prioritise the backlog maintenance programme to reflect the 5 year budget profile
- There is planned to be a significant investment in the GBH to deliver the option chosen as the most effective for NHS Shetland.
- The prioritised replacement of the highest risk items of Medical Equipment
- Continued improvement in the stability of IM&T and a focus on providing services more efficiently in terms of staff workflow and financially through partnership with other NHS Boards and at a national level.

NHS Shetlands Longer Term Strategy, up to the year 2024 includes;

- Agreement of Plans for long term future of the GBH,
- Replacement of telephone system with internet protocol based system,
- Electronic Patient record system including historical records,
- Reduction in physical IM&T assets by increased use of secure cloud computing

Risks to Delivery

The key risks, as identified above are the availability of adequate resources to support the services required. This includes both staffing, linked to recruitment and retention and finances (revenue and capital budget). Along with other support services the E&F directorate is currently working to deliver a 25% efficiency target over a 5 year period.
Agreement has already been reached to provide recruitment & retention “premia”, linked to Agenda for Change T&C’s for key trades staff and this has been agreed for a period of 3 years until March 2017.
In addition work a joint project is also underway to maximise opportunities from joint working with Shetland Island Council.

Performance Indicators

The PAMS (section 6) sets out a range of KPIs and mechanisms for performance monitoring. This includes indicators on:

- Energy Efficiency (HEAT)
- Property : SCART (quality indicators); Backlog maintenance etc
- Facilities: Patient Satisfaction (IP survey); Cleanliness Audits;
- Within the SAFR all Estates & Facilities services across Scotland are also measured for efficiency and comparative cost

These indicators show that a satisfactory service is being provided but that issues remain around ongoing maintenance levels and the relative efficiency of our services, driven, at least to some extent by relative economies of scale and low clinical throughput in our buildings.

Contact Details

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Further Reading

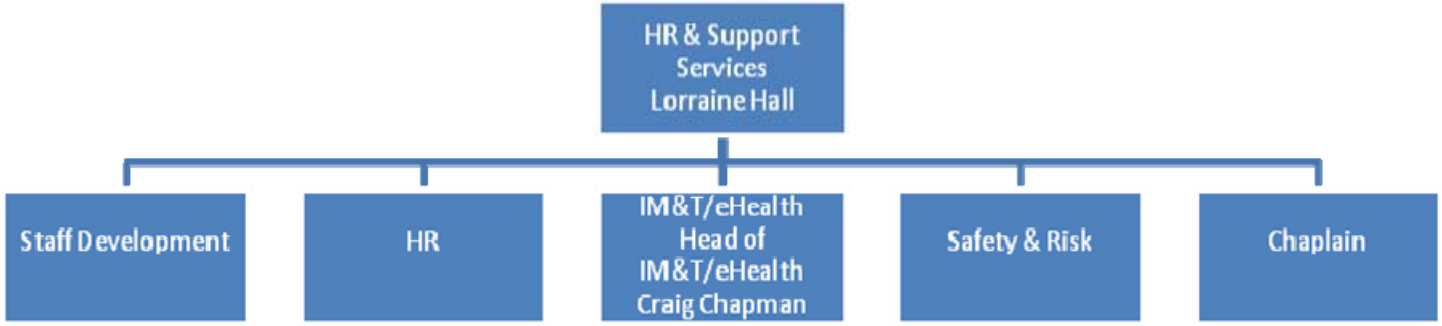
Property and Asset Management Strategy - NHS Shetland PAMS June 2014 Board Report
http://www.shb.scot.nhs.uk/board/meetings/2014/201406-Boardpack.pdf
State of the Estate Report - http://www.scotland.gov.uk/Resource/0044/00443826.pdf

HR Directorate Service
2015-16 Service Plan

Supporting Staff and the Organisation to deliver excellent quality of care

Introduction

This is the first year we have produced a detailed service plan for the Directorate in this format. The HR Directorate comprises, Personnel, Occupational Health, Clinical Governance team, Training and Education, Service Improvement. Health, Safety and risk, Spiritual Care Information and IT.



Vision Statement

The Directorates overarching aim is to deliver its Strategic objectives via the outputs of the HR and OD Strategy 2012-2015, the e-health Strategy 2012-2017 and the Risk Management Strategy and in doing so embed the Staff Governance Standard in the delivery agenda supporting NHS Shetland staff to be well informed, appropriately trained, treated fairly and consistently, to be involved in decision that affect them and providing a continuously improving safe working environment , promoting the health and wellbeing of staff, patients and the wider community. The Directorate actively contributes to the delivery of the national 2020 Vision and Quality Strategy.

Drivers for Change

- There are a number of Drivers for Change that impact across the Directorate which include, Delivering the National Everyone Matters- 2020 Workforce Vision, Public Bodies, (Joint Working) (Scotland) Act (Health and Social Care Integration), NHS Scotland Quality Strategy, Safe and Well at Work the Occupational Health and Safety Strategic Framework, NHS Scotland HR Shared Services, legislative changes and development including matters relating to Equality and Diversity, local mandates

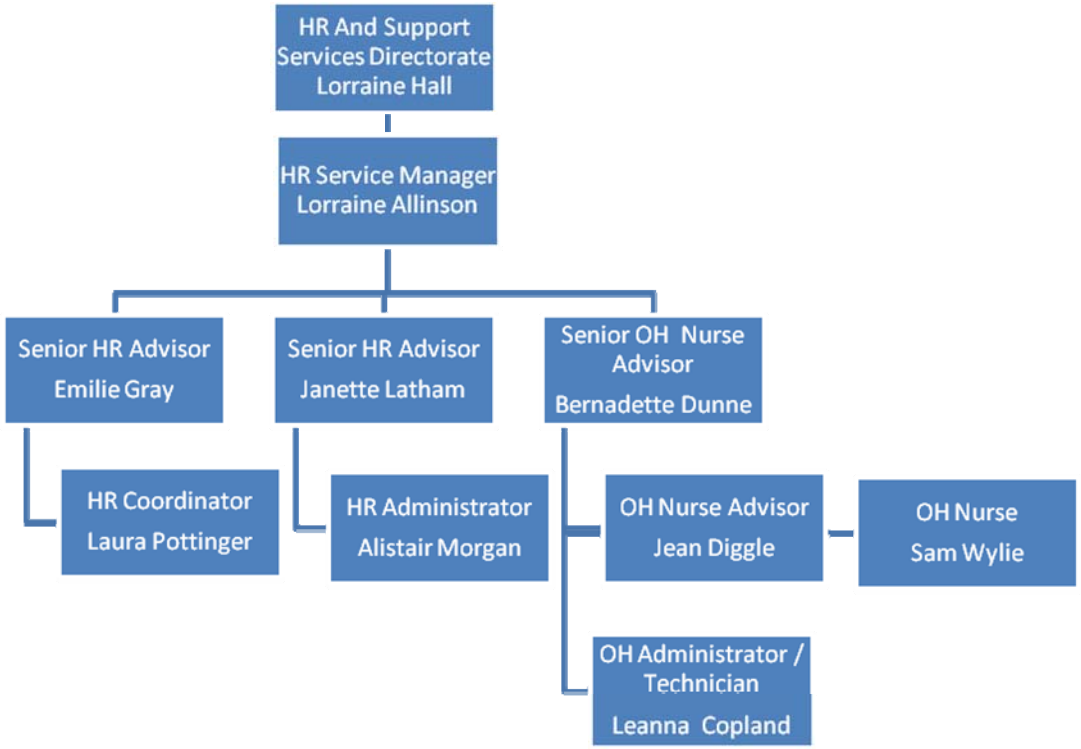
including outputs of the staff survey and implementation implications of imatters along with learning from Adverse Events, legal changes and impacts, internal and external audit reports and 25%efficiency savings the Public Health Records Act and the national eHealth Strategy 2014-17 NHS Scotland HR Shared Services

About Us as Individual Departments

Personnel and Occupational Health

The HR/OH Service is part of the HR and Support Service Directorate and reports to Lorraine Hall, HR & Support Services Director.

HR Team consists of 5.5 wte:	OH Team reports into the HR Service Manager and consists of 3 wte :
1x Band 8 A 2x Band 6 1x Band 4 1xBand 3	1 x Band 7 0.8 x Band 6 1 x Band 3
Vacancy: 0.5 wte Band 4 Covered by Bank Admin	Vacancy: 0.2 wte Band 5 Covered by Bank Nurse / Bank Admin



Governance

The Service's updates are reported to the HR Directorate Management Team monthly meetings, and via Area Partnership Forum and Staff Governance Committee.

Regulation and Compliance

Legislation

- Employment Law
- Data Protection

Regulatory Bodies

- NMC
- Faculty of Occupational Health
- GMC
- CIPD
- ICO

What We Do

HR Team, responsibilities include:

- Job Evaluation, Job Review: Supporting the development of job descriptions, training job matchers from management side, staff side, in partnership with HR, coordinating Job evaluation and consistency checking panels across the year to prevent delay in progressing approval and implementing change .
- Recruitment: Tracking vacancy approval process, developing adverts, vacancy bulletins, liaising with suppliers, managing costs, coordinating candidates / external panellists attending interview; tracking of interview process documentation, candidate / panel expenses /
- On Boarding of successful candidates, issue job offer and contract, relevant paperwork to process pre employment checks, checks including ID, references, disclosure checks, registration checks, confirm start dates and induction dates following confirmation of pre employment checks and deal with relocation queries and authorisation of claims.
- Supporting managers with performance monitoring, workforce planning, redesign, vacancies, redeployment, retirement
- Employee Relations: Include advising and supporting management of conduct and capability, grievance and whistle blowing procedures, developing and tracking relevant casework documentation, including dismissal, settlements, and tribunal advice and support.
- HR Policy and Procedure development, review, implementation and management training.
- Equality and Diversity champion for the Board – staff and service. Report Board compliance with legislative duty as a public sector organisation
- Corporate Absence monitoring and reporting, tracking of performance to meet National HEAT target of 4%
- Responsible for maintaining core workforce data and quarterly reporting requirements to Scottish Government / Board
- Management of core workforce data
- Compilation of service resource plans for the Board Workforce Plan and Staffing Projections on an annual basis

OH Team, responsibilities include:

- Management of Occupational Health records
- Pre-employment health assessment
- Health Surveillance
- immunisations
- Promoting attendance
- Management and self referrals – CBT case management approach
- Ill health retirement
- Workplace assessments / workstation advice
- Trauma response
- Needle stick injury management and preventative training
- Health and wellbeing guidance for occupational health related issues

Our Customers

Our customers include the current and future workforce, including all managers, employees, workers, students and volunteers; job applicants/ candidates. Occupational Health also deliver services to local businesses and their respective employees. Other stakeholders include NHS Scotland, Scottish Government.

Our Costs and Income

The HR & OH Service has 8.5 full time equivalent staff and annual revenue expenditure of £365,731

Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1 WTE	60,247		60,247	Nil
HR Team	4.5 WTE	351,280		351,280	Nil
OHS Team	3 WTE	161,442	57,430	104,012	nil
Equality and Diversity		2000		2000	nil
Service Total	8.5 WTE	574,969	57,430	517,539	Nil

Funding and resources

Summary of Budgetary responsibility totals 575K: HR 412K, E&D 2K and OH 161K Plus an income target of 58K

A 25% savings target was set for support services over a 5 year period

Savings target for 2014/15 for HR and Support Services Directorate was 10% which equates to £92,788

Service Aims/Priorities **HR TEAM**	**Objectives/Actions**
Full implementation EESS to provide online recruitment and an integrated electronic based HR system	Complete implementation and evaluation of IREC, Implement SSTS interface to provide annual leave and absence records in system Implement OLM – learn pro interface Implement – Payroll interface – reduce current duplication and paper based processes Implement manager self service (including cascade of outstanding training

Service Aims/Priorities HR TEAM	Objectives/Actions
	requirements) Evaluation of system implementation
Outcomes of National Review of HRSS TBC	TBC
Recruitment, selection & Retention review to improve recruitment responses /	Review recruitment advertising / use of micro site Review Northern Periphery work Establish Joint recruitment procedure with SIC Review national availability of skills NOSWFPG Exit interview data Employee Relations
Compliance with legislation	Integration of H& Social care – Agree HR workplan Implementation of PINS Review and update policies and procedures in line with HR policy plan HOD Development programme for HR Policies & Procedures Coordinate T&C's group to implement CEL's Attend NHS S Deputy HR Forum
Support the reduction of sickness absence HEAT target 4%	Monitor & report monthly data Review policy Re view causes of absence and plan preventative interventions Review support mechanisms in place to ensure suitable
Equality and Diversity highlight/ reduce inequality/ discrimination	Review action plan and update Plan Implementation of outstanding actions Collate & report diversity stats Assess & Monitor policies and procedures
Support the reduction of sickness absence HEAT target 4%	Review monthly absence data to establish cause / trends in absence Input to plan for supportive preventative interventions to maintain staff in work / early return

Service Aims/Priorities HR TEAM	Objectives/Actions
	Review availability and suitability of support / service available Increase take up of Flu Vaccine 2014 / plan 2015
Reduce Work related health risks	Review & Improve health surveillance activity against corporate risks / sickness absence monitoring Review risk register Deliver training needle stick Provide relevant health promotion
Reduce DNA's	Involve manager in appoint confirmation to ensure released to attend Case management – improve discharge rates / lengthen review timeframe
SEQOHS Accreditation	Preparation plan review & update pre assessment Schedule assessment Evaluate outcome / action plan

Risks to Delivery

- Lack of available skills / resources
- Appropriate equipment and technology
- Competing priorities
- Unknown / reactive challenges

Key Service Indicators

Performance Measure	Performance 2012/13	Performance 2013/14	Performance 2014/15	Target 2015/16	Performance Statement	Improvement Statement
Sickness absence	3.6%	4.39%	N/A	4%		

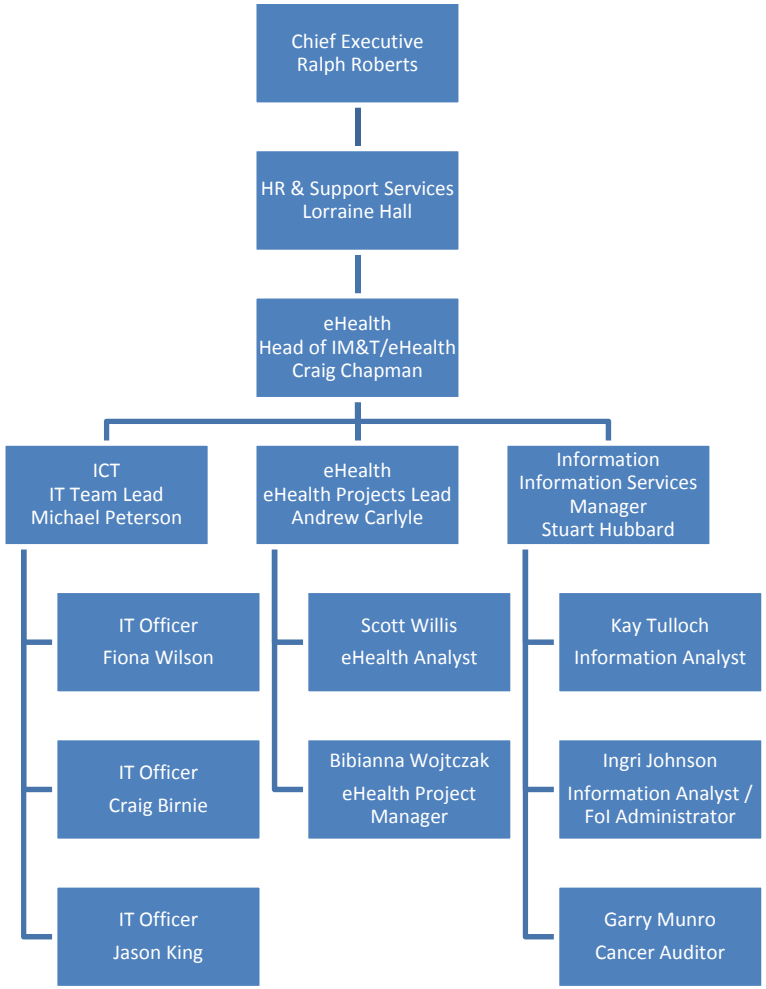
IT and Information

The Service was established in its current structure following a review in 2011. Currently as well as the established team, there are additional fixed term posts funded through national eHealth funding.

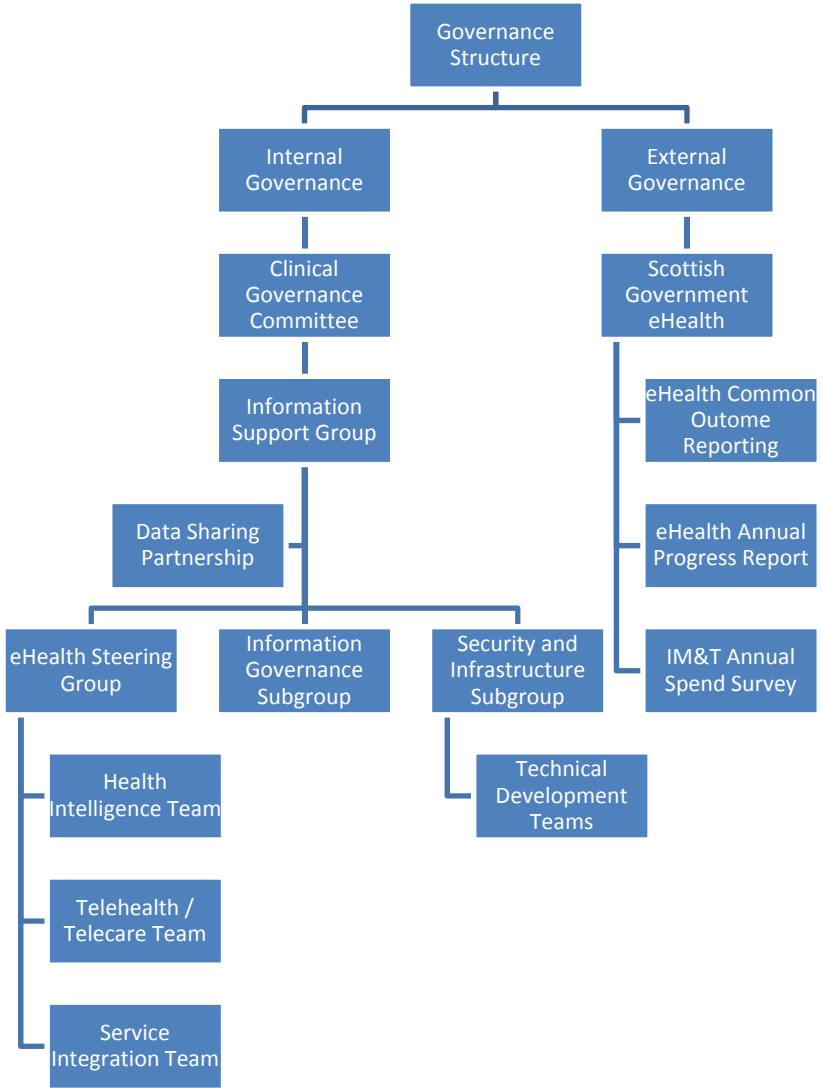
The service provides operational management, project management, technical support, and information governance functions across NHS Shetland, GP Practices, SIC Social Care and the Scottish Health Council.

The IM&T/eHealth Department is lead by the Director of HR and Support Services (Lorraine Hall) and consists of five Services (HR, Staff Development, Safety and Risk, IM&T/eHealth and Chaplaincy)

	Management **1 FTE**	**ICT Team** **4 FTE**	**eHealth Team** **3 FTE**	**Information Team** **4 FTE**
Core Funding	1 x Band 8A	1 x Band 7 3 x Band 5	1 x Band 6	1 x Band 7 3 x Band 5
eHealth Funding			2 x Band 6	
Vacancies	None	None	None	None



The IM&T/eHealth Service is part of the HR and Support Services Directorate and reports to the Clinical Governance Committee(s) via the governance structure below:


Governance Structure
Internal Governance
External Governance
Clinical Governance Committee
Scottish Government eHealth
Information Support Group
eHealth Common Outome Reporting
Data Sharing Partnership
eHealth Annual Progress Report
eHealth Steering Group
Information Governance Subgroup
Security and Infrastructure Subgroup
IM&T Annual Spend Survey
Health Intelligence Team
Technical Development Teams
Telehealth / Telecare Team
Service Integration Team

Regulation and Compliance

Legislation

- Data Protection Act 1998
- Freedom of Information Act 2000
- Privacy and Electronic Communications Act 2003
- Regulation of Investigatory Powers Act (RIPA) 2000
- Computer Misuse Act 1990

Regulatory Bodies

- Information Commissioners Office (ICO)
- CESG (Information Security arm of GCHQ)

What We Do

ICT Team, responsibilities include:

- Support and maintenance of all IT and telecommunications infrastructure including networks, servers, storage, desktops, peripherals, mobile devices
- Support and maintenance of all software assets including clinical applications, business applications, desktop applications, security and monitoring tools
- Maintaining asset inventories
- Fault resolution and escalation
- Security compliance including user access, usage monitoring, backups, investigation
- System upgrades and replacements
- Technical support of eHealth programmes

eHealth Team, responsibilities include:

- Delivery of local eHealth plan through formal Programme and Project management
- Analysis and development of systems to deliver and integrate healthcare

Information Team, responsibilities include:

- Support for clinical systems, including user management, application support and configuration
- Providing information support to clinical system users
- Providing information to internal and external bodies including statutory reporting
- Supporting statutory waiting and treatment time compliance
- Providing data analysis (health intelligence) function
- Ensuring Information Governance including information security, quality, availability requirements
- Processing Freedom of Information requests

Our Customers

Our customers include all managers, staff, students and volunteers of NHS Shetland, GP Practices and Scottish Health Council.

Our Costs and Income

The Service has 12 full time equivalent staff and annual expenditure (2014/15) of:

Core revenue	£621,000
eHealth Revenue	£578,000
Capital	£100,000

Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1		£0		£100,000
ICT	4		£0		
eHealth	3		£0		
Information	4		£0		
Service Total	12				£100,000

Aims and Objectives

Directorate Plan Aims	Supporting Service Objectives
Savings Target	Financial balance

Service Aims/Priorities	Objectives/Actions
Network Redesign	Change IP addressing scheme across all sites Implement SWAN replacement for N3 Network Switch Replacement Programme
Security and Infrastructure Compliance	Windows 7 desktop replacement programme Windows 2003 Server upgrades Delivery of Security Improvement Plan (SIP)

Service Aims/Priorities	Objectives/Actions
Service Redesign and Quality Improvement	Implementation of Development Teams to deliver technical workstreams Implementation of replacement Service Desk Implementation of formal Incident > Problem Management Implementation of formal Change and Release Management Establish IM&T Service Catalogue, Service Level Agreement and Service Desk Performance Management
eHealth Programme Delivery	Implementation of Patient Management Systems Implementation of Order Communications Electronic Patient Record / Patient Portal Increased use of digital workflow for document creation, transfer, storage and retrieval Increased use of digital communications (Video Conferencing, Online Collaboration) Implement Patient Portals to support self-management of conditions and care Increased use of telehealth to support patient in the community Participate in, and deliver national and regional eHealth programmes

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Digital Dictation	Competed on time	System now live in Medical Records. Several thousand documents now created using this system with plans to further expand use to other areas throughout 2015/16
EDT	Completed on time	System now live. Several thousand documents per quarter now being sent electronically rather than by mail.
Network Redesign Phase I (Capital Project)	Completed on time	Network switches upgraded in several areas and addressing scheme changed, resulting in more robust, faster network.
Cardiac Stress Analyser Replacement (Capital Project)	Completed on time	Replaced legacy equipment with supported hardware for this clinical diagnostic function
Brae Phone System (Capital Project)	Completed on time	Expected to reduce revenue costs for Brae phone system.
Health Centre Backups (Capital Project)		
Eyecare Referral Project	Project overran nationally. NHS delivered within national timeframes	National project. Referals from opticians now received electronically

Police Custody Suite	Completed on time	NHS network presence established in police station. Adastra national system implemented for service delivery.
R4 Upgrade	Completed on time	System upgraded to latest version, with back-end server and database upgraded at the same time.
Security Audit	Completed on time	Third-party accredited security audit completed and outcomes managed through Security Improvement Plan
GIRFEC system options appraisal	Completed on time	Recommendation made to NHS/SIC

Ongoing Actions/Projects Started prior to 2015/16

Description	PRINCE *	Start date/Comments	Expected Outcome
EMIS Web	Yes	First Phase (streaming) completed for 90% of sites. Scope of use of EMIS Web to be agreed in 15/16	Will provide a solution for the sharing of Primary Care patient records across sectors and care providers as appropriate
PMS Phase I	Yes	Commenced 2013. Implementation underway with go-live date of March 2nd 2015	Will replace Helix PAS with national standard Trakcare PMS
Wardview	Yes	Commenced 2014. Implementation underway with expected go-live of May	Will provide realtime management of inpatients on wall-mounted screens and mobile devices

Description	PRINCE *	Start date/Comments	Expected Outcome
		2015	
Service Desk Replacement	Yes	Procurement underway in conjunction with SIC. Expected go-live Feb/Mar 2015.	Will provide fit for purpose, ITIL-compliant service desk including incident mgmt., problem management, change management, auto-ticketing, and knowledge base.
Health and Social Care Network Integration	Yes	Scoping and various solutions under investigation and piloting. Fully integrated solutions planned for 15/16	Will enable staff across all areas to access appropriate clinical systems and information with in ways that do not negatively impact care delivery, supporting health and social care integration
eReporting	Yes	National project go-live June 2015	National project to reduce number of paper reports generated centrally and send to boards, creting significant savings.
Web Filter Replacement	Yes	Migration to new system planned for June 2015	Replacement for aging web-filtering solution.
Swift Upgrade	Yes	Various delays due to complex interdependencies. Revised go-live TBC but will be Q1 or Q2 2015.	Bring Swift up to date at Operating System, Database, Application and Reporting levels.
Windows 2003 Server Upgrades	Yes	Currently underway with completion date late 2015/16	Upgrade servers that will be on unsupported operating system

Description	PRINCE *	Start date/Comments	Expected Outcome
Windows 7 upgrades	Yes	Currently underway with completion date July 2015	Update desktops that will be on unsupported operating system. Enable improved functionality.
Security Improvement Plan	No	Ongoing work with agreed dates for each action.	Compliance with internal and external audit recommendations. Improvement in IT and Information system security.
Security Policy Refresh	No	Delayed due to other commitments. Now planned for early 15/16	Ensure up to date policy for the management of IT Security.
Development Teams Established	No	Most technical teams in place. Business Intelligence and Telehealth/Telecare to be established in early 15/16	Provide working platform for the ongoing delivery of IM&T/eHealth services
Service Redesign	Yes (phased)	Ongoing. Will be implemented throughout 15/16 following Service Desk upgrade.	Improved service delivery

New Planned Actions Due to Start in 2015/16

Description	PRINCE *	Start date/Comments	Expected Outcome
LIMS integration	Yes	Awaiting proposal from Labs.	Integrated Shetland and Orkney Labs data. Interface to Grampian for test ordering and reporting.
JAG compliance	Yes	Awaiting Board lead to be identified to develop business case	Endoscopy Management Information System as part of compliance with endoscopy regulations
PMS Phase II	Yes	Commencing June 2015 following Phase I and Maternity	Implementation of A&E Module and Order Communications for Labs and Radiology
Maternity System	Yes	Commencing April 2015 following PMS Phase I	Implementation of Badgernet Maternity Management Information System
GIRFEC System	Yes	Commencing April 2015. Options Appraisal complete, but business case required to identify funding	System to facilitate GIRFEC messaging

* **PRINCE** stands for "**PR**ojects **IN C**ontrolled **E**nvironments". It is an established method to run all types of projects in a consistent and controlled manner, with standard paperwork and controls.

Risks to Delivery

General Risks to Delivery

- Lack of available skills / resources
- Loss of key staff
- Competing priorities
- Unknown / reactive challenges
- Financial restraint
- Appetite for change

Project Risks

All risks associated with each project are managed through PRINCE. Projects have a risk summary section within the PID and larger projects have a Risk Log Maintained.

Service Risks

Departmental risks are managed through the NHS Risk Manage Process and maintained on Datix. Current departmental risks are:

Risk Type	Title	Risk level (current)	Risk level (Target)
Organisational	Primary Care: Data backups	Medium	Low
Confidentiality	Patient Administration System may be used inappropriately	Medium	
Confidentiality	Risk that patient identifiable data held on floppy disks is lost	Medium	Low
Information Technology	Share permissions on network drives might be inappropriate	Medium	Low
Information Technology	Intermittent yet persistent delays on x-ray images - particularly CT scans reaching national PACS & ARI due to N3 issues		
Confidentiality	Medical Imaging unable to comply with SHB Policy on data security by encryption of confidential records		
Information Technology	The risk that the phone system fails	High	Medium
Clinical Risk	Possible failure of cardiac arrest bleep system	Medium	Medium
Clinical Risk	Clinical Risk to Patients in non-doctor isles if all telecommunication links are lost	High	Medium
Clinical Risk	Patient information not updated on business continuity laptops	Medium	Medium

Key Service Indicators

Key Service Indicators will be established for IM&T/eHealth in 2015/16. It is planned to have two sets; one related to delivery of national eHealth Strategy common outcomes, and one related to the delivery of IM&T core functions such as Service Desk response.

Performance Measure	Performance 2012/13	Performance 2013/14	Performance 2014/15	Target 2015/16	Performance Statement	Improvement Statement
Percentage of Outpatient Clinics that only use electronic patient records (As a percentage of total no of clinics)	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of order comms reviewed and signed off electronically (as a percentage of total no of orders)	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of outpatient clinics that capture outcomes electronically (as a percentage of outpatient clinics)	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of clinical documents sent by EDT rather than mail	N/A	N/A			New eHealth target proposed for 15/16	
Number of GP Practices offering on-line services (Patient Portal)	N/A	N/A			New eHealth target proposed for 15/16	

Number of user accesses to GP online services	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of registered diabetic patients using 'My Diabetes My Way'	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of registered renal patients using 'Renal Patient View'	N/A	N/A			New eHealth target proposed for 15/16	
Number of KIS records created	N/A	N/A			New eHealth target proposed for 15/16	
Number of uses of KIS records	N/A	N/A			New eHealth target proposed for 15/16	
Number of registered users of Clinical Portal	N/A	N/A			New eHealth target proposed for 15/16	
Number of clinical portal accesses	N/A	N/A			New eHealth target proposed for 15/16	
Number of the 14 clinical priority information items available via Portal	N/A	N/A			New eHealth target proposed for 15/16	
Number of systems monitored by Fairwarning	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of referrals made electronically from	N/A	N/A			New eHealth target	

optometrists to Acute					proposed for 15/16	
Percentage of Optometrists making electronic referrals	N/A	N/A			New eHealth target proposed for 15/16	
Number of user accesses to ECS	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of IDL's issued electronically rather than paper.	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of Wards with real-time patient management system (Wardview)	N/A	N/A			New eHealth target proposed for 15/16	
Percentage of all Service Desk requests raised via Portal					New Service target proposed for 15/16	
Percentage of all Service Desk requests raised via E-mail					New Service target proposed for 15/16	
Percentage of all Service Desk requests Raised via Telephone					New Service target proposed for 15/16	
% of telephone calls fixed					New Service target	

at first contact					proposed for 15/16	
% of telephone calls answered within 15 seconds					New Service target proposed for 15/16	
% of telephone calls abandoned					New Service target proposed for 15/16	
% of tickets closed on time					New Service target proposed for 15/16	

Contact Details

eHealth NHS Shetland Breiwick House South Road Lerwick Shetland ZE1 0TG Shet-hb.ehealth@nhs.net 01595 743117	**ICT** NHS Shetland Breiwick House South Road Lerwick Shetland ZE1 0TG Shet-hb.ehealth@nhs.net Shet-hb.it@nhs.net 01595 743117	**Information** NHS Shetland Breiwick House South Road Lerwick Shetland ZE1 0TG 01595 743059 shet-hb.Informationdepartment@nhs.net	**Service Desk** ictservicedesk@shetland.gov.uk 01595 744777

Health, Safety and Risk Management

The Safety and Risk Management Team was created in 2009 and the department is responsible for the development, implementation and support of appropriate systems to identify and control risks that arise in the workplace. The remit of the team is broad and includes Equipment Co-ordination (receipt, assessment, cascade and monitoring of Safety Notices and reporting of defective/failed medical devices and equipment) and controlled drugs inspection in addition to health and safety and risk management. The Safety and Risk Manager also acts as an

Occupational Health and Safety Advisor to small and medium-sized enterprises [SMEs] in Shetland through NHS Health Scotland's Healthy Working Lives initiative.

The Safety and Risk Support Team's primary function is to help ensure that the Board, Senior Managers and staff at all other levels comply with the Health and Safety at Work etc Act [HSWA] 1974 (and other subordinate legislation) and, in particular, the Management of Health and Safety at Work Regulations [MHSWR] 1999. A crucial element of these regulations is the requirement for employers to have in place systems to manage health and safety. The technique of risk assessment - used to identify hazards, evaluate risks, support planning and put effective control measures in place - underpins such systems.

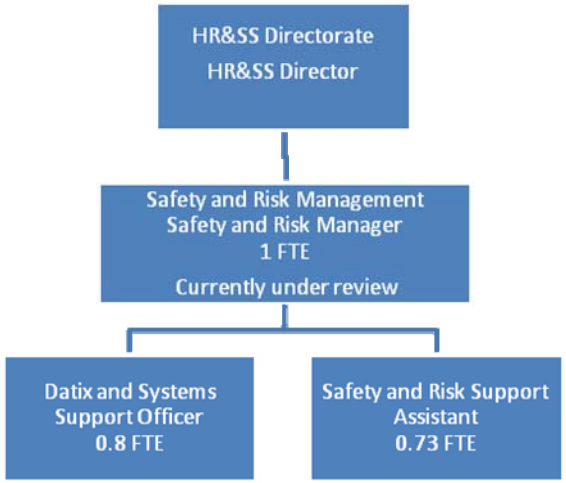
The Board's Safety and Risk Manager is required to have an advanced qualification in Safety and Risk Management to ensure that the Board complies with Regulation 7 of MHSWR 1999, which require the employer to appoint a competent person to assist with the delivery of the organisation's health and safety agenda.

Who We Are

The Safety and Risk Department was led by the Safety and Risk Manager and consists of five main Services:

- Health and Safety
- Risk Management
- Equipment Co-ordination
- Controlled Drugs Inspection
- Healthy Working Lives Occupational Health and Safety advice to SMEs

Please note that due to the untimely and sudden death of the postholder the delivery model of service is currently under review



Governance

The Safety and Risk Management Service is part of the Human Resources and Support Services Directorate and reports to the:

- Board
- Strategy and Redesign Committee
- Clinical Governance Committee
- Staff Governance Committee
- Health and Safety Committee
- Risk Management Group

The Service's performance is reported via Action Plan Update Reports every two months to the Health and Safety Committee and Risk Management Group.

A quarterly Risk Management Report (including Adverse Event Report) is provided for the Clinical Governance Committee. A quarterly Health and Safety Highlight Report is provided for the Staff Governance Committee. The Strategy and Redesign Committee receives an updated Corporate Risk Register every quarter and the Board receives an annual Corporate Risk Register Report.

Annual Reports for both the Health and Safety and Risk Management functions are produced.

Regulation and Compliance

- Health and Safety at Work etc Act [HSWA] 1974 (and subordinate legislation)
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations [RIDDOR] 2013
- Fire (Scotland) Act 2005
- Health Act 2006
- The Controlled Drugs (Supervision of Management and Use) Regulations 2006
- CEL 43 (2009) Safety of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities
- Health and Safety Executive [HSE] (regulatory body)

What We Do

1. Health and Safety including development and implementation of the Board's health and safety management system; online Safety and Risk Support Tool; executive support for the Health and Safety Committee; Health and Safety Inspection Visits, Reports and Action Plans; accident/incident investigations; co-ordination of reports to HSE under RIDDOR 2013; face fit testing; policies and procedures; reports

2. Risk Management including development and implementation of the Board's risk management system; executive support for the Risk Management Group; maintenance and development of DATIX (electronic adverse event/risk recording system); strategy, policies and procedures; reports

3. Equipment Co-ordination including receipt, assessment, cascade and monitoring of Safety Notices (i.e. Medical Device Alerts, Field Safety Notices, Estates and Facilities Alerts, Customer Alert Notices and Product Recall Notices); and reporting of defective/failed medical devices and equipment to Health Facilities Scotland Incident Reporting and Investigation Centre and/or NHS Scotland National Procurement; attendance at national Equipment Co-ordinators' meetings (via videoconference)

4. Healthy Working Lives including the Safety and Risk Manager acting as an Occupational Health and Safety Advisor to SMEs in Shetland which involves carrying out workplace assessment visits and providing a confidential, written report for the client(s)

5. Controlled Drugs Inspection including the Safety and Risk Manager developing and implementing a programme of inspection to promote the safe and effective use of controlled drugs; carrying out investigations as directed by the Accountable Officer [AO]; full participation in the local intelligence network established by the AO; acting as an authorised person for witnessing the destruction of controlled drugs

6. Information Management including final approval of adverse event reports submitted via DATIX; creating and running reports from DATIX; monitoring and reporting responses to Safety Action Notices; responding to Freedom of Information requests

7. Training including Corporate Induction; Compulsory Refresher; DATIX; Risk Assessment; Adverse Event Review (Incident Investigation); SYPOL (electronic chemical management system); workplace health and safety

Our Customers

The Safety and Risk Support Team are responsible for the provision of advice, motivational support and information across NHS Shetland. We interact with staff at all levels within the organisation, including the Chief Executive, Senior Management Team, Medical and Nursing Staff, Allied Health Professionals, Healthcare Scientists, Administrative, Technical and support staff.

The Team has close working relationships with other departments such as Occupational Health, Staff and Organisational Development, Estates and Facilities, Finance and Human Resources. Liaison with the Manual Handling, Fire, Control of Infection and Radiation Safety Committees is also an essential part of our work.

The role of Inspection Officer for Controlled Drugs involves working with the Board's Pharmacy Team, GPs, hospital nursing staff and community pharmacies.

The Team has working relationships with external agencies, such as enforcing authorities - including the HSE, Highlands and Islands Fire and Rescue Service, Scottish Environmental Protection Agency and Shetland Islands Council Environmental Health Department. In addition we contribute to Scottish Government, NHS Scotland and Local Authority partnership working groups/initiatives/projects. As part of health and social care integration, we work collaboratively with Shetland Islands Council Risk Management Team and carry out joint health and safety inspection visits of shared premises with the Council's health and safety staff.

An occupational health and safety service is provided for any SMEs located in the Shetland Islands.

Our Costs and Income

The Service has 2.53 full time equivalent staff and annual revenue budget of £99,156 as detailed below:

Service	Number of Staff (FTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	1 FTE	£60,247			Nil
Safety and Risk Support staff	1.53 FTE	£47,009			Nil
Non-pay		£2,900			Nil
Healthy Working Lives			£11,000		Nil
Safety and Risk Service Total	2.53	£110,156	£11,000	£99,156	Nil

Detailed Actions/Plan for Change

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Health and Safety Action Plan 2014-15 (approved by the Health and Safety Committee in May 2014)	Ongoing.	At 26 November 2014, out of 21 actions listed on the Action Plan Update Report: four RED; four AMBER and 13 GREEN
Risk Management Action Plan 2013-15 (approved by the Risk Management Group in July 2013)	Ongoing	At 25 November 2014, out of 24 actions listed on the Action Plan Update Report: two RED; 12 AMBER and eight GREEN (one action no longer relevant and one only required ‘as and when’)

Ongoing Actions/Projects Started prior to 2015/16

Description	PRINCE *	Start date/Comments	Expected Outcome
Implementation of Learning from adverse events through reporting and review. Healthcare Improvement Scotland's national framework for NHSScotland	No	Original framework document issued in September 2013 and due to be refreshed December 2014/January 2015	Implementation ongoing in conjunction with national team at Healthcare Improvement Scotland. Revised Adverse Event Policy will reflect updated framework as will refreshed Risk Management Strategy due 2015
Recommendations from internal audit of Risk Management and Health and Safety functions	No	Risk Management Audit Report (July 2014) and Health and Safety Audit Report (November 2014)	Management responses to recommendations to be incorporated into Health and Safety and Risk Management Action Plans for 2015-16 to track progress

New Planned Actions Due to Start in 2015/16

Description	PRINCE *	Start date/Comments	Expected Outcome
Health and Safety Action Plan 2015-16	No	First draft due in Q4 of 2014-15. Due to be approved by Health and Safety Committee in Q1 of 2015-16	
Risk Management Action Plan 2015-16	No	First draft due in Q4 of 2014-15. Due to be approved by Risk Management Group in Q1 of 2015-16	

Risks to Delivery

Reliance on limited staff resources. Any, two or all of the team members leaving the organisation or being off sick would significantly affect the delivery of the Health and Safety and Risk Management Action Plans and result in significant slippage (as would any serious technical issues with the DATIX system).

Staff Development and Organisational Development

The Service supports the delivery and the co-ordination of training to enable employees across the workforce deliver safe and effective care. The service supports creating a safe and effective clinical learning environment for those in training. The department also has a service improvement lead that provides training and project support across Health and Social Care.

The Staff and Organisational Development Team is responsible for: the delivery and the co-ordination of key personal and professional training to enable employees across the workforce including those in training to deliver safe and effective care. The department also has a service improvement lead that provides training and project support across Health and Social Care.

- The Staff and Organisational Development Team are responsible for offering wide range of training covering all areas required by the Board ensuring compliance with statutory requirements. The staff and Organisational Development Team are also responsible for assisting teams achieve targets and objects through specific interventions and for supporting staff with the KSF and JDR programme.

- The Clinical Education Team is responsible for creating and maintaining a clinical learning environment for all students. The team also delivers and coordinates a range of clinical training events and programmes to support the aim of appropriately trained staff.
- The Service Improvement Team is responsible for providing training and project support across the organisation. The team utilises a range of tools and techniques that are fundamental to getting to grips with the challenges of everyday service delivery and trialling and measuring ideas for change.

Service	Number of Staff (WTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	2.2	2.2 Band 7	.2 Ext		
Staff and Organisational Development	2.1	1 Band 3 1.1 Band 5	.24 Band 3 Ext		
Service Improvement and AHPs	.7	.3 Band 6 .4 Band 7	0.4 Band 7 Ext		
Clinical Education	1.5	.4 Band 3 1.1 Band 6	.5 Band 6 Ext		
Total	6.5				

The Staff and Organisational Development Department receives external funding for a range of posts including the Clinical Development Facilitator and Staff Development Administrator by Robert Gordon University. The Practice Education Facilitator for Nursing, Practice Education Lead for AHPs, Post-Graduate Medical Administrator is all or partially funded by NHS Education for Scotland.

Aims and Objectives

The Organisational and Staff Development Department delivers high quality education, organisational development and continuous service improvement across NHS Shetland supporting the Board achieving it Corporate Objectives.

Service Aims/Priorities	Objectives/Actions
To support the continued mainstreaming and embedding of the NHS Knowledge and Skills Framework (KSF) and Personal Development Review (PDR) process	Update Learning materials to support the continued use of e-KSF and effective JDR processes.
Corporate Induction and Compulsory Refresher Training.	Monitor attendance rates and ensure quality and currency of induction and refresher training.
Support the delivery of Service Improvement within the Board.	Provide support for projects as requested by the Senior Management Team eg localities and pathways projects. Establish a Service Improvement Forum where staff can share knowledge, skills and experiences in a safe learning environment.
iMatter Staff Experience Tool Implementation	Support the implementation of the programme with Cohort 1 staff in line with SGHD plan. This includes: Finance, Human Resources and Support Services, Public Health and Performance.

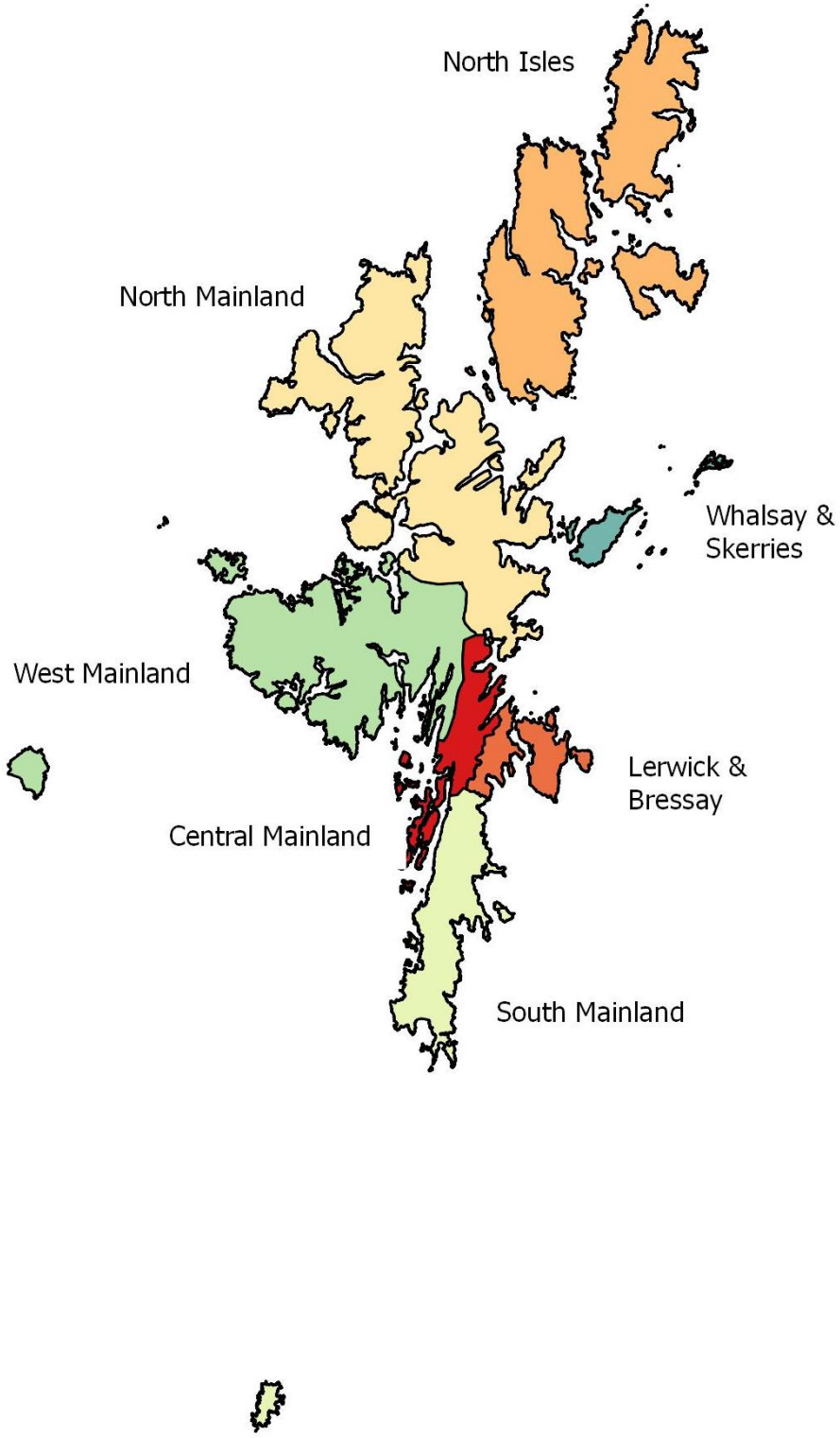
Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Restructure of the Staff and Organisational Development Team.	On time	Savings were made based on change in structure which now does not include and overall service lead (3 team leads).
Support and embed service improvement delivery within the Board.	On time	Provide 3 internal secondment opportunities within the Board which will enable staff to deliver improvement methods via work based projects.

Contacts:

Sally Hall Staff and Organisational Development Manager Montfield (Lower) Hospital Burgh Road Lerwick ZE1OLA 01595-743-081	Mhairi Roberts Clinical Education Montfield (Lower) Hospital Burgh Road Lerwick ZE1OLA 01595-743-204	Bruce McCulloch Service Improvement Montfield (Lower) Hospital Burgh Road Lerwick ZE1OLA 01595-743-202

Appendix 1: Localities Map



IJB Finance Report
Financial Year 2015/16
Sep-15

	C						B						
	Managed Sevices			Managed Sevices			Planning (Set Aside) Services	Planning (Set Aside) Services			Total		
Service Plan	NHS	SIC	Total	NHS	Budget	Variance	NHS	NHS	Budget	Variance	NHS	Budget	Variance
	Annual Budget (£s)			Year to Date Expenditure (£s)			Annual Budget (£s)	Year to Date Expenditure (£s)			Year to Date Expenditure (£s)		
Adult Services													
Learning Disabilities Nurse	68,104	0	68,104	34,148	34,052	-96				0	34,148	34,052	-96
Management Costs	0	92,945	92,945			0				0	0	0	0
Residential Short Breaks (Respite)	0	702,266	702,266			0				0	0	0	0
Supported Living & Outreach	279,181	2,563,340	2,842,521	139,591	139,591	0				0	139,591	139,591	0
Supported Vocational Activity	0	1,468,974	1,468,974			0				0	0	0	0
Total	347,285	4,930,125	5,277,410	173,739	173,643	-96	0	0	0	0	173,739	173,643	-96
Adult Social Work													
"With You For You" - Customer Relations Function	0	31,185	31,185			0				0	0	0	0
Advocacy	0	30,114	30,114			0				0	0	0	0
Direct Payments (CAB SLA)	0	4,590	4,590			0				0	0	0	0
Fieldwork Preventative Services	0	900	900			0				0	0	0	0
Social Work	0	633,350	633,350			0				0	0	0	0
Total	0	700,139	700,139	0	0	0	0	0	0	0	0	0	0
Allied Health Professionals													
Adaptations	0	355,000	355,000			0				0	0	0	0
Community Alarm	0	18,000	18,000			0				0	0	0	0
Dietetics	103,764	0	103,764	50,115	53,925	3,809				0	50,115	53,925	3,809
Operational Costs	0	100,334	100,334			0				0	0	0	0
Orthotics	137,409	0	137,409	68,418	70,203	1,784				0	68,418	70,203	1,784
OT Staffing including Management & Admin	184,383	699,446	883,829	84,658	92,192	7,534				0	84,658	92,192	7,534
Physiotherapy	582,841	0	582,841	287,813	292,777	4,964				0	287,813	292,777	4,964
Podiatry	222,588	0	222,588	105,056	111,294	6,238				0	105,056	111,294	6,238
Specialist Aids	0	193,792	193,792			0				0	0	0	0
Specialist Equipment	0	1,500	1,500			0				0	0	0	0
Speech and Language Therapy	81,180	0	81,180	36,804	40,590	3,786				0	36,804	40,590	3,786
Telecare (Net of Customer Income)	0	6,530	6,530			0				0	0	0	0
Disability Shetland - Access Project	0	18,576	18,576			0				0	0	0	0
Total	1,312,165	1,393,178	2,705,343	632,864	660,979	28,115	0	0	0	0	632,864	660,979	28,115
Carers													
Respite Care at Home	0	86,640	86,640			0					0	0	0
	0	86,640	86,640	0	0	0	0	0	0	0	0	0	0
Community Care													
Day Care	0	468,798	468,798			0				0	0	0	0
Care at Home Domestic Tasks	0	794,467	794,467			0				0	0	0	0
Local Residential Placements	1,039,925	5,036,499	6,076,424	519,963	519,963	0				0	519,963	519,963	0
Management Costs	0	74,813	74,813			0				0	0	0	0
Care at Home Personal Care Service	0	4,152,480	4,152,480			0				0	0	0	0
RVS	0	1,530	1,530			0				0	0	0	0
	1,039,925	10,528,587	11,568,512	519,963	519,963	0	0	0	0	0	519,963	519,963	0

Community Nursing Services

Community Nursing	2,339,090	0	2,339,090	1,206,925	1,195,999	-10,926				0	1,206,925	1,195,999	-10,926
Total	2,339,090	0	2,339,090	1,206,925	1,195,999	-10,926	0	0	0	0	1,206,925	1,195,999	-10,926
Criminal Justice Service													
Offender Services	0	-5,899	-5,899			0				0	0	0	0
Youth Crime	0	15,733	15,733			0				0	0	0	0
Total	0	9,834	9,834	0	0	0	0	0	0	0	0	0	0
Mental Health													
Community Alcohol & Drugs Services Shetland	0	166,200	166,200			0				0	0	0	0
Community Mental Health Nursing	279,366	0	279,366	121,590	120,626	-963				0	121,590	120,626	-963
Community Mental Health Support Service	0	1,324,400	1,324,400			0				0	0	0	0
Dementia Services	68,184	0	68,184	40,541	34,092	-6,449				0	40,541	34,092	-6,449
Dogs against Drugs		27,000	27,000			0				0	0	0	0
Mental Health Officer Services	0	147,159	147,159			0				0	0	0	0
Mental Health Services Management	0	81,350	81,350			0				0	0	0	0
MHO Preventative Services	0	1,000	1,000			0				0	0	0	0
Moving On - Supported Employment	0	54,484	54,484			0				0	0	0	0
Off-Island Placements/Treatment	0	0	0			0	375,000	150,410	150,409	-1	150,410	150,409	-1
Psychological Services	611,587	0	611,587	274,467	305,794	31,326				0	274,467	305,794	31,326
Rehabilitation Placements	0	54,500	54,500			0				0	0	0	0
Specialist Social Worker	0	1,505	1,505			0				0	0	0	0
Substance Misuse	350,934	0	350,934	180,781	175,467	-5,314				0	180,781	175,467	-5,314
Total	1,310,071	1,857,598	3,167,669	617,379	635,979	18,600	375,000	150,410	150,409	-1	767,789	786,388	18,598
Oral Health													
Dental	3,284,888	0	3,284,888	1,581,191	1,598,023	16,832					1,581,191	1,598,023	16,832
Total	3,284,888	0	3,284,888	1,581,191	1,598,023	16,832	0	0	0	0	1,581,191	1,598,023	16,832
Pharmacy & Prescribing													
Chemists (Non Discretionary) *	749,561	0	749,561	374,780	374,780	0				0	374,780	374,780	0
Prescribing	5,135,024	0	5,135,024	2,768,431	2,558,452	-209,979				0	2,768,431	2,558,452	-209,979
Total	5,884,585	0	5,884,585	3,143,211	2,933,232	-209,979	0	0	0	0	3,143,211	2,933,232	-209,979
Primary Care													
GP Practices	4,000,738	0	4,000,738	2,152,110	1,974,294	-177,815				0	2,152,110	1,974,294	-177,815
Out of Hours	258,400	0	258,400	138,503	129,200	-9,303				0	138,503	129,200	-9,303
Management Costs	205,628	0	205,628	90,587	89,297	-1,290				0	90,587	89,297	-1,290
Total	4,464,766	0	4,464,766	2,381,200	2,192,791	-188,409	0	0	0	0	2,381,200	2,192,791	-188,409
Unscheduled Care Service													
Accident & Emergency	0	0	0			0	757,802	408,337	385,937	-22,399	408,337	385,937	-22,399
Ward 3	0	0	0			0	1,003,821	527,482	499,974	-27,508	527,482	499,974	-27,508
Medical	0	0	0			0	995,735	554,010	505,139	-48,870	554,010	505,139	-48,870
Total	0	0	0	0	0	0	2,757,358	1,489,829	1,391,051	-98,777	1,489,829	1,391,051	-98,777
Planned Care Service													
Ronas	0	0	0			0	513,866	261,577	257,256	-4,321	261,577	257,256	-4,321
Total	0	0	0	0	0	0	513,866	261,577	257,256	-4,321	261,577	257,256	-4,321

Public Health Department													
Health Promotion	0	0	0			0	286,571	144,455	149,968	5,513	144,455	149,968	5,513
Smoking Cessation	0	0	0			0	49,903	18,936	24,952	6,015	18,936	24,952	6,015
SADAT	0	0	0			0	219,183	97,307	99,471	2,164	97,307	99,471	2,164
	0	0	0			0				0	0	0	0
Total	0	0	0	0		0	555,657	260,698	274,391	13,693	260697.59	274390.6	13693.01
Directorate Management Costs													
Efficiency Target 2015/16	-480,694	0	-480,694	0	-240,347	-240,347				0	0	-240,347	-240,347
Equipment	20,000	0	20,000	9,095	9,095	0				0	9,095	9,095	0
Management Costs	68,463	236,743	305,206	36,138	34,488	-1,650				0	36,138	34,488	-1,650
Opthalmic (Non Discretionary)	445,281	0	445,281	222,641	222,641	0				0	222,641	222,641	0
Integrated Care Fund	410,000	0	410,000	67,615	67,615	0				0	67,615	67,615	0
Total	463,050	236,743	699,793	335,488	93,492	-241,997	0	0	0	0	335,488	93,492	-241,997
	20,445,825	19,742,844	40,188,668	10,591,962	10,004,100	-587,862	4,201,881	2,162,514	2,073,107	-89,407	12,754,475	12,077,206	-677,269

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20th November 2015
Report Title:	Proposed Establishment of Strategic Planning Group
Reference Number:	CC-50-D1
Author / Job Title:	Dr Sarah Taylor, Director of Public Health and Planning

Decisions / Action required:

The Integration Joint Board is asked to approve the arrangements for establishing the Strategic Planning Group; specifically to agree:

1. The Terms of Reference
2. Membership
3. The appointment of the Chairman and Vice-Chairman
4. The establishment of the Group.

High Level Summary:

National guidance on Integration obliges Integration Joint Boards to establish a Strategic Planning Group to support the Integration Joint Board (IJB) in development of future Joint Strategic Commissioning Plans. In Shetland this will replace the current shadow group that brings together members of the Health & Social Care Strategic Management Team and the Integration Steering Group.

The remit and membership of the Strategic Planning Group is determined by guidance http://www.gov.scot/Resource/0046/00466819.pdf, and the local terms of reference are written to reflect the guidance in the context of Shetland.

Corporate Priorities and Strategic Aims:

Development of the process of joint strategic planning will help strengthen delivery of both organisations' work to improve services in community health and social care and deliver against Directorate and Service Plans. The establishment of the Strategic Planning Group and development of locality planning for Integration will help support Single Outcome Agreement priorities on community engagement.

Key Issues:

In Shetland historically, joint strategic planning has been developed through client group focussed partnerships (such as the Mental Health and Drug & Alcohol Partnerships), and through strategy development (recently the Older Peoples Strategy and currently the Primary Care Strategy). The establishment of the Strategic Planning Group will complement these and build on them to ensure that local strategic commissioning is done with due regard to engagement of the full range of stakeholders.

Further detail of the process of strategic planning for health and social care integration, including Locality Planning, is provided in a briefing paper available on the Integration web-site http://www.shetland.gov.uk/Health_Social_Care_Integration/Briefings.asp.

The report outlines proposed Terms of Reference, Membership and routes for obtaining external stakeholder representation on the Group. It seeks to establish the group to support and inform the process of agreeing the Joint Strategic Commissioning Plan for 2016-19 and for future years.

Implications :	
Service Users, Patients and Communities:	The Strategic Planning Group is set up to ensure appropriate participation of services users and communities, through Locality Planning and other mechanisms, in the development of the Joint Strategic Commissioning Plan. Any significant service change would need a separate process for public and user engagement in line with NHS, SIC and IJB policies.
Human Resources and Organisational Development:	The establishment of the Strategic Planning Group and the planning function will be supported by the NHS Director of Public Health and Planning on behalf of the IJB, within existing resources.
Equality, Diversity and Human Rights:	The establishment of the Strategic Planning Group should help to ensure that the Strategic Plan is developed with due regard to equality and diversity issues, and that an Equality Impact Assessment is undertaken.
Partnership Working	Membership of the Strategic Planning Group should ensure partnership engagement in the strategic planning process.
Legal:	The Strategic Planning Group is established to comply with guidance issued in support of the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.
Finance:	The Group will operate within existing resources.
Assets and Property:	There are no implications for major assets and property i.e. buildings and equipment.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	The Strategic Planning Group will report any significant risks in its operation through the IJB's Risk Register in line with the Risk Management Strategy. If the IJB should NOT approve the arrangements then the risk is that the development of the Joint Strategic Commissioning Plan for 2016/17 is done without due process in line with the legislation and guidance, and without due regard to engagement through partnership.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015. Once it has approved a Strategic Plan it assumes responsibility for the functions delegated to it by the Council and the Health Board, which includes approval of the establishment of the Strategic Planning Group.	
Previously considered by:	Draft Terms of Reference, Membership and Strategic Planning arrangements have been considered by: the shadow Strategic Planning Group; Area Clinical Forum, User and Carer representatives; service managers and staff via the Health & Social Care Joint Strategic Officers Group; and IJB	26th June 2015 13th August 2015 11th August 2015

	members through their Induction workshop.	2nd June 2015

Agenda Item

4

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	20th November 2015
Report Title:	Proposed Establishment of Strategic Planning Group
Reference Number:	CC-50-15 D1
Author / Job Title:	Dr Sarah Taylor, Director of Public Health and Planning

1. Introduction

1.1 The aim of this paper is to propose the establishment of a Strategic Planning Group to support the integration of Health & Social Care in Shetland and the work of the Integration Joint Board.

2. Background

2.1 As part of the requirements laid down in the Public Bodies (Joint Working) (Scotland) Act 2014, the Integration Joint Board must produce a Strategic Commissioning Plan that sets out how they will plan and deliver services over the medium term (three years) and, through this, how they will meet the 9 National Health and Wellbeing Outcomes and achieve the core aims of integration:

- To improve the quality and consistency of services for patients, carers, service users and their families;
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

2.2 All stakeholders must be fully engaged in the preparation, publication and review of the Strategic Commissioning Plan as part of an on-going, cyclical

process. To ensure this, the Act requires each Integration Authority to establish a Strategic Planning Group.

2.3 This will build on the joint strategic planning work done locally to date through client group focussed partnerships (such as the Mental Health and Drug & Alcohol Partnerships), and through strategy development (recently the Older Peoples Strategy and currently the Primary Care Strategy). The establishment of the Strategic Planning Group will complement these and build on them to ensure that local strategic commissioning is done with due regard to engagement of the full range of stakeholders.

2.4 Further detail of the process of strategic planning for health and social care integration is provided in a briefing paper available on the Integration web-site http://www.shetland.gov.uk/Health_Social_Care_Integration/StrategiesPolicyPlans.asp

3. Role of the Strategic Planning Group

3.1 The role of the Strategic Planning Group (SPG) is to support the Integration Joint Board in the cyclical development and finalising of the Plan and the continuing review of the progress in its delivery against the agreed national and local outcomes.

3.2 In terms of governance, the SPG is a reference and advisory group reporting to the Integration Joint Board. It has no executive function.

3.3 The role of the Strategic Planning Group is in developing and finalising the strategic commissioning plan and in continuing to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators. The Strategic Commissioning Plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.

3.4 The views of localities must be taken into account with the Integration Authority required to identify the most appropriate person to represent each locality on the Strategic Planning Group. Local flexibility is allowed, so that an individual can represent more than one locality.

4. Membership

4.1 The Statutory Guidance on Strategic Planning, published in December 2014, provides local flexibility on the size and composition of the Strategic Planning Group. However, the Integration Authority is required to involve a range of relevant stakeholders. These groups must include representatives of groups prescribed by the Scottish Ministers in regulations as having an interest.

4.2 The proposal for membership is set out in the draft Terms of Reference (Appendix 1) and is based on the following principles:

4.2.1 Group members represent their communities of interest/professional groups.

4.2.2 The arrangements are seen as a starting point and are kept under review to ensure that they are as effective as possible.

4.2.3 Including the required representation within the Strategic Planning Group has the potential to create a large and unwieldy group. There is clearly the need to strike a balance between an effective and manageable group and effective representation of prescribed communities of interest as well as localities.

4.3 In drawing up the proposed membership and terms of reference, engagement through discussion and consultation on a draft was held with the range of stakeholders represented on the Strategic Planning Group. Feedback was received from the users and carers representatives on the IJB. Specifically the view from the carers representative and the Carers Link Group was: There is no need for separate representation of carers of users of social care and carers of users of health care. There is value in separate representation on the Strategic Planning Group of both unpaid carers and carers' support (ideally by the Carers Support Worker). A minority view was that for some caring situations, either health or social care services are not really relevant, so there may be a case for separate representation. The example given for this was for care of a child, so it may be considered less relevant to the core business of the IJB

4.4 In consulting on membership questions were asked about any other particular membership. The only specific response on this or other issues that was received, was a request of membership for the NHS Director of Acute Services (currently the Director of Nursing) to ensure a contribution from those hospital services that are included within Integration, and for whole systems planning across NHS Shetland. This has therefore been included in the proposed members nominated by the Health Board.

5. Terms of Reference

5.1 A draft Terms of Reference is set out in Appendix 1 including the role of the group and the role of representatives as defined in the Guidance.

6. Recommendations

The IJB is asked to:

6.1 Agree the Terms of reference

6.2 Agree Membership of the Strategic Planning Group

6.3 Agree the appointment of the Chairman and Vice-Chairman

6.4 Agree the establishment of the Group.

7. Conclusions

7.1 This report is written to seek agreement to the establishment of a Strategic Planning Group to support the development of the Joint Strategic Commissioning Plan and the work of the IJB as set out in Guidance.

For further information please contact:
Dr Sarah Taylor, Director of Public Health
01595 743072 sarahtaylor1@nhs.net
1 November 2015

Appendices:
Appendix 1: Draft Membership and Terms of Reference

Background Documents:

Health and Social Care Integration Public Bodies (Joint Working)(Scotland) Act 2014
Strategic Commissioning Plans Guidance
http://www.gov.scot/Resource/0046/00466819.pdf

Health and Social Care Integration Localities Guidance
http://www.gov.scot/Resource/0048/00481100.pdf.

Briefing Paper on Strategic Commissioning
http://www.shetland.gov.uk/Health_Social_Care_Integration/StrategiesPolicyPlans.asp

Strategic Planning Group – DRAFT Terms of Reference and Membership

This paper sets out the proposed terms of reference and role descriptions for the Shetland Health and Social Care Integration Joint Board Strategic Planning Group.

Purpose

All stakeholders must be fully engaged in the preparation, publication and review of the Strategic Commissioning Plan as part of an on-going, cyclical process. To ensure this, the Act requires each Integration Authority to establish a Strategic Planning Group.

Role

The role of the Strategic Planning Group (SPG) is to support the Integration Joint Board in the cyclical development and finalising of the Plan and the continuing review of the progress in its delivery against the agreed national and local outcomes. The Strategic Commissioning Plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.

The Strategic Planning Group will take account of the relevant legislation and national guidance specifically the Strategic Commissioning Plans Guidance http://www.gov.scot/Resource/0046/00466819.pdf and Localities Guidance http://www.gov.scot/Resource/0048/00481100.pdf.

It will be concerned with supporting and challenging those responsible for strategic commissioning in the development of the local plan, for instance through asking:

- What exactly are we trying to achieve, and for whom?
- How successful have we been?
- What do we need to do differently for a better result, and how are we going to resource that?

Or using the series of questions included in the guidance based on work by Audit Scotland:

• How many people will need services and what type will they need?
• What is the current provision, is it the right level, quality and cost?
• How can these services improve people's lives?
• Which Services will best achieve this?
• How do we develop these services at an affordable cost?
• How do we procure and deliver these services to best effect?
• How do we monitor and review these services?

The views of localities must be taken into account so that the Strategic Commissioning Plan reflects closely the needs and plans articulated at locality level.

Support for meetings

The secretariat for the Strategic Planning Group will be provided by the NHS Director of Planning in line with Shetland's Integration Scheme.

Agendas for meetings will be issued no later than five working days before the date of the meeting. Papers will be issued electronically, but will be available as paper copies on request or by arrangement. Meetings will be formally minuted, and the minutes will be reported to the IJB on a regular basis.

Frequency of meetings

It is anticipated that the Strategic Planning Group will meet formally once a quarter. Additional meetings may be called to deal with particular items of business in agreement with the Chairman. A schedule of meetings in line with the planning cycle for developing the Joint Strategic Commissioning Plan will be drawn up once the IJB has approved the Terms of Reference and Membership.

Notice of meetings

All ordinary meetings of the Strategic Planning Group shall be called by notice in writing issued by or on behalf of the chairman at least five working days before the date of the meeting.

Conduct of meetings

The Strategic Planning Group is an advisory group to the IJB and therefore there will be no formal voting in meetings. Differences of opinion will be reported to the IJB to take into account in its decision making.

A meeting shall be considered quorate if a minimum of seven members are present.

Minutes shall be taken of the proceedings of the Strategic Planning Group. Draft Minutes shall be distributed for consideration and review to the Chairman of the Meeting and the draft Minutes shall be presented at the next Meeting of the Group for approval. Formally approved Minutes shall be included in Integration Joint Board Meeting papers for noting.

The meetings will not be held in public (minutes will be published via reporting to the IJB).

Membership
Membership is set out in Table 1.

Table 1

STATUTORY MEMBERSHIP	LOCAL REPRESENTATION
Users of health care	A health care user representative to be identified from the current PFPI arrangements
Users of social care	A social care user representative to be identified from the current PFPI arrangements
Carers of users of health care Carers of users of social care	A carers representative to be identified from the current Carers Support arrangements representing carers of health and social care users. A representative of carers' support via the Carers Support Team
Commercial providers of health care	A representative of local commercial providers to be sought (engagement with Boots,

	Freefield and Brae commercial pharmacy businesses; Independent dental and optometry businesses)[1]
Commercial providers of social care	N/A
Non-commercial providers of social care	Crossreach (Walter and Joan Gray Care Centre, Scalloway)
Non-commercial providers of social housing	Hjatland Housing Association
Non-commercial providers of health care	N/A
Health professionals[2]	A representative to be identified via Area Clinical Forum
Social care professionals[3]	A representative to be identified via Area Clinical Forum
Third sector bodies carrying out activities related to health or social care	A representative identified via Voluntary Action Shetland
Members[4] nominated by the Local Authority or the Health Board, or both	Director of Public Health & Planning (Chair) IJB Chief Officer / Director of Community Health & Social Care (Vice-Chair) Director of Nursing & Acute Services (NHS) Other officers as determined by the IJB Chief Officer
Representatives of the interests of each locality[5]	TBC by IJB Chief Officer, Director of Community Health & Social Care
Other persons the Integration Authority considers appropriate, such as Local Authority housing colleagues	A representative of SIC Housing Dept

Chairman: The role of Chairman will be taken initially by the Director of Planning (NHS, post currently held by the Director of Public Health) who has responsibility to the IJB for supporting the development of the Joint Strategic Commissioning Plan as set out in Shetland's Integration Scheme.

The role of Vice-Chairman will be taken by the IJB Chief Officer, the Director of Community Health & Social Care.

Members Roles

Strategic commissioning is crucially about establishing a mature relationship between different partners from across the public, third and independent sectors in a way which will help to achieve the best services for the population. Providers themselves will bring knowledge and experience of their services and the outcomes they are delivering. Every partner has a role to play in strategic commissioning, and that is why it is important that

[1] A meeting of local commercial providers will be held to seek representation

[2] As described in the legislation – see Strategic Commissioning Guidance

[3] As described in the legislation – see Strategic Commissioning Guidance

[4] The group must involve members nominated by the Local Authority or the Health Board, or both. In effect, this provides for the partners who prepared the Integration Scheme, and are party to the integrated arrangements, to be involved in the development of the strategic commissioning plan.

[5] The Integration Authority is required to identify the most appropriate person to represent each locality on the Strategic Planning Group. Local flexibility is allowed, so that an individual can represent more than one locality.

local arrangements promote mature relationships and constructive dialogue. Members will be expected to:

- represent their sector or professional area (community of interest) see Table 1 and relevant Guidance;
- ensure the interests of the agreed localities are represented;
- develop and maintain the necessary links and networks with groups and individuals in their community of interest to enable views to be sought and represented over the development, review and renewal of the Strategic Commissioning Plan;
- take an active role in the development of the initial draft of the Strategic Commissioning Plan (as well as the subsequent drafts);
- help ensure the Plan reflects the needs and expectations (and that there has been an adequate assessment of those needs and expectations) both across Shetland and in the localities.

Agenda Item

5

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board (IJB)
Date:	20th November 2015
Report Title:	Participation and Engagement Strategy Action Plan
Reference Number:	CC-53-15 F
Author / Job Title:	Edna Mary Watson, Chief Nurse Directorate of Community Health and Social Care

Decisions / Action required:

To approve the IJB Participation and Engagement Strategy Action Plan

High Level Summary:

The IJB was formally constituted on 27th June 2015 and the inaugural meeting, which confirmed the full membership of the IJB, was held on 20 July 2015.
At the second meeting of the IJB on 29 July 2015, the IJB approved their Standing Orders, Scheme of Administration and Financial Regulations.

The IJB is required to have a Participation and Engagement Strategy, as laid out in the Integration Scheme. The Participation and Engagement Strategy was approved by the IJB on 25 August 2015 and the Chief Officer was instructed to prepare a strategy Action Plan by 31st December 2015.

This draft Action Plan is presented today to the IJB for discussion and approval.

Corporate Priorities and Joint Working:

The IJB Participation and Engagement Strategy Action Plan sets out how Shetland's Health and Social Care Partnership will work to actively involve individuals and local communities in the decision making process as required by the Public Bodies (Joint Working) (Scotland) Act 2014.

The aims of Shetland's Health and Social Care Partnership are set out in the Integration Scheme and include:-

- Agencies working together in partnership within local communities;
- Actively engaging people and their carers;
- Services integrated around the needs of our customers; and
- Listening and responding to individual and community needs and aspirations.

Key Issues:

Shetland Health and Social Care Partners are committed to working collaboratively with service users, carers and the wider community in all aspects of health and care service

delivery from strategic planning through to the realisation of individual preferences in response to assessed needs. The Action Plan sets out the detail and timescales of various activities which support the implementation of the Participation and Engagement Strategy for the IJB.

Implications :	
Service Users, Patients and Communities:	The IJB Participation and Engagement Strategy Action Plan sets out the steps Shetland's Health and Social Care Partnership will take to ensure stakeholders are involved in decision making processes. Individuals, patients, service users, their families and carers as well as local communities can expect to be treated as equal partners in decisions taken by Shetlands Health and Social Care Partnership.
Human Resources and Organisational Development:	All staff across the partnership will implement the principles of participation and engagement in their work. A range of training resources are available to support individuals. The Scottish Health Council also provide resources to support staff in undertaking participation and engagement activities.
Equality, Diversity and Human Rights:	Reporting on Equalities, Diversity and Human Rights is an integral part of the activities of the Council and the Health Board and any performance issues for the functions delegated to the IJB will be reported to the IJB or to the IJB Audit Committee as appropriate.
Legal:	The engagement of stakeholders is a statutory responsibility on the Integration Authority in the preparation of the Strategic Plan, locality planning and associated commissioning processes.
Finance:	There are no financial implications associated with this report. The Action Plan will be developed, maintained and implemented within existing resources.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The main risk associated with this report is failure to agree a Participation and Engagement Strategy Action Plan for the IJB. Subsequent and consequent risks would be the failure to appropriately involve stakeholders throughout decision making processes.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015. The IJB has the authority to approve the Action Plan set out in this report.
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

5

Shetland Islands Council

Meeting:	Integration Joint Board (IJB)
Date:	20th November 2015
Report Title:	Participation and Engagement Strategy Action Plan
Reference Number:	CC-53-15 F
Author / Job Title:	Edna Mary Watson, Chief Nurse Directorate of Community Health and Social Care

1. Introduction

1.1 This report presents a draft IJB Participation and Engagement Strategy Action Plan for discussion and approval.

2. Background

2.1 The IJB was formally constituted on 27th June 2015 and the inaugural meeting, which confirmed the full membership of the IJB, was held on 20 July 2015. At the second meeting of the IJB on 29 July 2015, the IJB approved their Standing Orders, Scheme of Administration and Financial Regulations.

2.2 The IJB is required to have a Participation and Engagement Strategy, as laid out in the Integration Scheme.

2.3 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) stipulates that the IJB must have a Participation and Engagement Strategy in place by April 2016 in order to support its 2016-19 Strategic Plan. However, early adoption of the Strategy will support and further inform current work on localities and on the key Strategic plans relating to Older People's services, Dementia and the Primary Care Strategy.

2.4 The Participation and Engagement Strategy was approved by the IJB on 25 August 2015 and the Chief Officer was instructed to prepare an Action Plan by 31st December 2015.

3. Participation and Engagement

3.1 The IJB Participation and Engagement Strategy Action Plan at Appendix 1 sets out the work that will be undertaken by Shetland's Health and Social Care Partnership in order to actively involve individuals and local communities in the decision making processes as required by the Public Bodies (Joint Working) (Scotland) Act 2014.

3.2 The IJB, with support from the Council and the Health Board, has developed an action plan, which stipulates how the IJB will engage with stakeholders at key decision making points.

3.3 To minimise duplication the IJB has agreed that it will build on the existing Patient Focus Public Involvement (PFPI) arrangements for Health and Social Care services. The Public Participation Forum (PPF) will help to support the development of public involvement mechanisms in localities e.g. public/citizen panel concept. The agreed governance arrangements are described at Appendix 2.

3.4 The "Our Voice" Framework aims to ensure people who use health and care services, carers and the public are enabled to engage purposefully with health and social care providers to continuously improve and transform services. It will provide people with feedback on the impact of their engagement, or a demonstration of how their views have been considered. See Appendix 3. The Action Plan recognises the importance of implementing the "Our Voice" Framework as an integral part of the IJB's Participation and Engagement Strategy.

3.5 The IJB must make sure that an appropriate performance framework is established with regard to the functions delegated to the IJB by the Council and the Health Board. Participation and Engagement activities are monitored through an annual process, whereby organisations are asked to self assess against the "Participation Standard". The self assessment is then verified by the Scottish Health Council by inviting local people to comment on how well the organisation has engaged people in it's activities.

3.6 With the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 and the anticipated Community Empowerment (Scotland) Bill, amongst others, local communities can expect to be treated as equal partners in decisions made by Shetland's Health and Social Care Partnership.

The Action Plan identifies a range of activities to enable the IJB to be assured of the effectiveness of its participation and engagement strategy.

Recommendations

3.5 It is recommended that the IJB:

- Approve the IJB Participation and Engagement Strategy Action Plan, attached at Appendix 1
- Instruct the Chief Officer to prepare an annual report on the delivery of the IJB Participation and Engagement Strategy.

4. Conclusions

4.1 The engagement of stakeholders is a statutory responsibility on the Integration Authority in the preparation of the Strategic Plan, locality planning and associated commissioning processes.

4.2 The development of a Participation and Engagement Strategy Action Plan demonstrates the IJB's commitment to the participation and engagement of people throughout it's functions.

Contact Details
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Appendices

Appendix 1	Participation and Engagement Strategy Action Plan
Appendix 2	Patient/Customer Participation Framework for NHS Shetland and the Integrated Joint Board
Appendix 3	Our Voice – Information Leaflet

Background Documents

H&SCI Integration Scheme
http://www.shetland.gov.uk/Health_Social_Care_Integration/Integrationscheme.asp

Joint Strategic (Commissioning) Plan
http://www.shetland.gov.uk/Health_Social_Care_Integration/StrategicPlan.asp

Our Voice Framework
http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice.aspx

Supporting Public Involvement and Community Engagement
http://www.scottishhealthcouncil.org/about_us/what_we_do/community_engagement.aspx

Working together to Improve Health and Social Care in Scotland – Summary of Proposals June 2015

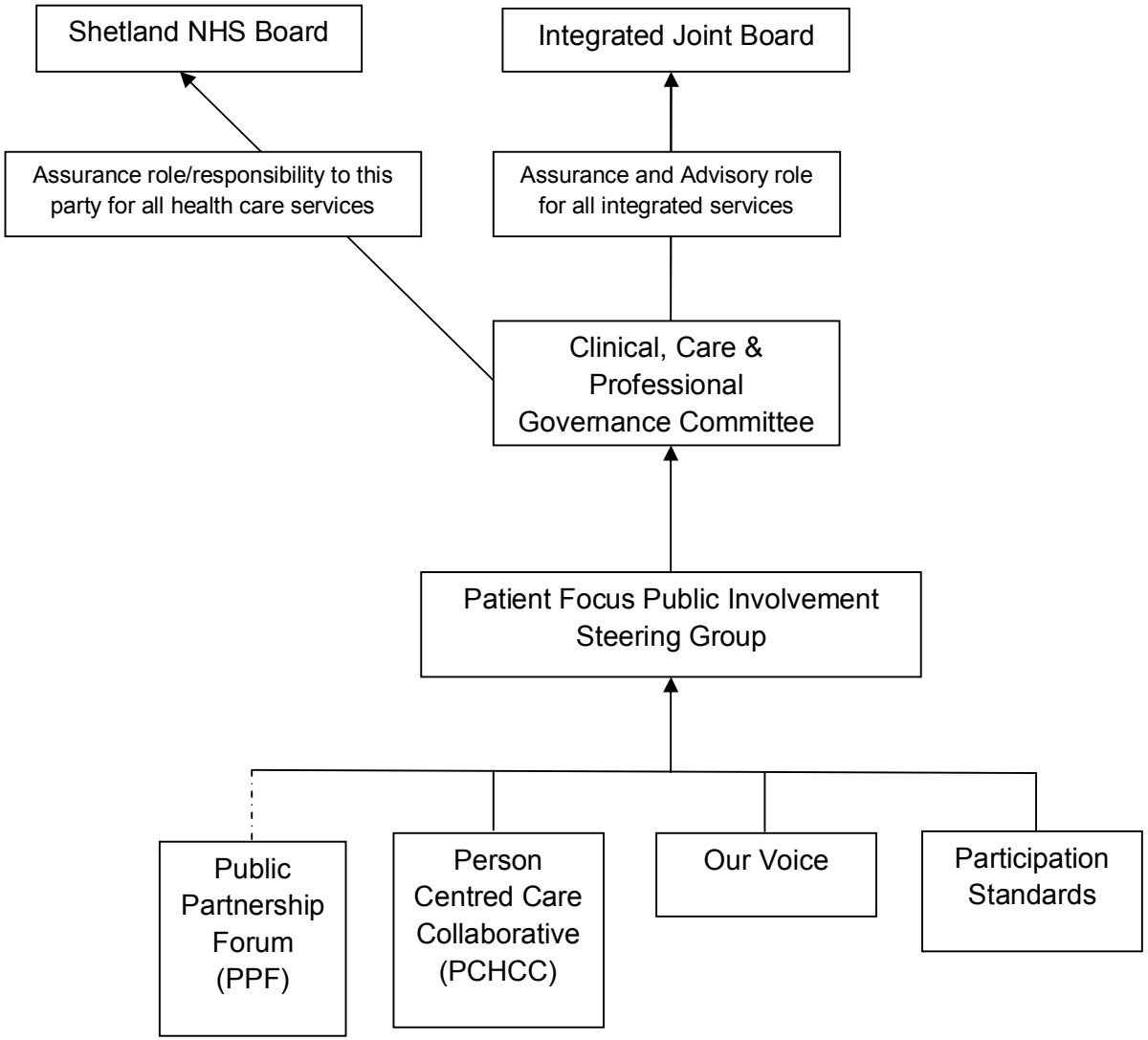
Participation Standard
http://www.scottishhealthcouncil.org/patient__public_participation/participation_standard/participation_standard.aspx

END

Recommendation	Group/Individual responsible for action	Timescale	Desired outcome	Progress
1. Map the processes and assets already in place to enable effective public participation and engagement within NHS Shetland and Shetland Islands Council.	Simon Bokor-Ingram / Kathleen Carolan / PFPI Steering Group	By 1 April 2016	People have readily accessible information on how they can participate in, provide feedback on and engage with, the services provided by the IJB.	
2. Review the IJB Participation and Engagement Strategy to ensure it is fully aligned with existing NHS Shetland and Shetland Islands Council participation and engagement strategies	PFPI Steering Group	By 1 April 2016	Single approach to participation and engagement across Health and Social Care services	
3. Review the PFPI Steering Group membership and terms of reference to ensure it encompasses all relevant Health and Social Care activities and partners.	Simon Bokor-Ingram / Edna Mary Watson, PFPI Lead	By 1 January 2016	Single structure supports participation and engagement across Health and Social care	
4. The PFPI Steering Group and PPF Chair work together to expand the reach of the PPF to enable locality views to inform IJB discussions.	Edna Mary Watson, PFPI Lead / Harold Massie, PPF Chair	By 1 April 2016	IJB decisions are informed by the voice of local communities	

Recommendation	Group/Individual responsible for action	Timescale	Desired outcome	Progress
5. Revise 2015/16 PFPI work plan to support the objectives of the IJB Participation and Engagement Strategy.	Edna Mary Watson, PFPI Lead	By 1 January 2016	Workplan accurately reflects key activities to be taken forward across Health and Social Care	
6. Work with the Scottish Health Council and the PPF Chair to develop locality level "Our Voice" peer networks. These networks will make it possible for people to select the activities they wish to engage in and put their energies into specific projects.	Simon Bokor-Ingram / Edna Mary Watson, PFPI Lead / Harold Massie, PPF Chair Scottish Health Council – locally and nationally	April 2017	People are able to actively engage in specific projects of interest to them.	
7. Submit Participation Standard self assessment to demonstrate effectiveness of the IJB participation and engagement strategy.	Simon Bokor-Ingram / Kathleen Carolan, Executive Lead Patient Experience	June 2016	People are engaged at all levels in the work of the IJB	
8. Produce an annual report of activities undertaken to progress the implementation of the IJB's participation and engagement strategy.	Edna Mary Watson	April 2017	Year on Year progress can be demonstrated in engaging people in the work of the IJB. Consecutive increase in assessment against Participation Standard	

Patient/Customer Participation Framework for NHS Shetland and the Integrated Joint Board



Working together to improve health and social care

The vision

Our Voice is based on a vision where:

> People who use health and care services, carers and the public will be enabled to engage purposefully with health and social care providers to continuously improve and transform services. People will be provided with feedback on the impact of their engagement, or a demonstration of how their views have been considered.

Developing Our Voice

Our Voice has been developed in partnership by a team involving the Scottish Health Council, Healthcare Improvement Scotland public partners, The ALLIANCE, COSLA and the Scottish Government.

The team engaged widely across Scotland to develop their thinking. This engagement was taken forward under the 'Stronger Voice' banner. In total, the team heard from 1,188 individuals and groups, covering every local authority and health board area in Scotland. All of the comments and views received were considered, along with the key themes that emerged from desk research. This was used to inform the final proposals. Views were also sought on the name and the identity for the initiative. 'Our Voice' was felt to help create a sense of shared ownership across health and social care sectors and – importantly – with the general public.

How it will work

Our Voice will operate at an individual, local and national level to support improvement and to empower people to be equal partners in their care.

At **individual level**, people should be fully involved in decisions about their treatment and care, and they should be empowered and supported to feed back about the care and services they receive. Their feedback

should be used to drive and inform continuous improvement to services. Integration stakeholders will work together to develop systems for hearing and responding to feedback that are accessible, manageable for staff, and capable of being transferred across settings.

At **local level**, a peer network will support people to engage purposefully in local planning processes. Guidance, tools and techniques will build people's capacity to get involved in, and to lead, local conversations. Particular support will be given to those whose voices are not always heard, and to develop local networks of people who are willing to get involved.

At **national level**, a citizen voice 'hub' will tap into existing structures and networks, gathering intelligence on issues of concern and involving as wide a range of people as possible in improving services. Strategic gathering and analysis of individual stories on topics of national interest will provide policy-makers and health and care providers with powerful evidence for improvement. Citizens' panels will create opportunities for people to engage in national policy debate.

A **leadership coalition** of health and social care service users, carers and leaders in the NHS, local authorities and the third sector will guide the development of the framework, work to maintain the momentum, and act as champions for a stronger citizen voice within their organisations. It will be independently chaired by a member of the public.

Find out more

If you would like further information, or to connect more closely with the Project Team, please contact:

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Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Public Health Annual Report 2015
Reference Number:	CC-52-15 F
Author / Job Title:	Dr Sarah Taylor, Director of Public Health

Decisions / Action required:

The Integration Joint Board is asked to:

(i) receive the Public Health Annual Report;
(ii) support efforts to improve the public health in Shetland through the promotion of healthy eating;
(iii) support public health work on 'investing to save' to reduce long term preventable morbidity and mortality.

High Level Summary:

This year's Public Health Annual Report has a theme of Food and Health - what we eat and how it affects our health. Building on last year's report on physical activity, we cover the topics of: how food affects our health, what makes up a healthy diet, diet and mental wellbeing, why it can be so difficult to eat healthily, and what we can do about it.

Finally, we include some challenges, not only for us as individuals in helping ourselves be healthier, but also for policy makers and decision makers, about the society that we are living in, and how we create environments that either contribute to a culture of over-consumption and unhealthy eating, or one of healthy choices and a healthier future.

In this Annual Report we have also included appendices on the work of the public health and health improvement team, including our progress towards delivering the 10 year plan.

Corporate Priorities and Strategic Aims:

This report relates to the National Health and Wellbeing Outcomes of:
1. People are able to look after and improve their own health and wellbeing and live in good health for longer, through delivering effective programmes on prevention and health improvement;
5. Health and social care services contribute to reducing health inequalities, through direct action on tackling inequalities; and
9. Resources are used effectively and efficiently in the provision of health and social care services, through considering the longer term gain from investing in effective prevention and early intervention.
The work delivers on the NHS Shetland corporate objective: To improve and protect the health of the people of Shetland;

and the Single Outcome Agreement priorities of Living Longer Healthier Lives and Tackling Inequalities.

Key Issues:

On healthy eating:

- Understand key messages for healthy eating and help us to promote these as healthy goals for everyone in Shetland:
  - Eat at least 5 portions of fruit and vegetables each day
  - Eat more fibre
  - Eat less salt
  - Eat less sugar
  - Cut down on unhealthy (saturated) fats;
- Lead by example in eating healthily as individuals and with our families;
- Make policy decisions to make healthy eating choices easier for people to take;
- Directly tackle the inequalities that exist in Shetland in people's access to healthy food, which includes working with partners locally to stop food poverty in Shetland, and working with government to change policies that cause or contribute to food poverty in Scotland.

On progress towards the 10 year plan:

- Progress on tackling risk factors depends on focussing available resources on the most effective interventions at individual, community and policy levels.
- Decisions on 'invest to save' and the resources invested in improvement activity will have an impact on the progress we make towards our longer term goals and 'changing the world'.

Implications :	
Service Users, Patients and Communities:	The public health programmes on Healthy Eating specifically, and on other risk factors and general inequalities, are designed to impact positively on the health of Shetland's people including service users.
Human Resources and Organisational Development:	Health improvement in the workplace is supported through Healthy Eating Policies (NHS Shetland) and Healthy Workplace programmes.
Equality, Diversity and Human Rights:	Inequalities and actions to tackle them are described in terms of food poverty and vulnerable groups specifically, and the wider public health work on tackling Inequalities in general. An Equalities Impact Assessment is not required.
Partnership Working	Links to action on healthy eating, tackling inequalities and 'invest to save' through prevention and early intervention, can only be achieved in partnership and by Community Planning partners in their own organisations.
Legal:	There is potential for legislation to have an impact on healthier eating at a national level. Current work is done within existing legislation.
Finance:	Work on public health and health improvement including healthy eating is done within existing resources. However, savings plans to meet financial targets for 2016/17 and beyond will reduce staffing levels in the Public Health team, and the team will need to redesign and refocus its priorities to minimise the impact on achieving long term outcomes.

Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	Risks to delivery are included within the Shetland NHS Board risk register. They relate to available resources and the fragility and sustainability of the small specialist team in Public Health. These are mitigated by partnership working and the successful engagement of the wider workforce and partners in delivering health improvement programmes. As the Integration Joint Board develops its own understanding of risk, some of the risks to delivery through integrated services may be included in the IJB Risk Register.

Policy and Delegated Authority:	A range of health improvement activity is delivered through services that sit within the delegated authority of the IJB. Though Public Health sits out with Integrated Services, it relies on partnership for delivery of improvement outcomes.	
Previously considered by:	Shetland NHS Board	8 October 2015

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Shetland Islands Council

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Public Health Annual Report 2015
Reference Number:	CC-52-15 F
Author / Job Title:	Dr Sarah Taylor, Director of Public Health

1. Introduction

1.1 Each year the Director of Public Health (DPH) produces a Public Health Annual Report, which is designed to raise awareness about the public's health and action to improve the health of the people of Shetland. This year we are presenting the Public Health Annual Report to the Integration Joint Board (the IJB) to bring public health to the forefront of IJB thinking.

2. Background

2.1 The IJB's responsibilities focus on improving health and wellbeing outcomes for the people of Shetland, as set out in the Public Bodies (Joint Working) (Scotland) Act 2014 and the National Health and Wellbeing Outcomes. This sits well with the aims of public health: described as that branch of medicine which is concerned with improving the health of the population, rather than treating diseases of individual patients.

2.2 Over the years Public Health Annual Reports in Shetland have aimed to add to our local knowledge and understanding of the health of the people of Shetland, and we have focussed on a range of themes: inequalities that affect people living in Shetland; looking more widely at information and information systems, to show in more depth some of the data and statistics that we use to 'measure' health and ill-health; making the economic case for investing in prevention.

3. The Ten Year Plan

3.1 During 2011/12 the Public Health Department decided that the time had come for a change. We could carry on doing the things we have traditionally done, making slow but steady progress, or we could be more ambitious, set our sights higher, do things differently. We set down these thoughts in our Ten Year Plan: Changing the World: What can we achieve to improve health in Shetland? How much should we invest? Where should we focus our effort? Are there different approaches that we should take?

3.2 We wanted to set out a bold and radical vision for the future of Shetland in which people live longer, in good health, and where everyone contributes to the communities that they live in. Our strategy looked longer term, to be more ambitious, to think more holistically about health, to make better use of the resources we have: through being more efficient, building our knowledge and experience of what works, and having a bigger impact in what we do. We wanted to move beyond just focusing on specific “unhealthy“ behaviours, to take a more positive approach to improving our health both personally and as a community.

3.3 So we summarised the case for investing in health improvement, with evidence for savings to be made on health (and other) services through the prevention of ill-health. We set out the current context of non-sustainable public sector services, and reducing budgets. We developed the theme of 'doing things differently' through early intervention, asset based approaches, developing resilience at personal and community levels, with an emphasis on tackling inequalities - not widening the gap.

3.4 In 2013 we picked up the theme of localities and communities, all very relevant to the business of Health and Social Care Integration.

3.5 Since then, we decided to focus on the big challenges that we still face in public health – the topics that we are not yet succeeding in tackling, the areas where we particularly need to do things differently if we are to change our own health and the health of future generations. In 2014 we looked at physical activity (motivated by the Commonwealth Games and the Queen’s Baton Relay), and this year we have looked at Food and Health.

4. Food and Health

4.1 Along with physical activity (the theme of last year’s report), alcohol and tobacco, our eating habits are a major factor in our wellbeing, and in the development, or prevention, of health problems.

4.2 Food and diet are complex issues. We know that what we eat affects our health: too much of some foods, or too little of others. We have to eat to survive, but there are lots of different factors that influence what foods we choose to eat. In fact sometimes there may be no choice. For many people, the availability and cost of food severely limits what they can and can't eat. For others, medical conditions such as life threatening allergies dictate what they can and can't eat. We are all also influenced by our own culture and traditions, lifelong habits and beliefs about food and diet.

4.3 Tackling diet-related health issues needs action on numerous levels. Accurate and relevant information that can help us make healthy choices is a starting point. However, the amount of information that there is available to us about diet and nutrition can be daunting and confusing. The public health profession strives to give people sound advice based on scientific evidence. But this is often distorted, confused, or dismissed by the media, the food industry and pressure groups who want to challenge the evidence or are pursuing their own agenda.

4.4 Information is not enough: as well as knowledge, we need the skills to be able to put it into practice. And we need an environment that supports healthy choices. This can and must be achieved through national policy and legislation; and local support and action; on issues such as farming and land use, food production, the role of retailers, public services and the voluntary sector.

4.5 Efforts to improve diet can also have other positive impacts at a community or population level; for example encouraging individuals and communities to 'grow your own' has the potential to support carbon reduction, improve community cohesiveness, increase physical activity, help develop skills and tackle inequalities.

4.6 In this report we explain the links to the major preventable diseases: heart disease and diabetes in particular; and to the rising problem of obesity – the next major public health epidemic that we need to address. We include information to dispel common myths around food allergies and intolerances, diet fads, food labelling. We explore the links between 'food and mood' (food and wellbeing), and some of the ways in which we can take control ourselves over what we eat and how we eat, to improve our own health. We describe how poverty has a real impact on what people can afford to eat, here in Shetland, and how this impacts on their health and wellbeing. We also describe some of the innovative work being done locally to work with individuals and communities who are particularly vulnerable.

5. Progress: Public Health and Health Improvement Activity and Headlines from the 10 Year Plan

5.1 In addition to our main theme, we have taken this opportunity to report on the work of the public health department (Appendix 1 to the main report). We thought it would be helpful to publish a report of activity to describe the range of work that takes place under the headings of public health and health improvement. We report annually on targets, but it can be useful to see the breadth and scope of the work that happens in support of the targets.

5.2 We also specifically wanted to present an update on the three main priorities within the Ten Year Plan, obesity, smoking and alcohol, (Appendix 2) since progress against these marks our progress towards a healthy Shetland. We want it to show the 'pay off' from our 'Invest to Save' programme, how far we have come, and how much further we have to go.

6. Recommendations

6.1 The purpose of producing the Public Health Annual Report is to influence those who themselves influence both local services and local communities. So it is fitting to present the Report to the Integration Joint Board to enlist their support in taking action to improve the public health of Shetland.

6.2 The IJB is therefore asked to:

6.2.1 receive the Public Health Annual Report;

6.2.2 support efforts to improve the public health in Shetland through the promotion of healthy eating;

6.2.3 support public health work on 'investing to save' to reduce long term morbidity and mortality, and to reduce inequalities in Shetland.

7. Conclusions

7.1 Shetland has a high quality of life and good health for many of us. All the more reason to take action to tackle the preventable ill health that exists, to aim for a Shetland that is properly healthy, and health promoting for all of us. We know who we are trying to reach, we can put numbers on how many of us need to change what we eat, how much more physically active we need to be, how many substances we need to stop abusing our bodies with. And what the pay off would be in terms of less illness, fewer early deaths, less spend in services, and more positive health and wellbeing. This report aims to help us focus on what will make a difference, and what more we need to do to achieve our vision

of health for the people of Shetland.

For further information please contact:
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2 November 2015

Appendices:
Public Health Annual Report 2015 http://www.shb.scot.nhs.uk/board/publichealth/phars.asp

References:
http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20th November 2015
Report Title:	Joint Strategic Commissioning Plan 2016-2019 Cover Paper
Reference Number:	CC-49-15 F
Author / Job Title:	Dr Sarah Taylor, Director of Public Health

Decisions / Action required:

The Integration Joint Board is asked to comment on the draft Joint Strategic Commissioning Plan for 2016 - 2019.

High Level Summary:

The Joint Strategic Commissioning Plan (referred to as the Strategic Plan) for 2016-19 is now at a draft stage for consultation. It sets out plans for how resources are to be delivered through integrated services; how services will contribute to improving people's lives, health and wellbeing; and plans for change to improve the health and wellbeing of people in Shetland, as measured through national and local outcomes.

It is structured around the client groups / services that are included within the delegated authority of the new Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

Each section includes drivers for change, decisions about disinvesting in current services in order to reinvest in improvement or in other services, and supports that are required to meet on-going and changing demand. It specifies key actions and priorities for the present year.

Corporate Priorities and Strategic Aims:

The Plan supports delivery of the following outcomes in the Shetland's Single Outcome Agreement (SOA):
"We have tackled 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.";
"People are supported to be active and independent throughout adulthood and in older age"; and "We live longer healthier lives".

The Plan sets out how the Integration Joint Board and integrated services will deliver on the National Health and Wellbeing Outcomes (as detailed in the Strategic Plan).

Key Issues:
The Strategic Plan has been developed since the previous plan to focus more on plans for change and on achieving specific outcomes. Additional work on strategic needs assessment in some areas is informing specific sections such as Primary Care. There are still some sections that need further work before the Plan is finalised, with the intention of producing a more standardised format across the sections, but the consultation draft represents plans submitted at the date of circulation. Further development work has been done on some of the arrangements for carrying out the integration functions which is included in the Plan, specifically on Locality Planning. Further work is underway to include before the Plan is finalised, particularly on budget setting at locality level. Consultation on the draft plan will now be undertaken in line with the IJB's Participation and Engagement Strategy, through the Strategic Planning Group mechanism once agreed by the IJB, and publicly through publication on the Integration web-site. Comments and feedback will be incorporated into a final version to be agreed by the IJB at a future meeting.

Implications :	
Service Users, Patients and Communities:	The Strategic Plan is intended to bring about improvements in the health and wellbeing of service users and the Shetland community. It is also written to describe service change and should detail any expected impacts on users. Any significant service change would need a separate process for public and user engagement in line with NHS, SIC and IJB policies.
Human Resources and Organisational Development:	Service change may potentially have an impact on staff, and should be planned and delivered in partnership with staff and through due process. Headline workforce change should be signalled in individual service sections.
Equality, Diversity and Human Rights:	Some sections of the plan deal specifically with some services and client groups relevant to the equality legislation. No equalities issues have been identified to date. An Equality Impact Assessment will be completed before the Plan is finalised.
Partnership Working	The Plan is written to deliver partnership working across Integrated Services. A range of services and activities in the Plan also support and rely on wider partnership working particularly with third sector partners.
Legal:	The Plan is developed to comply with the requirements of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014, and associated guidance.
Finance:	The Plan describes services commissioned to be delivered within the budgets delegated to the IJB from SIC and NHS Shetland.

Assets and Property:	There are no implications identified to date for major assets and property i.e. buildings and equipment.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	The IJB has agreed a Risk Management Strategy and Risk Register which should include risks associated with the delivery of the Strategic Plan. Key risks relate to failure to deliver service change including the achievement of recurring savings within some services.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015. Once it has approved a Strategic Plan it assumes responsibility for the functions delegated to it by the Council and the Health Board, which includes approval of future Joint Strategic Commissioning Plans.	
Previously considered by:	This is the first consideration of the draft Strategic Plan for 2016/17.	

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Shetland Islands Council

Meeting:	Integration Joint Board
Date:	20th November 2015
Report Title:	Joint Strategic Commissioning Plan 2016-2019
Reference Number:	CC-49-15 F
Author / Job Title:	Dr Sarah Taylor, Director of Public Health and Planning

1. Introduction

1.1 This report presents the draft Joint Strategic Commissioning Plan for 2016/19 to the Integration Joint Board (IJB). The draft Joint Strategic Commissioning Plan (known as the Strategic Plan) is attached at Appendix 1.

2. Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint bodies (in Shetland the Integration Joint Board) to create a Strategic Plan for the integrated functions and budgets that they control. The Strategic Plan for 2015/16 was presented to the IJB for approval earlier in this meeting, and once adopted, the IJB assumes responsibility for the functions delegated to it by the Council and the Health Board including future strategic commissioning.

2.2 The Shetland Joint Strategic (Commissioning) Plan for 2016/19 builds on the previous plan, but has been amended in format and content to take account of feedback and also to present the development work that has been done during the first few months of operation of the IJB, in developing a more outcomes-focussed approach to strategic commissioning and service planning, in joint budget setting and locality planning.

3. The Plan

3.1 The Strategic Plan is structured around the client groups / services that are included within the delegated authority of the new Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

3.2 Each section is designed to include a brief outline of relevant policy context and current services, funding and resources including savings targets and workforce implications, drivers for change, needs and unmet needs, plans for change linked to expected outcomes and key risks to delivery.

3.3 The Plan should be informed by local strategies and strategic needs assessment work undertaken.

3.4 The Plan is also required to set out the arrangements for carrying out the integration functions in Shetland over the period of the plan, and will include more detail on some of these areas where development work has been done or is being planned:

3.5 The arrangements for each locality established for locality planning purposes: the IJB has 7 localities for strategic planning purposes, detailed in Appendix 1 to the Plan. During 2015/16 a round of meetings has been held across localities to inform the development of joint commissioning at locality level, and feedback from this engagement has been given to service managers to take account of in writing their plans. Locality issues will be considered by the Strategic Planning Group when it considers the draft Plan, and a summary will be included in the final Plan.

3.6 The operation of the Strategic Planning Group for the purposes of preparing the strategic commissioning plan: during 2015 a shadow Strategic Planning Group was established for the purposes of preparing the strategic commissioning plan, and the Integration Joint Board is being asked to approve the establishment of a substantive Strategic Planning Group to take forward preparation of future plans. This, and the process for Strategic Commissioning to support development of future plans as detailed in a separate report to the IJB, will be used in the finalisation of the Strategic Plan for 2016-17 and appended to the Plan.

3.7 The date on which functions are delegated will be determined by the adoption of a Strategic Plan by the IJB and will be included in the final publication of that Strategic Plan on the Shetland Integration web-site.

3.8 Further development work to be included in the Joint Strategic Commissioning Plan for 2016-19:

- The current CHCP Procurement Strategy will be replaced by an updated Joint Commissioning and Procurement Strategy with the ambition of providing one strategy that will be adopted by the Council, NHS Shetland and Shetland's Integration Joint Board for health and social care.

- An agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions, will be developed, building on an update of the NHS Board's Decision Making Policy and current best practice in both NHS Shetland and Shetland Islands Council.

- A Market Facilitation Plan will be developed in line with national guidance and relevant to the Shetland context.

3.9 The Plan includes headline figures on service budgets, which are aligned with the budgets being used for budget setting for 2016/17.

4. Performance monitoring

4.1 Once adopted, the IJB will monitor progress against the plan through its performance monitoring systems.

5. Recommendation

5.1 The Integration Joint Board is asked to comment on the draft Joint Strategic Commissioning Plan for 2016 -2019.

6. Conclusions

6.1 This is the first presentation of the draft Joint Strategic Commissioning Plan for 2016/19 for comment. Further consultation will be undertaken with the public, professional groups, staff and other stakeholders through the mechanisms of the Strategic Planning Group, before being re-presented to the IJB for approval at a future meeting.

For further information please contact:
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30 October 2015

Appendices:
Appendix 1 - The Draft Joint Strategic Commissioning Plan 2016-19

Background Documents:

Strategic Commissioning Plans Guidance issued by Scottish Government
http://www.gov.scot/Resource/0046/00466819.pdf

NHS SHETLAND

SHETLAND ISLANDS COUNCIL

Draft Joint Strategic (Commissioning) Plan 2016-19

Version 3 - November 2015

Introduction

The Joint Strategic (Commissioning) Plan for 2016/19 is developed jointly in partnership with stakeholders, for adoption by the Integration Body. It is compliant with Strategic Commissioning Plans Guidance issued by Scottish Government:
http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

It is structured around the client groups / services that are included within the delegated authority of the Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

The strategic commissioning plan takes account of other local policy directions as outlined in the Shetland Single Outcome Agreement, Shetland NHS Local Delivery Plan, Shetland Islands Council Housing Strategy, Shetland Community Plan and other local corporate plans.

The Strategic Commissioning Plan is intended to describe how people's lives, health and wellbeing will be improved. This will include decisions about disinvesting in current services in order to reinvest in other services, and redesign of services to meet on-going and changing demand.

In addition, we expect the Joint Strategic (Commissioning) Plan to increasingly reflect the developing engagement with stakeholders and local communities in Shetland, through Locality Planning and links to Community Planning, professional involvement and user and carer fora (through strategic planning on older people and primary care strategy development etc). The Integration Body's Communication and Engagement Plan sets out more detail of how we will do this.

Guidance sets out the need for Joint Strategic Needs Assessments (JSNAs) to inform the development of the Strategic Plan through the analysis of the needs of local populations. These Needs Assessments will also inform and guide the commissioning of health, wellbeing and social care services. In Shetland the specific strategies that have informed the Strategic Plan (on Carers, Mental Health, Older People, Dementia and Primary Care) include Joint Strategic Needs Assessments, as well as Locality Profiling to inform Locality Planning, and components of Needs Assessments have been included in Service Plans. Again, this will be an area of development in future iterations of the Strategic Plan, taking into account the NHS National Services Scotland (NSS) linked longitudinal health and social care datasets as they become available.
A further area for future development is on performance monitoring, and developing the key performance indicators already in place to show progress towards meeting the national health and wellbeing outcome indicators.

The views and priorities of localities must be taken into account in the development of the Strategic Plan, which means we need to develop localities in Shetland to the point where localities can plan for how the Integration Authority's resources are to be spent on their local population, and the strategic plan should then consolidate plans agreed in localities.

During 2016/17 we will produce locality plans for Shetland to inform the first year update of this Strategic Commissioning Plan. Each locality plan should include:

- A list of all the services under the management of the Integration Authority of which the locality is a part;
- A note of priorities for each locality under each of the service headings; and

- Planned expenditure under each service heading, using locality budgets.

Financial analysis of service delivery and change will also be developed over the coming year to support analytical processes such as programme budgeting / marginal analysis, and budgeting for locality plans to show how the Integration Authority's resources are currently used by the locality population. In future this historic share should be set alongside a "fair" share target, based on locality populations weighted to take account of population need and any factors relating to provision of service in the area.

Framework for the Shetland Joint Strategic Commissioning Plan

Principles

The integration **delivery principles** are:

- that the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users,
- that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:
    - is integrated from the point of view of service-users
    - takes account of the particular needs of different service-users
    - takes account of the particular needs of service-users in different parts of the area in which the service is being provided
    - takes account of the particular characteristics and circumstances of different service-users
    - respects the rights of service-users
    - takes account of the dignity of service-users
    - takes account of the participation by service-users in the community in which service-users live
    - protects and improves the safety of service-users
    - improves the quality of the service
    - is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
    - best anticipates needs and prevents them arising
    - makes the best use of the available facilities, people and other resources

The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.

Integration is designed to bring about fundamental change in the way we deliver services, in order to achieve these outcomes, for instance in shifting the balance of care from institutions to the community, e.g. reducing unplanned hospital admission rates and addressing delayed discharges.

National health and wellbeing outcomes
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

The Plan is written to identify the resources that are being used to help address these challenges, and sets out how service provision will shift over time to support anticipatory and preventative care.

Separate sections of the plan focus on particular sections of the population such as older people and adults with a physical disability, and on specific delegated services such as primary care, mental health services and criminal justice.

The Strategic Plan also sets out the arrangements for carrying out the integration functions in Shetland over the period of the plan including:

- The arrangements for each locality established for locality planning purposes – Appendix 1: Shetland Localities, and Locality Planning process detail included in the briefing on Strategic Planning for Health & Social Care Integration – web-link.
- The operation of the Strategic Planning Group for the purposes of preparing the strategic commissioning plan – see separate paper to IJB – to be added as a web-link subject to agreement by the IJB.
- The date on which functions are to be delegated (to be added, subject to adoption of the 2015/16 plan by the IJB).
- The current CHCP Procurement Strategy will be replaced by an updated Joint Commissioning and Procurement Strategy with the ambition of providing one strategy that will be adopted by the Council, NHS Shetland and Shetland's Integration Joint Board for health and social care.

Work will be done during 2016/17 to develop an agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions; and to develop a Market Facilitation Plan in line with national guidance as relevant to the Shetland context.

Health & Social Care Integration Plans

Mental Health Service Plan

Policy context

The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in October 2005. The Act contained much more than simply legislation for new forms of compulsory powers and safeguards. Its underpinning principles heralded a new era of rights-based care for people who use mental health services. As well as providing care and treatment, services are now required to promote social inclusion and a wider citizenship agenda.

A number of policy documents have shaped the development of local mental health services: Delivering for Mental Health (2006) set out national policy for the development of Mental Health services and the improvement of mental health in Scotland. This was followed by Better Health Better Care (2007) which established additional improvement objectives and National Targets/Standards. In 2009, Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 outlined the roles and responsibilities of government, local public agencies and third partner agencies in promoting positive mental health.

In August 2012, the Scottish Government published a Mental Health Strategy for Scotland with a renewed emphasis on "prevention, anticipation and supported self management". This focus is central to mental health policy in Scotland and the strategy emphasises a range of improvements and interventions that are in accordance with the best evidence for return against investment over time. The strategy focuses on actions that people can take for themselves and with their communities to maintain and improve their own mental health.

Other strategies closely associated with the 2012 strategy for the delivery of mental health services are Suicide Prevention, Dementia and Substance Misuse.

An updated Mental Health Strategy for Shetland, written in accordance with Scottish Government priorities was agreed by Shetland Islands Council and NHS Shetland in May 2014. The over arching aim of the Shetland Mental Health strategy is to have a single plan that will deliver comprehensive mental health services; use available resources to deliver services in the most effective way and avoid harmful gaps and wasteful overlaps. This will involve health, social care, housing, education, and employment, voluntary and other agencies working jointly in the provision of complementary services across the whole spectrum of mental health support and treatment.

The vision of a 21st century mental health service for the people of Shetland is build upon the principle of person centred partnership with patients, carers and staff. This principle will be at the heart of our service change and improvement initiatives.

Current Services

Adult Mental Health services became part of the Community Health and Social Care Directorate following the decision by the Council and Health Board to jointly appoint a director of Community health and Social Care in February 2014. This was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

The Service comprises a number of regulatory and front-line services and has specific responsibilities in respect of *The Mental Health (Care and Treatment) (Scotland) Act 2003* and associated legislation and policy.

Current Mental Health provision encompasses a range of responsibilities and services, all of which can be accessed via a GP by means of an Electronic Single Point of Referral. Our aim is to deliver safe and effective care, with people being seen by the right clinician at the right time.

The Mental Health Service is led by the Service Manager with the support of a 7 person operational team composed of a Clinical Director, 5 Clinical Leads and a Social Care Manager. The seven operational services that make up Shetland's Mental Health Service are:

- Community Psychiatry Services (CPS)
- Community Psychiatric Nursing Service (CPNS)
- Psychological Therapies Service (PTS)
- Substance Misuse and Recovery Service (SMRS)
- Dementia Service (DS)
- Community Mental Health Support Service (CMHSS)

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Mental Health				2,743,300	

Needs/Unmet needs/Drivers for change

Needs

Insert relevant demographics from the Shetland Mental Health Strategy and details of any needs assessment undertaken.

Unmet Needs

The 2014 Mental Health Review highlighted a number of unmet needs and service development requirements including; improving access to evidence based psychological therapies and Clinical/Counselling Psychology, support for Adults with ASD, increased availability of OOH psychiatric emergency services and improvements to the facilities available to support those experiencing a psychiatric emergency.

Drivers for Change

The key drivers of service change and redesign are the Scottish Patient Safety Program for Mental Health, improved support for Carers, a new emphasis on the importance of Personal Outcomes and growing public pressure for mental health services to match the provision and responsiveness of physical care services. The recent Scottish Government "Responding to Distress" initiative and the associated Distress Brief Intervention (DBI) proposal requires frontline healthcare staff to undertake assessment and signposting of those presenting in distress and, where appropriate, ensure they receive further contact within 24 hours for community problem solving and support for a period of up to 14 days.

Plans for change

The changes required to redesign services and address gaps in provision are identified, monitored and reviewed via a number of strategy specific Action Plans (e.g. Mental Health, Dementia, Substance Misuse). The headline objectives are as follows:

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Improve local access to evidence based psychological therapies	David Morgan	Ongoing	Outcomes 3, 4 & 5
Establish a local Clinical/Counselling Psychology service	David Morgan	April 2016	Outcomes 3, 4 & 5
Develop local capacity to diagnose and support adult ASD	David Morgan	April 2016	Outcomes 1, 3, 4 & 5
Extend the availability of the Out of Hours response to psychiatric emergencies	David Morgan	Ongoing	Outcomes 3 & 7
Provide a purpose built room for the management of psychiatric emergencies	Lawson Bissett	June 2016	Outcomes 3 & 7
Improve support for people who present in distress (DBI Initiative)	David Morgan	September 2016	Outcomes 2, 3, 4 & 7
Establish a person centred Consultation & Engagement Framework (inc Website)	David Morgan	Ongoing	Outcomes 1, 8 & 9

Key Risks to Delivery

There is a national increase in the demand for, and public expectation of, mental health services. Mainland services are meeting these demands by enhancing community provision and resourcing this change in focus by disinvesting in inpatient facilities. The local service needs additional resource to develop services that meet current standards and expectations and ensure that those services are safe and sustainable. There are significant risks to delivery of the above objectives in the current financial environment. These risks will be managed by the strategic allocation of available resources and partnership working with patients, carers and staff to redesign services to achieve maximum efficiency and effectiveness.

Performance Targets with links to National Outcomes

18 Weeks RTT for Psychological Therapies
Substance Misuse HEAT Target
Dementia Standard.

Insert performance references (e.g. A12 etc)

Contact Details

Service Manager - Mental Health
Mental Health Manager
Montfield – Upper Floor
Burgh Road
Lerwick
ZE1 0LA
(01595) 743697
david.morgan3@nhs.net

Further Reading

Needs developed with references – to include key documents for each topic referenced above: e.g.

Mental health Act
"The Matrix" (NES)
Dementia Strategy
SMRS
Responding to Distress
Etc.

Substance Misuse Service Plan

Policy context

External and national drivers for taking a new approach to substance misuse include:

There are a number of national strategic plans for both alcohol and drugs which underpin the aims of the Shetland Alcohol and Drug 2011 – 2015 strategy;

- Changing Scotland's Relationship with Alcohol a framework for action (2009) Scottish Government,
- The Road to Recovery' (2008) Scottish Government
- Essential Care'(2008) Scottish Government
- Quality Alcohol Treatment and Support Report (2011) Scottish Government
- Review of Opioid Replacement Therapy'(2013) Scottish Government
- Quality Principles' for alcohol and drug services (2013) Scottish Government
- Outcomes Framework for Problem Drug Use

The clear focus is on ensuring that services and interventions delivered are of high quality, are effective and cost effective, and focus on supporting people in recovering from substance misuse.

Substance Misuse impacts on individuals, families and communities. A number of local service providers exist to offer treatment and support to both individuals with their own issues and people who are affected by others misuse.

In Shetland, Alcohol and Drug Services are commissioned through Shetland Alcohol and Drug Partnership (SADP). SADP is a multi agency strategic partnership that meets bi-monthly to oversee the design and development of services.

In addition to SADP the Shetland Alcohol and Drug Forum, a multi agency operational group, also meets bi-monthly. Its aim is to provide SADP with information on operational issues and assist with the planning process.

Current Services

In recent years the main services in Shetland providing help and support to a) people with their own substance misuse issues and b) people affected by those who are misusing substances, have been delivered by three distinct agencies; namely NHS Shetland, Shetland Islands Council and Community Alcohol and Drug Services Shetland (CADSS). The new Substance Misuse and Recovery Service is part of the Community Health and Social Care directorate and started operating in April 2015.

There are a range of services in Shetland that provide help and support to people with their own substance misuse issues or have been affected by another person's substance misuse. Historically, these services have been delivered by a number of providers including NHS Shetland and Shetland Islands Council.

NHS Shetland provides specialist treatment and support through a Substance Misuse Service (Prescribing Clinic) and a Dual Diagnosis service. The Substance Misuse Service offers medicated detox for both alcohol and drugs. The Dual Diagnosis service currently offers support for clients with both alcohol and mental health issues.

These services are provided by:

- Medical Prescriber (Consultant Psychiatrist)
- GP with Specialist Interest (GPwSI)
- Substance Misuse Nurses
- Substance Misuse Support Workers

Referrals to the service are via GP. In addition to the above, Generic treatment and support for people experiencing difficulties with their use of alcohol and drugs can be accessed through A&E, the Mental Health Department and GP surgeries.

Shetland Islands Council employs a Specialist Substance Misuse Social Worker who provides support for people who are not currently accessing treatment or support for their substance misuse. This post holder also undertakes work to support access to residential rehabilitation services on the basis of the person's assessed needs. In addition, the Local Authority Criminal Justice service works in partnership with CADSS to provide support for those subject to Drug Treatment and Testing Orders (DTTOs) imposed by the Courts.

The statutory services also work in partnership with the following local Voluntary Sector services:

- CADSS who provide early intervention, treatment, support and aftercare of those who misuse drugs and alcohol; young person's services including input into the Schools programme; working both with individuals who have substance misuse issues and those who are affected by others misuse. Their adult services focus on the psychosocial aspects of substance misuse and work very closely with the Substance Misuse Social Worker. The CADDS Aftercare Service supports clients with alternative ways of spending leisure time and avoiding relapses.
- SCBP (Shetland Community Bike Project) is an employment based project where all clients must be substance free to participate. A programme of approximately 6 months in length is developed with each individual with the ultimate outcome being further employment. SCBP has a 60% success rate with securing future employment for its participants.
- DAD (Dogs Against Drugs) is a small charitable organisation that is involved in early intervention and enforcement. DAD is involved in the input to the Schools programme. It also works closely with Northern Constabulary on the detection of illegal substances in Shetland.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Substance Misuse				650,944	

Needs/Unmet needs/Drivers for change

The review of Tier 3 Substance Misuse services has been undertaken over the last two years. SADP is now reviewing Tier 1 and 2 services to ensure the same level of effectiveness and cost-effectiveness. A Service Users Group is involved in helping us to understand the needs of

service users, and we continue to develop better ways of collecting, understanding and using the data that is available to us to inform the development of services.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Review of Tier 1 and 2 substance misuse services	Alcohol and Drug Development Officer	October 2015	Links to National Outcomes 1.Improving Health & Wellbeing 5.Reducing health inequalities 7. Safe from harm 9. Resource used efficiently

Key Risks to Delivery
Workforce/capacity issues mean that other professional staff don't have the time they would like in order to undertake preventative work.
The main risk is the requirement to achieve savings, which makes it harder to 'invest to save' in the way that we would like to do. We are addressing this through the use of volunteers, where at all possible, and think of ways to maximise the contributions of staff that we do have.

Performance Targets with links to National Outcomes

The Core Outcomes for Alcohol and Drug Partnerships in Shetland can be found here: http://www.gov.scot/Resource/0039/00394539.pdf

a. Shetland Alcohol and Drug Partnership Strategy Outcomes are to:

- Reduce prevalence of alcohol and drug use in adults by 5% by 2020, through early intervention and prevention;
- Reduce alcohol and drugs related harm to children and young people;
- Improve recovery outcomes for Service Users;
- Reduce drug and/or alcohol/suicide related deaths to 2 or less a year by 2020

b. Single Outcome objectives under Outcome B: We live longer healthier lives

- To reduce alcohol consumption as a key risk factor for poor health outcomes; specifically focusing on the most vulnerable and disadvantaged individuals and communities.

c. Public Health Ten Year Plan Targets:

- To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s). The table illustrates Scotland-wide compared to Shetland rates of premature mortality.
- To reduce the number of alcohol related admissions (discharges) from a baseline of 761/100,000 discharges in 2009/10 to a target of 500 / 100,000 discharges by 2014/15, and 300/100,000 by 2021/22. (This target is based on the best performing Boards in Scotland)

Contact Details

Substance Misuse Recovery Service
Lerwick Health Centre
South Road
Lerwick
Shetland, ZE1 0TB
Tel: 01595 743006

Further Reading

- Shetland Alcohol and Drug Partnership Strategy 2016-2020
- Public Health Ten Year Strategy 'Changing the World' (2012-2022)
- Outcomes Framework for Problem Drug Use, October 2014, NHS Health Scotland
- CEL 01 (2012) Health Promoting Health Service

Oral Health

Policy context

The Scottish Government expects the overwhelming majority of primary dental care to be provided through independent NHS dental practices, with a Public Dental Service (PDS) meeting any shortfall in provision. A range of specialist dental services is expected to be available to provide treatment that is deemed beyond what would be expected of a primary care dentist, or is not suitable to be provided within a primary care setting.

According to the Scottish Government the remit of the Public Dental Service, is to:

- provide care for people with special needs, including people who would have difficulties accessing general dental practices
- complement the current General Dental Service and specialist services, especially in remote and rural areas
- have a public health role, and oral health promotion targeted both at populations and individuals
- assess and treat people referred for specialised and specialist services, including the use of sedation and general anaesthesia.

Current Services

For the last five years Shetland has had no local independent NHS dental practices, and the PDS has been providing primary dental care to the whole population in addition to its more targeted/ specialist remits.
A new independent NHS dental practice is expecting to open in Lerwick during 2015/16 with the capacity to register up to 6000 people for NHS primary dental care.
Despite this development the PDS will continue to provide:

Planned Care - Routine clinical primary care dental services for people who are registered with the PDS for dental care. Even with a new NHS dental practice due to open in 2015/16, Planned Care will continue to be a major part of current PDS services. Even if several more NHS dental practices were to open, the PDS would continue to provide its remit of planned care for people with special/additional needs.

Unscheduled Care - Emergency clinical primary care dental services for the whole population, irrespective of whether they are registered with a local dental service or not

Children Services - The dental input required for Childsmile and the National Dental Inspection Programme, as well as routine clinical dental care for children registered with the PDS

Older People - Providing Dental Screening and oral health promotion in Care Homes, as well as routine dental care for older people, in clinics and in homely settings

Visiting Consultants from NHS Grampian provide Specialist oral health care services for the whole population – for orthodontics and oral & maxillo-facial surgery in particular.

The Oral Health Promotion team provides a range of dental public health activities for the whole population, including Childsmile activities in clinics, schools, and other community settings and provides Oral Health education to groups and individuals

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Oral Health				3,382,294	

Needs/Unmet needs/Drivers for change

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan	CADO	First d raft published 10/2015	Outcomes 1 - 9
Encourage independent NHS dental practices to open in Shetland	CADO	Ongoing	Outcomes 1, 3, 4, 5, 6, 7, 8, & 9
Develop referral protocols for use by local dental practices	CADO	11/2015	Outcomes 1, 3, 4, 5, 8 & 9
Review local oral health care for people with Special/ additional needs	CADO	4/2016	Outcomes 1-9
Review local availability of specialist oral health care	CADO	4/2016	Outcomes 1-9
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs	CADO	4/2016	Outcomes 1, 3, 4, 5, 8 & 9

Key Risks to Delivery

Risks	Mitigation
The shortfall in primary dental care capacity – both the infrastructure (dental surgeries) and the staff - dentists/ other dental care professionals.	The national Scottish Dental Access Initiative is focused to encourage independent NHS dental practices to open in Shetland.
The geographical isolation of remote, rural and island communities, challenges the cost-efficient provision of oral health care.	
The increasing number of elderly people requiring domiciliary visits for high-maintenance dental care of their own teeth.	By increasing oral health promotion targeted at adults, to improve the oral health of the population prior to people becoming frail.
The ability to recruit suitably experienced dentists to build sustainable, long-term dental services for Shetland residents.	By building/using managed clinical networks in North of Scotland, to provide specialist clinical leadership and reduce clinical isolation.
The difficulty in providing post-graduate training opportunities for existing dentists, coupled by a lack of resources for post-qualification opportunities for other Dental Care Professionals	

Performance Targets with links to National Outcomes

Performance Measure	**Outcomes**
Decay experience of children in P1: The mean DMFT (decayed, missing or filled teeth per child) of children aged 5-6 years in P1 attending SIC primary schools	Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer
Number of people with access to Occasional NHS treatment who are waiting to register with PDS for Continuing Care	Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users
The percentage of the adult and child populations who are registered with Shetland dentists for NHS dental care	Outcome 5 - Health and social care services contribute to reducing health inequalities
The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland	Outcome 9 - Resources are used effectively in the provision of health and social care services, without waste

Contact Details

Montfield Clinic Burgh Road Lerwick ZE1 0LA Tel: 01595 743160	Dental Clinic St Olaf Street Lerwick ZE1 0ES Tel: 01595 745769	Dental Suite Gilbert Bain Hospital Lerwick ZE1 0TB Tel: 01595 743681	Dental Clinic Brae Health Centre Brae ZE2 9QJ Tel: 01806 522098	Dental Clinic Whalsay Health Centre Symbister Whalsay ZE2 9AE Tel: 01806 566469	Dental Clinic Yell Health Centre Mid Yell Yell ZE2 9BX Tel: 01957 702031

Pharmacy & Prescribing

Policy context

The Scottish Government document “Prescription for Excellence” builds on the Government’s 2020 Vision Route Map and Quality Strategy Ambitions. It recognises pharmacists as experts in the therapeutic use of medicines and highlights their potential contribution through integration into health and social care teams.

Over the next few years significant changes will occur in medicine and therapeutics. These changes necessitate the development of new and innovative models of care to enable patients to obtain the maximum benefit. Pharmacists will have a key role in this. Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and reduce the likelihood of adverse events.

These aspirations will result in clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners An early and key task in Shetland is the review of medicines to ensure that each medicine still provide benefit. This approach is detailed in the national strategy for polypharmacy.

The NHS continues to face increasing workforce pressures. The inclusion of NHS accredited clinical pharmacists into the primary care team is intended to increase the clinical capacity and assist in addressing the growing demands in primary care, particularly as our population in Shetland ages, and the complexity of their care increases.

Current Services

The department has been in place since 1998 it has steadily grown since then and for the first time in 2012 has sufficient staffing to provide a service rather than an input. The service is now within the Health and Social Care directorate following the decision by the council and Health Board to jointly appoint a director of Community health and Social Care in February 2014. The Pharmacy service is overseen by the Director of Pharmacy who has joint responsibility for NHS Orkney.

Pharmacy services

The pharmacy service is integrated both between Primary and Secondary Care and within Health and Social Care, and is adapting to a locality led service. People are at the heart of pharmacy services and Prescription for Excellence envisages patients linking and registering with a particular pharmacist who will support them in managing their medicines wherever they are, at home, in a care setting or in hospital. The developing service is being designed around the patient’s needs aspirations and views, and will enable the pharmacist with the patient to draw on help from specialist pharmacists when required. Community pharmacies will increasingly be used as a single point of access to health care.

The pharmacy service will prioritise the national health and wellbeing outcomes through ensuring that people are enabled able to look after and improve their own health and wellbeing and live in good health for longer, through providing better access and tailored support
Pharmacy services are particularly designed for people, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. With medicine management support and polypharmacy reviews being provided wherever people live. And when people use , in particular, social care services the aim is for those have positive experiences of those services, and have their dignity respected through supporting patients in taking their medicines through which are designed around the needs and wishes of patients in a way that preserves their involvement, choices and dignity.
Again, and in line with the national health and wellbeing outcomes the national patient safety programme is being implemented with the aim of ensuring that people being prescribed medicines within health and social care services are safe from harm. (national outcome 7) Part of this is around ensuring that people who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Ensuring that resources are used effectively and efficiently in the provision of health and social care services is both a national and local priority. (national Outcome 9)

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Pharmacy & Prescribing				6,500,724	

Needs/Unmet needs/Drivers for change

Recent reviews of the Out of Hours primary Care arrangement has identified roles for pharmacists identified in this plan. The need for pharmaceutical care is outlined in Prescription for Excellence. Local need is identified through referral, pharmaceutical care planning and data obtained through PIS and SPPARRA data. There are many patients in Shetland who require support in managing their medicines in their own homes. Of these there are a growing number of patients who require medicine (polypharmacy) reviews

Plans for change

Plans continue to develop the role of pharmacy in an incremental way as outlined in the pharmacy work plan; “creating pharmacy capacity” is required to ensure that Prescription for Excellence is delivered locally. Delivery of the plan will involve recruiting a sustainable workforce, this additional staffing commitment will ensure that polypharmacy work will increase, that the GP workforce will operate more efficiently,

Supporting Social Care Workers and patients in their own homes will help to reduce medicine waste, and supporting GP practices in improving repeat prescribing should also help too contain medicine cost. Both these interventions will also reduce the risk to patients of harm from there medicines.

In summary the plans for 2016-17 are to

- Recruit an additional 2-3 pharmacists/technicians to the workforce
- Increase the availability of support to patients in their own homes and in Care homes
- Increase the number of polypharmacy reviews by 20%
- Develop a training and support programme for Remote and Rural pharmacists

Key Risks to Delivery

Recruitment and retention of pharmacists is problematic, and to ensure a sustainable service a remote and rural fellowship is being developed which will encourage pharmacists to train and develop skills locally. Where clinicians are not engaged with the programme then this would also represent a risk to delivery.

Performance Targets with links to National Outcomes

Prescribing Performance reports are produced quarterly and the following Key Performance indicators are in place

Performance Measure	Current Performance 2015/16	Target 2016/17
Cost per patient (GP Prescribing) should be less than Scottish average i.e. less than 100% (national outcome 9)	116%	100%
Number of prescriptions for antibiotics per 1000 patient population should be less than the Scottish average i.e less than 100% (national outcome 7)	101%	95%
Number of polypharmacy reviews completed per month (national outcome 7)	30	40
Percentage of patients who's medicines are reconciled by a pharmacist within 72 hours of admission per month (national outcome 7)	77%	75%
Number of discharge prescriptions dispensed out of hours by nursing staff should be less than 50 per month (national outcome 7)	51	48

Contact Details

The pharmacy department can be contacted on 743370.
Director of Pharmacy is Chris Nicolson at christophernicolson@nhs.net

Further Reading

The pharmacy and prescribing services has pages on the internet.
National Polypharmacy guidance describes the national context for planned pharmacy work within the context of the national Pharmacy vision and work plan, Prescription for Excellence

Primary Care

Policy context

- Integration of health and social care and implementation of Health and Wellbeing Outcomes.
- Introduction of a new GP contract in April 2017
- Primary Care strategy (in progress)
- National Out of Hours review

Primary health care services will be required to adapt to meet the health care needs of an ageing population that has rising expectations of health care and treatments. Other factors that affect the development of services include statutory guidance on working hours, rising professional standards and a shortage of health care professionals.

The key drivers for looking at how primary care operates are:

- We want to improve the health of the people in Shetland and ensure healthcare services are meeting public expectation;
- There is greater demand on local health services in part due to an aging population, with greater health needs;
- A hospital setting is not always the answer; more care can be delivered in primary care and community settings than ever before and patients benefit from care provided closer to their home;
- There are workforce challenges (for example recruitment of GPs) which currently affect delivery of the best quality care and optimal patient outcomes;
- We need to adopt new models of care and best practice which can deliver better health outcomes for patients;
- We want to ensure care is safe, effective, efficient and patient centred.

Current Services

Traditionally, the "four pillars" of Primary Care have been GP Services, Pharmacy Services, Dental Services and Ophthalmic Services. There are separate dental and pharmacy departments in Shetland and these are therefore not covered in this section.

For GP Services, there are currently ten Health Centres in Shetland, together with five non-doctor islands which are staffed by Community Nurses and who receive GP services from a local health centre. Of the ten GP Practices, three are directly salaried to NHS Shetland (all staff are employed by NHS Shetland) and the other seven are what is known as independent practices – this means they contract with NHS Shetland to provide core GP services to their practice population, for which they receive funding worked out through a national formula and it is the responsibility of the independent GP practice to decide how to use this funding to provide the contracted services. It should be noted that the NHS in Scotland will see the introduction of a new GP contract in April 2017, although details on the format of this new contract are still to be released. It is expected that substantial work will be required across Scotland to introduce the new contract and Shetland will be no different in this regard; this is referred to in the actions for 16/17 and this service plan will be updated once the detail of the contract has been negotiated.

Within Ophthalmic services, there are three providers of general ophthalmic services in Lerwick, which are open to all Shetland residents. There are also visiting Ophthalmic Consultants who hold clinics in Gilbert Bain Hospital for patients referred to them with complex eye problems. NHS Shetland contracts with NHS Grampian for the provision of an Optometry Advisor role, with the Optometry Advisor undertaking three yearly Ophthalmic Premises inspection visits in conjunction with the local Primary Care Manager, in addition to being a member of the Eyecare Managed Clinical Network. The most recent visits were completed in September 2015.

Funding and Resources

Table of budget and savings targets, including workforce details. Please note that workforce details for the independent practices are not available and any additional income e.g. dispensing income within independent practices will not be shown below.

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Primary Care Department (incl. appraiser costs)	2.4	157,637			
Lerwick Health Centre	17.83	1,157,124	4,400		
Yell Health Centre	4.81	314,282	0		
Whalsay Health Centre	3.6	278,559			
Unst Health Centre		263,067			
Hillswick Health Centre		329,144			
Brae Health Centre		358,191			
Scalloway Health Centre		395,794			
Bixter Health Centre		274,221			
Walls Health Centre		223,774			
Levenwick Health Centre		377,415			
Out of Hours (including police)	Bank rota	258,400			
Ophthalmic		364,700			
Primary Care				4,402,320	

Needs/Unmet needs/Drivers for change

Primary Care has been set a savings target for 2016/17 of £275,000. This will be across all areas of the budget although the actual detail of savings will not be examined until after the publication of the primary care strategy.

Drivers for change:

- There is variation in opening times, different appointment systems and waiting times for appointments between practices;
- There is variation in additional services provided, for example enhanced family planning and minor surgery;

- There are current difficulties with balancing the requirements to provide enough appointments to meet demand within waiting times, with the need to spend sufficient time with patients;
- There are geographical issues, which may influence ease of access;
- There are noticeably different arrangements in hours and out of hours;
- Recruitment and retention has proven to be problematic in recent years, across all Practices in Shetland. It is not unusual for there to be several rounds of advertising and it is becoming more difficult to recruit staff who wish to work in a remote and rural location;
- A changing workforce profile and changing skills set needed for new models of care;
- Changes to secondary care provision in terms of services now being offered through primary care providers rather than the hospital;
- Inequity of funding provision across Primary Care in Shetland;
- Clinical/medical innovations and improvements such as telehealth.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Implement 2016/17 GP Contract and QOF amendments	Lisa Watt	April 2016	All Shetland practices to have a contract based on 15/16 contract and QOF amendments once issued by Scottish Government. (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Implement agreed actions from Primary Care Strategy (due to report by February 2016). Service Plan will be updated with specific actions once these are agreed	Lisa Watt	April 2016	(H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards. Details of the contract will only be announced in Spring 2016 and there is therefore no further detail to hand at present.	Lisa Watt	April 2016	Smooth implementation for go live date of 1st April 2017, ensuring seamless transition and no disruption to services (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015	Lisa Watt	April 2016	(H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)

Continue to support the growth of the Scalloway practice	Lisa Watt	April 2016	Increasing the practice size in Scalloway will help practice viability, as well as ensuring a more even spread of patient numbers across central Shetland. (H&WO 3, 4, 5, 7, 8, 9)

Key Risks to Delivery

Risk	Mitigation
GP Recruitment across 5 GP Practices in Shetland	Service redesign including use of Advanced Nurse Practitioners in Lerwick Health Centre. Different types of advertising are being used, including Facebook and attendance at the RCGP conference to promote Shetland as a place to work and live.
Recruitment and retention of staff at all grades	There is low unemployment in Shetland at the moment, which is leading to difficulties in recruitment. Promoting NHS Shetland as a favourable place to work and actively supporting training schemes (such as the GP Training scheme) has benefits to recruiting staff.
Capacity in small Primary care management team required for day to day management and ongoing service redesign	Under review

Performance Targets with links to National Outcomes

Measure	National Outcome
Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre	Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer
Percentage conversion of OOH GP house visits converting to admission to hospital	Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

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Further Reading

[1] http://www.shb.scot.nhs.uk/board/planning/2020VisionReport.pdf

Community Nursing Services

Policy context

The Scottish Government's 2020 vision is "that by 2020 everyone is able to live longer healthier lives at home or in a homely setting". NHS Scotland notes that they will achieve this vision by delivering a healthcare system which has

- An Integrated Health & social care service
- A focus on prevention, anticipation, and supported self management
- Person-centred care, delivered to the highest standard of quality and safety
- Care provided in community settings unless hospital treatment is required
- People back to their home/community as soon as possible with minimal risk of readmission.

The delivery of the Scottish Government's vision will be influenced by the demographic challenges posed by the local community, as well as those experienced within the District Nursing workforce which is also an ageing workforce. The ageing population sees people living longer with more complex healthcare needs, and with more longterm conditions.

The District Nursing service assists with the delivery of the following targets

- Reduction in the number of avoidable A&E attendances and admissions;
- Early supported discharge and reduction in delayed discharges from hospital;
- Reduction in emergency in-patient bed day rates for people aged 75years or over;
- Percentage of time in the last 6 months of life spent at home or in a community setting;
- Shifting the balance of care into an anticipatory model rather than reactive model to support long term conditions management; and
- Proportion of people aged 75years and over living at home who have an Anticipatory Care plan shared.

A new GP contract is being developed for implementation in April 2017 and a national review of District Nursing services is currently taking place, which is scheduled to report in April 2016. Both of these areas of work will influence the future shape and delivery of nursing services in the Community Setting for the future.

Current Services

The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting.

The District Nursing service is the largest part of Community Nursing services and provides a nursing service to individuals within their own home, or a care home, on a 24 hours a day, seven days a week, 365 days a year basis.

The District Nursing service provides

- Acute care at home;
- Complex care at home;
- End of life care at home.

From April 2012, the District Nursing service has provided a shift based, 24 hours a day, 7 days a week service on mainland Shetland.

The following groups of staff who provide care in a community setting are also provided, and managed, via the Community Nursing service:

- Practice Nurses – the Practice Nursing service for all of the Board provided general practices, namely Lerwick, Yell and Whalsay;
- Advanced Nurse Practitioners – the Advanced Nurse Practitioner posts based at the Lerwick Health Centre;
- Specialist Nurses, eg Continence Nurse Advisor;
- Non-Doctor Island/Out of Hours Nursing – there are resident nurses on the non-doctor islands of Fair Isle, Foula, Fetlar, Skerries and Bressay. Some of these postholders, along with their relief colleagues, provide the overnight nursing service on mainland Shetland; and
- Intermediate Care Team – this multi-disciplinary, partnership team provide additional support at home for individuals to prevent unnecessary admission to hospital or provide additional support to increase independence on discharge home from hospital. This additional support is provided on a time limited basis of up to 6 weeks. The team are based at the Independent Living Centre, Gremista, Lerwick.

Whilst the Community Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16years and are housebound, the services will endeavour to meet the needs of any individual across the lifespan from birth to death, within the community setting who have a nursing and/or health need.

All of the component services within Community Nursing services work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.

Funding and Resources

The overall Community Nursing Services has approx 48.1 full time equivalent staff and an annual revenue expenditure of £2.3 million. The staffing establishment is as detailed below:

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Community Nursing services	48.1			£2,398,437	

Needs/Unmet needs/Drivers for change

Service Aims/Priorities	Objectives/Actions
There will be a demonstrably healthier local population who are able to remain in their own	All community based nurses will promote healthy lifestyles to all individuals on the caseload.

Service Aims/Priorities	Objectives/Actions
homes or in a homely environment for as long as they so wish.	Anticipatory care plans will be developed with individuals in order to support them to remain in their own homes for as long as possible.
The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so	District Nurses/Community Nursing service will work as part of a locality service delivery model, influencing and leading care for individuals with a health need.
Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to "tell their story once".	District Nurses will actively adopt the case manager role for individuals with complex health needs.

Plans for change

New Planned Actions Due to Start in 2016/17					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service	Intermediate Care Team	April 2016	July 2016	Sustainable service in place	Provides a 24hour nursing and care service at home thus supporting early supported discharge from hospital as well as avoiding unnecessary admissions
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care	Chief Nurse	April 2016	March 2017	Electronic record keeping/management system in place	Enhance communication across multidisciplinary, interagency teams thus supporting improved seamless care for individuals
Further develop model of case management	Chief Nurse	Ongoing		District Nurses undertake case management role	Better co-ordinated care for individuals with complex health needs

New Planned Actions Due to Start in 2016/17					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
within Community Nursing services					
Continue to support implementation of eKIS Anticipatory Care Planning across the services	Chief Nurse/ Clinical Team Leaders	Ongoing		Increase in eKIS plans in place across all General Practices in Shetland	Enhance anticipatory approach to care for individuals with complex health needs.
Conduct review of local District Nursing services in line with national "Transforming Nursing Roles" project	Chief Nurse	April 2016	September 2016	Ensure that District Nursing workforce locally continues to develop with national direction	District Nursing workforce is fit for purpose for 21st century
Develop Nursing in Community Strategy	Chief Nurse	September 2016	March 2017	Set strategic direction for nursing in community settings	Strategy developed to support careers in nursing in a community setting which provides a career framework from initial registration to Advanced Practice. Nursing service supports implementation of new GP contract from April 2017

Key Risks to Delivery

During 2015-2016 the Community Nursing service has continued to experience significant difficulty with recruitment in the service, the effects of this in terms of service provision being

further compounded by a number of staff who have had a period of longterm sickness absence whilst awaiting or recovering from surgical interventions.

It is hoped that a number of these issues will be resolved before we enter 2016-2017 The impact of these issues has been to limit service development in 2015-2016 as staff have had to focus on meeting the current clinical needs of patients on the active caseload.

Performance Targets with links to National Outcomes

The overall aims and objectives of all the constituent parts of the Community Nursing services are to:

- Support and maximise the health potential of individuals, as well as address the health and care needs of various client groups and/or their carers within the wider community; and
- Utilise a holistic approach to providing safe, effective, person-centred care in a variety of community settings.

These aims and objectives contribute to the delivery of the National Health and Wellbeing Outcomes, in particular:

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Service Aims/Priorities	**Objectives/Actions**
There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish.	All community based nurses will promote healthy lifestyles to all individuals on the caseload. Anticipatory care plans will be developed with individuals in order to support them to remain in their own homes for as long as possible.
The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so	District Nurses/Community Nursing service will work as part of a locality service delivery model, influencing and leading care for individuals with a health need.
Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to “tell their story once”.	District Nurses will actively adopt the case manager role for individuals with complex health needs.

Performance Measure	Performance 2015/16	Target 2016/17
Number of Early Supported Discharges Number of Admissions Avoided through involvement of Intermediate Care Team		
Number of individuals with complex health needs whose care is case managed by a District Nurse		
Number of Anticipatory Care Plans in place and shared across services		
Number of early supported discharges with no re-admission in 30 days		
Number of people supported to die in preferred place of care		
Number of people supported to have a solution to their continence problem which is not a containment solution		
Number of individuals seen by an Advanced Nurse Practitioner as first point of access to healthcare		
Number of individuals seen by an Advanced Nurse Practitioner who subsequently referred to another practitioner for a “second opinion”		
Patient Satisfaction survey of patients seen by Advanced Nurse Practitioners		

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Intermediate Care

Policy context

The background to the implementation of intermediate care is detailed in the Scottish Government's Reshaping Care for Older People strategy:

http://www.scotland.gov.uk/Resource/0039/00398295.pdf,

and in the Intermediate Care Framework for Scotland:

http://www.scotland.gov.uk/Resource/0039/00396826.pdf

The Reshaping Older Peoples Care Agenda aims to reduce unplanned admissions to hospital or long term care, enhance discharge planning, recovery and self-management.

Some of the key drivers behind this agenda are:

- HEAT Targets – the delayed discharge target is for no person to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015.

- AHP National Delivery Plan (Scottish Government, 2012) http://www.scotland.gov.uk/Resource/0039/00395491.pdf
    - Action 2.3 AHP directors will work with directors of social work and their NHS boards to maximise the AHP contribution to achieving delayed discharge targets and reduce overall length of stay in hospital, which will support the delivery of the legal treatment time guarantee.
    - Action 2.4 AHP directors will work with directors of social work to support older people and those with disability and complex needs to live independently in their own home/homely setting for as long as possible, delaying or reducing admissions into institutional care.
    - Action 2.5 AHP directors will work with directors of social work to reconfigure "enabling" services, such as rehabilitation and reablement, to deliver best value and enhance care experiences for people who use services and their families and carers.

Current Services

Intermediate care will deliver the following.

- Individuals will be supported to remain at home, thus avoiding unnecessary admissions to the hospital;
- Individuals will be supported home from hospital and can receive 24 hour care at home for the first 5-7 days thus providing time to undertake further assessment of need once at home and within familiar surroundings;
- Enhanced care to palliative care patients who can receive additional nursing care and support on a 24/7 basis;
- Provision of support and advice to care centre staff on the management of clients with nursing, healthcare and therapy needs;
- Enhanced therapy input to ensure functional abilities are maximised.
- Additional "enabling" and "reabling" input through therapy assistant input.
- Assessment of individual patient needs on a 24/7 basis by Registered Nursing staff.

- First point of access to healthcare for patients with care needs via support/ advice/assessment provided by District Nurses/Nurse Practitioners contacted directly by care staff.

The Intermediate care team has to deliver the following outcomes:

- Reduction in numbers of individuals admitted to the Gilbert Bain Hospital or residential setting with primarily a social or nursing care need;
- Reduction in emergency admissions to the GBH and residential care.
- Increase in the number of people successfully returned to a home / residential care setting post GBH admission;
- Increase in number of people who could be considered to be cared for primarily in a community setting due to support being available from the overnight nursing and care team.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Intermediate Care Service	5.8 WTE employed by SIC 1.3 WTE Availability			TBC	

Needs/Unmet needs/Drivers for change

Service redesign is based on the availability of funning for the next finical year. The service is currently expanding to meet the needs of an elderly population. The growth of their service will expand across the who of Shetland mainland.

Plans for change

Currently the service has been developing for the past 12 months. Service evaluation is currently being taken place. At his time there are no plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)

Key Risks to Delivery

Funding cute are a viable risk. Audit is begin conducted on a regular bases to show the cost saving of patients in the community setting vs hospital settings. This will show over the next finical year a trajectory of service delivery thus meeting the needs of the national outcomes measures.

Performance Targets with links to National Outcomes

2 - People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

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Sexual Health

To follow

Adult Services

Adult Learning Disability and Autism Spectrum Disorder Service

Policy context

There are a wide range of legislative provisions which impose powers and duties on the local authority with regard to the care and support of people with learning disabilities. The main statutory duties are contained in Sections 25 and 26 of the Mental Health Care and Treatment (Scotland) Act 2003. For the purposes of this Act a mental disorder includes learning disabilities and autistic spectrum disorders. Section 25 provides that a local authority is obliged to provide or arrange the provision of care and support to people who have or have had a mental disorder and are in need of services. Section 25 states that the care and support services provided shall be designed to minimise the effect of the mental disorder on such persons; and give such persons the opportunity to lead lives which are as normal as possible. This can include accommodation and care at home to support both quality of life and safety.

Section 26 provides that the local authority shall provide services which promote the social development and well being of persons with a mental disorder. This includes services which provide the following:

- Social, cultural and recreational activities;
- Training for such of those persons as are over school age;
- Assistance for such of those persons as are over school age in obtaining and in undertaking employment

Other legislation which shapes service delivery for people with learning disabilities and autistic spectrum disorders includes; Social Work (Scotland) Act 1968; NHS and Community Care Act 1990; Adults with Incapacity (Scotland) Act 2000; Regulation of Care (Scotland) Act 2001; Mental Health (Care and Treatment) (Scotland) Act 2003; Adult Support & Protection (Scotland) Act 2007; Social Care (Self-directed Support) (Scotland) Act 2013; Public Bodies (Joint Working) (Scotland) Act 2014; Carers (Scotland) Bill 2015.

Current Services

In recent years there has been a growing commitment across the health and social care to focus on the outcomes important to the person and to support families and carers maintain their caring role and have a life outside of caring. This attention to individual outcomes puts the person at the centre of support and ensures that organisations are focussed on the positive difference their involvement makes to people's lives

Supported Living and Outreach Service (SL&O) provides Supported Tenancies for adults with learning disability, autism spectrum disorder and complex needs. Outreach support for people living in their own or family home may also be available..Each person will is supported to develop a person centred plan that assists them to achieve goals and outcomes and manages welfare and financial risks.

Supported Vocational Activity Service includes the Eric Gray Resource Centre (EGRC) which provides a range of educational, recreational and social activities to meet the assessed need of adults with a learning disability, autism spectrum disorder and complex needs in line with EGRC criteria.

In addition, Supported Employment opportunities are provided through third sector providers including; COPE, which offers a range of supported employment placements in their small

businesses and works closely with EGRC; and the Moving On Employment Project (MOEP), which provides Job Brokerage and Tapered Support to sustain people into mainstream employment.

A Short Break and Respite Service is provided from Newcraigielea service which offers 8 en-suite bedrooms and 1 self-contained bedsit for short breaks and respite to meet the assessed need of adults with a learning disability, autistim spectrum disorder and complex needs and that of any unpaid carer in line with eligibility criteria. Newcraigielea also offers a day care services through the GOLD Group for older people with learning disability to meet the level of assessed need in line with eligibility criteria.

Learning Disability Nurse is a single handed, community nursing service offered throughout Shetland for people aged 5 - 75 with a learning disability in addition to a health need. The nurse works with a range of services such as Education, Social Work, Supported Employment, Day and Voluntary Sector Services. There is a consultative and liaison service with Secondary Health Care, Adult Mental Health, CAMHS, Community and Children's Nursing.

Specialist Psychiatry and Clinical Psychology are provided by a visiting Consultant Psychiatrist and a visiting Clinical Psychologist offer outpatient appointments or home visits as appropriate.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Adult Services				5,330,617	

Needs/Unmet needs/Drivers for change

The number of people in Shetland with learning disability, autistic spectrum disorder, profound and multiple complex needs known to the Local Authority is slightly above the national average with just over 8 people per 1000 compared to the Scottish average of 6 people per 1000 [1]. At October 2015, this translates into 197 adults with either Learning Disability or Autism Spectrum Disorder and a further 51 under 16's year olds in Shetland.

Advances in medical and social care have led to a significant increase in the survival rate and life expectancy of the population as a whole, including people with learning disabilities and autistic spectrum disorder.

As the population of people with a learning disability and autism spectrum disorder grows larger and are reaching older age, experiencing the issues associated with older age such as arthritis, the menopause and dementia, it is increasingly important to consider what enables people to remain in their own homes and have meaningful lives in their communities.. Additionally, it is recognised that the biggest challenge for the foreseeable future will be to maintain, with limited resources, both the level and quality of care the people of Shetland have come to expect:

- Growing public expectations that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
- Demographic change with increasing birth survival rates and life expectancy,
- Rise in prevalence of people with autism spectrum disorder
- Increased risk for people with learning disabilities to experience age related issues, e.g. dementia;

[1] Scottish Consortium for Learning Disability Learning Disability Statistics Scotland, 2014. http://www.scld.org.uk/wp-content/uploads/2015/09/Learning-Disability-Statistics-Scotland-2014-report.pdf

- Reductions in public funding due to the recession and current ongoing difficult economic climate;
- Persisting inequalities in health;
- The need to demonstrate outcomes not just process;
- The need to consider the sustainability of services.

The Scottish Government, COSLA and ADSW have been working in partnership to review services for people with learning disability. The strategy entitled, '*The Keys to Life*' covers the period 2013 to 2023 and aims to build on themes of independence and joint working approaches from the first strategy '*The Same as You?*' (SAY), which ran from 2000 to 2010.

'*The Keys to Life*' aims to progress priority topics which include improved health outcomes, equality and the personalisation agenda. It also focuses on the potential of Self Directed Support; addresses challenges around the affordability and outcomes for people with high cost support needs and aims to advance the adult protection agenda.

Addressing need in relation to autistim spectrum disorder is recognized as a national priority. In 2011, the Scottish Government and COSLA launched the Scottish Strategy for Autism. The vision of this policy is to ensure progress across Scotland in delivering quality services to people with autism and their families, underpinned by values that have been recognised as important, namely; being respected, accepted, treated fairly, valued by the community and being able to have satisfying and meaningful lives.

Plans for change

Description	Lead Officer	Start date/ target end date	Expected Outcome(s) (link to National Outcomes)
Progression of the Day Services New Build (EGRC)	Clare Scott	Started July 2014. Ongoing April 2016	• Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. • People who use health and social care services have a positive experience of those services, and have their dignity respected.
Holistic review of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the review.	Clare Scott	April 2016	• People with LD/ASD are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community, • Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. • People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. • Ensuring that resources are used effectively and efficiently in the provision of health and social care services.

Key Risks to Delivery

Risk	Mitigation
Staff Numbers/Skill Shortage/	Maximise retention of staff, develop flexibility and resilience within teams and across service area We will do this by; ensuring that staff across all service areas are engaged in the work they do and are supported to continuously improve the information, support, care and treatment they provide; ensuring that Maximising Attendance Policy is strictly adhered to; maintaining good working relations between staff and line managers; ensuring recruitment processes are LEAN and that any barriers to recruitment are dealt with promptly; continuation of Modern Apprenticeship scheme and Traineeship in collaboration with Shetland College to attract new staff; ensuring succession planning and CPD opportunities are central to review cycles.
Business Continuity Plans Inadequate	Business continuity plans are in place for each service strand in Ad.Svs - LD&ASD with contingencies plans in place to address key business failures that could impact on service delivery. Plans are monitored and reviewed a minimum of annually or as and when required.
Contractual Liabilities and Failure Of Key Supplier	Service Level Agreements (SLA) and/or Grant Condition Agreements are in place for all services purchased from local voluntary and not for profit organisations. Procedures set out in clear document available to all. Each SLA has a nominated Lead to oversee functioning of provision.
Managing Expectations of the Community	Develop user friendly, public information resources and ensure availability in a number of formats (e.g. electronic; easy read; paper; etc). Set clear criteria for services. Eligibility criteria for community care services are in place and in line with revised national guidance. This forms an integral part of the revised SSA process With You, For You.

Performance Targets with links to National Outcomes

Measure	Aim	National Outcome
Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills	Adults with learning disability, autistic spectrum disorder and/or complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted	Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users
Number of emergency respite nights provided for adults with LD/ASD. *An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays.*	Advance Care Plans will be developed with people, those close to them and service providers to make decisions with respect to their future health, personal and practical aspects of care and support. The risk of unscheduled care will be reduced.	Outcome 6 - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing
Number of Social Care staff trained to implement Positive Behaviour Support.	Staff will have the knowledge and theory of Positive Behaviour Support and be able to put into practice in the support they provide.	Outcome 8 - People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do

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Further Reading

Keys to Life. Improving quality of life for people with learning disabilities.
http://www.gov.scot/resource/0042/00424389.pdf

Scottish Government's Scottish Strategy for Autism Website. This website will keep you informed about current developments, news and events and progress relating to the strategy.
http://www.autismstrategyscotland.org.uk/strategy/linking-goals-aims-and-recommendations.html
Mental Health Care and Treatment (Scotland) Act 2003
http://www.scotland.gov.uk/Publications/2005/08/29100428/04330

Comprehensive information on the provisions of the relevant legislation is available from the Scottish Government website http://www.gov.scot/Home

Adult Social Work

Policy context

- Integration of health and social care and implementation of Health and Wellbeing Outcomes
- Self directed support
- Carer's legislation
- Inspection regime

Current Services

The Service comprises a team of professionally qualified social workers, support workers and administration support staff who undertake a range of statutory social work functions, primarily in three areas:

Community Care Assessments and Care Management - Screening referrals to establish whether or not a social work response is required. This area of work may result in no further action, offer of advice, signposting or referral to other service areas, referral to social work assessment. Assessment of social need and care management – assess whether or not an adult (aged 18 or over) requires support. For complex cases the team will manage the case, this is called care management.

Adult Support and Protection – receive and assess adult protection referrals which involves working with police and health services, investigate whether or not an adult is in need of protection from abuse. If this is the case a protection plan will be put in place to support the individual. This will be care managed by a social worker. Additionally working with adults who are subject to protection plans to reduce risk of abuse and to provide them with support.

Mental Health Officer functions - Mental Health assessment, support and intervention – assess whether or not an individual requires support due to a mental health disorder. There are a number of specific functions only a Mental Health Officer can perform.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Adult Social Work				1,530,881	

Needs/Unmet needs/Drivers for change

The Adult Social Work Team provides a service to any adult who requests or requires an assessment under the legislation listed above. Customers include adults with dementia, mental health difficulties, brain injuries, lifelong conditions, learning disabilities, physical disabilities, older and frail people, carers and those at risk of abuse.

The amount of people supported by this service through care management is typically around 180 at any one time. The number of people supported on a short term basis, either through screening or assessment will be higher than this and can fluctuate.

Population projections for our customer base show the following:

Adults

The population of adults (18-64) is predicted to decrease by 6.6% (13,691 to 12,791) between 2013 and 2023 and by 15% by 2033 (to 11,641).

Over 65's

The population of over 65's is predicted to increase by 32% (4,200 to 5,544) between 2013 and 2023 and by 65% by 2033 (to 6,924).

Over 85's

The population of over 85's is predicted to increase by 44% (533 to 769) between 2013 and 2023 and by 143% by 2033 (to 1,294).

The drivers for change for Adult Social Work are:

1) To ensure appropriate involvement in the integration agenda through locality working.
2) Through Self-directed Support continue to enable people to achieve better outcomes through enhanced choice.
3) Implement the recommendations from the recent inspection of services to older people, including improvements to risk assessment and risk management.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)

Key Risks to Delivery

Risk	Mitigation
Recruitment of staff	

Performance Targets with links to National Outcomes

Performance Measure	Performance Statement	National Outcome
Number and percentage of assessments completed on time	Ensure all assessments are completed on time	**Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected**
Number and percentage of reviews completed on time	Ensure all reviews are completed on time	**Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected**
Number and percentage of outcomes for individuals are met	Outcomes are improved for individuals	**Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer**

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Community Care Resources

Policy context

In March 2010, Reshaping Care for Older People: A Programme for Change 2011-2021 set out the Scottish Government's vision and immediate actions for reshaping the care and support of older people in Scotland.

The programme provides a framework, built on consensus across all sectors and interests, to address the challenges of supporting and caring for Scotland's growing older population into the next decade and beyond. It aims to improve the quality and outcomes of current models of care, whilst developing services in a sustainable way that address current demographic and funding pressures.

New legislation, in the form of the Public Bodies (Joint Working) (Scotland) Act 2014 came into force on 1 April 2014. The Act requires Health Boards and Local Authorities to integrate their health and social care services. Integration is focused on person-centred care, health, planning and delivery so people get the right advice and support in the right place and at the right time.

Current Services

The Community Care Resources provides services to adults in need across Shetland. Our purpose is to enable people to remain within their own homes and communities by providing person centred care to increase levels of independence, self-care and self-managed care. We reduce unplanned, emergency and inappropriate admissions to hospital and facilitate early discharge from hospital wherever possible through the use of Care at Home and Care Centre resources. The service has the following elements, delivered from a number of localities around Shetland:

- Residential care used for long term care or short breaks (respite)
- Day services
- Care at home
- Domestic
- Meals on Wheels

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Community Care Resources				10,111,603	

Needs/Unmet needs/Drivers for change

- Our population is ageing fast. In Shetland it is anticipated that by 2016, the number of people aged 65 or over will be 38% greater than in 2006 and 92% greater by 2031. This is higher than the national average and the fourth highest rate of change across Scotland's 32 local authorities. The biggest challenge for the foreseeable future will be to maintain, with limited resources, both the level and quality of care the people of Shetland have come to expect
- Growing public expectations that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;

- Difficulty in recruiting social care staff;
- Demographic change with increasing life expectancy, a larger older population, greater social mobility of the population and a rise in the number of people living alone;
- Increasing prevalence of long term conditions and increasing multiple morbidity;
- Reductions in public and Shetland Charitable Trust funding and difficulties in recruiting will challenge the way care is delivered in Shetland. The sustainability of services needs to be addressed in order to ensure that the model of care delivered is fit for purpose.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Review current models of care in Shetland to ensure sustainability of service.	Director of CH&SC	Sept 16	Outcome 9 -Resources are used effectively. Outcome 2 -People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.
To work with locality partnerships to plan / deliver local services.	Team Leaders	May 16	Outcome 3 -People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.
Review roles and responsibilities within the care sector.	Executive Manager	April 16	Outcome 8-People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.
Sector review of procedures and processes	Executive Manager TLs	June 16	Outcome 9 – Effective use of resources, avoiding waste and unnecessary variation.

Key Risks to Delivery

- During 2014-2015 the Community Care Resource service has experienced significant difficulty with recruitment, particularly with regards to community based social care

workers. A recruitment campaign was commenced and contracted hours and rota patterns were remodelled. This remains a high risk area.

- Reductions in public funding and Shetland Charitable Trust funding will impact on the way we deliver services if the status quo continues. The way care is delivered in Shetland and the sustainability of services needs to be addressed in order to ensure that the model of care delivered is fit for purpose.

Performance Targets with links to National Outcomes

HEAT, Single Outcome Agreement or any other performance targets and outcome measures.
To be added in later

Measure	Outcome
Percentage of people over 65 being supported in a non institutionalised setting	Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Percentage of people receiving intensive care at home	As above
Number of over 65's receiving Personal Care at Home.	As above
Delayed discharge from Hospital - no delays exceeding 14 days	Outcome 7 - People who use health and social care services are safe from harm
Delayed discharge from care centres - no delays exceeding four weeks	As above
Number of individuals identified as having unmet need	As above
Risk and need assessment and support plans in place within 7 weeks.	As above
Occupancy of care homes	Outcome 9 - Resources are used effectively in the provision of health and social care services, without waste

Contact Details

Community Care Resources
Montfield Offices
Burgh Road
Lerwick
Shetland ZE1 0LA

Further Reading

- Social Work Services, Care Homes, Respite Providers and Care At Home Services are subject to inspection by the Care Inspectorate www.careinspectorate.com
- The manager of each service area must be registered with the Care Inspectorate as a Registered Manager. Each service is inspected at least annually by the Care Inspectorate and is measured against the National Care Standards. All social care staff must be registered with Scottish Social Services Council in order to practice and must abide by the Codes of Practice. www.sssc.uk.com

Criminal Justice

Policy context

The Strategy for Justice in Scotland sets out the Government's approach to make the Scottish justice system fit for the 21st century. The second phase of the Reducing Reoffending Programme which began in 2012 is focused on making sure that the right services and support are provided so that prolific offenders can address their reoffending and its causes.

Criminal justice social work services are statutory partners in ensuring effective community justice in local communities. Community Justice is currently the responsibility of Community Justice Authorities; however, following a redesign as set out in the draft Community Justice (Scotland) Bill, CJA's will be disbanded on 31 March 2017. From the 1 April 2017 responsibility for community justice will be transferred to 'community justice partners', with oversight and assurance to Ministers being given by a new national body, Community Justice Scotland. In Shetland, a local Community Justice Partnership will be established and will report to the Shetland Partnership. The Partnership will be responsible for producing a strategic plan that will address local and national priorities. A transition plan is being formed and will be submitted to the Scottish Government in 2016.

Current Services

The Service comprises of a small team of professionally qualified social workers and support workers who undertake a range of statutory social work functions that ensures all people who commit offences are appropriately assessed, supervised and risk managed. The service is responsible for the delivery and development of all criminal justice social work services throughout Shetland. This includes the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences.

Funding and Resources

Funding for Criminal Justice Social Work Services is ring fenced and allocated by the Northern Community Justice Authority on an annual basis. The funding covers the meeting of statutory duties. The service works collaboratively with other statutory and third sector partners in Shetland to ensure that receive the assistant and support their need to stop their offending behaviour.

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
	7.49	340,654			

Needs/Unmet needs/Drivers for change

The main driver for change is the redesign of community justice which evolved from the Commission on Women Offenders Report and Audit Scotland's evaluation of Community Justice Authorities. The service also takes account of relevant evidence as summarised in the 2011 report "What Works to Reduce Reoffending: A Summary of the Evidence".

Women who offend
http://www.scotland.gov.uk/News/Releases/2012/04/womenoffenders17042012

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Participate in the transition phase of the Redesign of Community Justice at a local and national level.	Executive Manager	April 16	Reduce reoffending / Safer Communities.
To work with local partners and partnerships to plan / deliver local services.	Executive Manager/ Senior Social Worker	May 16	Offenders within Shetland have the best opportunities to make positive changes to their lives.
To contribute to the National outcomes, performance and improvement framework.	Executive Manager	Oct 16	An outcome focussed approach to the planning and delivery of community justice services.
Review of processes and procedures to ensure they remain fit for purpose	Executive Manager	June 16	The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.
Continue to promote increased use of fiscal and police direct measures.	Senior Social Worker	April 16	Fewer people appearing in Court.

Key Risks to Delivery

- The future funding formulae for criminal justice social work has not been decided. Any reduction in annual funding will have a significant impact on the delivery of service and the service's ability to meet statutory duties and contribute to community safety.

Performance Targets with links to National Outcomes

Measure	Outcome
Percentage of people commencing supervision within 7 working days of being sentenced.	People have access to swift justice.
Percentage of court reports submitted on time.	People have access to swift justice.
Percentage of risk and need assessment completed within 20 days.	Reduce reoffending.
Percentage of individuals showing a decrease in assessed risk and need at end of order	Reduce reoffending.
Percentage of Unpaid work commenced within 7 working days.	Reduce reoffending.

Contact Details

Denise Morgan
Executive Manager Criminal Justice
Grantfield Offices
Lerwick
Shetland

Email: denise.morgan@shetland.gov.uk

Housing Support Services

Adult's Speech and Language Therapy

Policy context

Nationally agreed 9 Health and Wellbeing Outcomes as put in place following the Public Bodies (joint working) (Scotland) Act 2014 and Royal College of Speech and Language Therapy clinical guidelines.

Current Services

Speech and language therapy in Shetland provides life-changing treatment, support and care for adults who have difficulties with communication, or with eating, drinking and swallowing. Speech and language therapists (SLTs) work closely with families, carers and other professionals such as nurses and occupational therapists. SLTs work in the Gilbert Bain Hospital, Care Homes, the SLT base at the Independent Living Centre, people's own homes and at Supported Living and Outreach settings. They work with adults with:

- Communication or eating and swallowing problems following neurological impairments and degenerative conditions, including stroke ,head injury, MS, Parkinson's disease and dementia.
- Head, neck or throat cancer
- Voice problems
- Learning difficulties
- Physical disabilities
- Stammering

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Speech & Language Therapy				88,135	

Needs/Unmet needs/Drivers for change

20% of population will have speech, language and communication needs at some time in their life affecting their ability to sustain family and social relationships, income levels, education, employment, health, social care and justice services. Communication and/or eating and drinking difficulties are part of life for many, if not all, people with the following long-term conditions-stroke, head and neck cancers, dementia, autistic spectrum disorder, brain injury, cerebral palsy and motor neurone disease, multiple sclerosis, Parkinson's disease and learning disability
The current Speech and Language Therapy adult caseload is 94 adults, of these, 34 are adults with learning disability. The majority of the Speech and Language service is funded by the SIC Children's service. There has been a steady growth in referrals for adults over the past 5 years and this is expected to continue. The current capacity does not allow for development of the service to groups such those with dementia where the service is restricted to providing support to those with dysphagia (swallowing difficulties).

Plans for change

The service is trialling a communication group with the support of the Shetland Stroke Support Group for those with Aphasia (language difficulties following stroke), in order to support those individuals who have moved on from regular therapy and are benefitting from the peer support

from the group. SLT was involved in the multiagency communication skills training programme supporting those involved with Adult Learning Disabilities accessing health care. Further communication training programmes to support those working with and living with people with barriers to communication will be developed if capacity allows.

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Implementation of fast track referral to facilitate discharge	Shona Hughson	November 2015	For Adult LD email/phone named clinician for advice Outcome 5
Implementation of designated phone-in advice and information sessions to ensure more efficient use of qualified Speech and Language therapy resources.	Clare Burke	February 2016	Reduction in travel time for therapists and users Outcome 9 and 5
Implementation of monthly drop -in sessions at Independent Living Centre for patients/ parents with SLT related concern	Clare Burke	February 2016	More efficient use of time and resources, and meeting needs at an earlier stage. Outcome 9 and 5
Participate in Skype/VC telehealth project as part of a research project aiming to use technology to meet Speech and Language needs more efficiently. Implement recommendations from research project findings if results are positive/ effective.	Shona Hughson	January 2016	To ensure most effective use of scarce professional resource. Outcome 5 and 9

Key Risks to Delivery

Risk	Mitigation
Reduction in staffing levels, leading to service loss to inpatients with dysphagia and associated life threatening aspiration risk.	Staff retention and maintaining clinical competencies. Dysphagia screening training provided to ward nurses.
High caseload numbers mean limited capacity to provide universal services such as communication skills training to families and carers	Regular monthly monitoring
Removal or reduction of funding from SIC Children's Service to NHS (SIC currently funds 55% of SLT service)	Ensure both NHS and SIC are aware of risks and consequences around withdrawal of funding to service

Performance Targets with links to National Outcomes

HEAT, Single Outcome Agreement or any other performance targets and outcome measures.

Target	Outcome
Patients with swallowing difficulties in GBH – respond within 48 hours	1
6 weeks to first appointment	1

Contact Details

Speech and Language Therapy Department
The Independent Living Centre
Gremista
Lerwick
Shetland
ZE1 0XY

Telephone: 01595 744242
Email: shet-hb.SpeechDepartment@nhs.net

Further Reading

www.nowhearme.co.uk

www.rcslt.org (**for** policy position papers on e.g. dementia, learning disabilities.)

Children's Speech and Language Therapy

Current Service

Speech and language therapy in Shetland provides life-changing treatment, support and care for children who have difficulties with communication, or with eating, drinking and swallowing. Speech and language therapists (SLTs) work closely with parents and other professionals such as teachers, psychologists and other AHPs. SLTs work in schools, early years settings, the SLT base at ILC and in peoples own homes. They work with babies with feeding and swallowing difficulties and children with

- Mild, moderate or severe learning difficulties
- Physical disabilities
- Language delay
- Specific language impairment
- Hearing impairment
- Specific difficulties in producing sounds
- Cleft palate
- Stammering
- Autism/social interaction difficulties
- Voice disorders
- Selective mutism

Needs/Unmet needs/Drivers for Change

The current SLT children's caseload is 267 children, 2 wte SLTs funded through the SIC children's service. Service demand exceeds capacity. Nationally a move towards greater SLT involvement in universal rather than targeted input is expected and a move away from what is considered more "traditional "therapy models advocated.

Plans for change

Locally the service is considering alternative therapy options including

- phone in advice and information sessions
- monthly drop-ins,
- parent groups,
- as well as ongoing trials of "5 minute therapy",
- outcome measures and some
- joint group work with early years providers.
- looking into involvement into a research project on use of VC/Skype and SLT provision

Key Risks to Delivery

The key risks to delivery involve any reduction in staffing levels as demand already exceeds capacity. Staff retention and maintenance of clinical competencies are essential in order to at least maintain current levels of service delivery. Monthly caseload monitoring is in place. Work life balance treated with consideration and links established and maintained with local SLT students and graduates. We have struggled in the past to fill vacancies both temporary and permanent.

Performance targets

Waiting times for new referrals, SLTs aim to offer a first appointment within 6 weeks and this is usually achieved. Open referral policy is in operation and self referral is available.

Contact details

Speech and Language Therapy are now based at the Independent Living Centre in Gremista. You will find us on the right hand side of the road, past the Shetland College junction.

Speech and Language Therapy Department
The Independent Living Centre
Gremista
Lerwick
Shetland
ZE1 0XY

Telephone: 01595 744242
Email: shet-hb.SpeechDepartment@nhs.net

Nutrition and Dietetics Services

Policy context

SIGN, NICE, British Dietetic Association, HPC, BAPEN, NHS Shetland Guidelines and Policies, Diabetes UK.

To be added in next draft.

Current Services

The main areas of practice are Diabetes, Gastro Intestinal and Weight Management. The dietetic service also has a responsibility to ensure MUST and other nutrition training is in place for care home and care at home staff and to deliver staff and patient education on all the areas listed above.

Dietetic services are provided at 3 in-patient wards in the Gilbert Bain Hospital, out-patient clinics at the Gilbert Bain Hospital, Care Homes, through telephone appointments and domiciliary visits where there is assessed need.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Nutrition and dietetic service	2.8 WTE			118,839	

Needs/Unmet needs/Drivers for change

The dietetic service is in a vulnerable position having had a high turnover of staff in the last few years. It is currently undergoing significant development to ensure it is meeting the needs of the population of Shetland, however this development is challenged by a current vacancy.
The particular areas requiring further development and consolidation are described in the plans for change section.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Complete Development and implementation of bariatric pathway	Lead dietician	Underway	People are able to look after and improve their own health and wellbeing and live in good health for longer
Complete development of and implement general Weight Management plan, and roll out sessions in specific Health Centres	Lead dietician	Underway	People are able to look after and improve their own health and wellbeing and live in good health for longer
Complete development of diabetes pathway and roll out as appropriate	Lead dietician	Underway	People are able to look after and improve their own health and wellbeing and

			live in good health for longer
Complete and evaluate pilot training programme to care homes and roll out across care home estate	Lead dietician	Underway	People using health and social care services are safe from harm
Design web page on the Dietetic service including referral criteria and pathways for all referring clinicians.	Lead dietician	April 2016	Resources are used effectively and efficiently in the provision of health and social care services

Key Risks to Delivery

Risk	Mitigation
Reduction in dietetic time will mean that only urgent cases will be seen meaning that less preventative work is undertaken	Cases will be prioritised, however risk remains that a single dietician will be unable to manage even high priority cases
Unable to obtain approval to recruit to vacant dietetic post	Case will be made to EMT to recruit to vacant positions
Positions prove unattractive to potential applicants due to fragility of service meaning posts remain unfilled.	Attempts will be made to ensure stability of service

Performance Targets with links to National Outcomes

Performance target	National outcome
18 WRTT	Resources are used effectively and efficiently in the provision of health and social care services
To be added in next draft	

Contact Details

Dietetic Service
Breiwick House

Podiatry Services

Policy context

Public Bodies (joint working) (Scotland) Act 2014; National Health and Wellbeing Outcomes; National Delivery Plan for AHPs in Scotland (2012); NHS Shetland Workforce plan 2014-17; Localities Planning; 18/52 RTT; 4/52 MSK RTT; AHP MSK Minimum pathway standards; SIGN; HCPC; Older People Health and Wellbeing Strategy; Scotland's Dementia Strategy 2013-16; Shetland NHS Intermediate Care Operational Plan; Prevention and Management of Falls; GIRFEC.

Current Services

Podiatry Services provide a comprehensive range of treatment, advice and education to the population of Shetland. Services provided include: routine podiatry, nail surgery, nail management, vascular and neurological assessment and screening; MSK assessment and orthoses prescription; footwear advice; falls prevention advice; diabetic foot assessment and screening; wound care.

Podiatry services have successfully implemented and continue to promote both open and self referral (AHP NDP target), as well as introducing, implementing and enforcing the Personal Footcare guidelines (AHP NDP target).

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Podiatry	4.4			224,917	2%

Needs/Unmet needs/Drivers for change

Podiatry services will continue to have to provide to frail and elderly. It is clear that the number of elderly in Shetland will increase. This will have demand implications for Podiatry. Existing patients will continue to be provided with scheduled care where assessed and appropriate. The increasing number of elderly patients who are not currently registered with Podiatry will be a potential unmet need and could have unscheduled care requirements.

Podiatry will continue to provide current range of services, but in addition unmet need in falls prevention, vascular assessment, orthopaedic triage, dementia care, wound management, health education and telehealth will need to be addressed.

Children's services continue to develop both as Podiatry only input and as part of greater multi-disciplinary workstreams.

Greater joint working with Physiotherapy has commenced and will continue to develop. Joint working with non-NHS teams, such as falls prevention and care at home will change workload demands. Podiatry has commenced Orthopaedic triage which will continue to increase in frequency. Podiatry team have plans to commence direct referral to Medical Imaging, Orthopaedics, Pain clinics and Rheumatology.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.	Chris Hamer	October 2015	Maintaining foot health, enabling patients to remain mobile. NHWO's 1,2,3,4,9.
Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.	Chris Hamer	October 2015	Recognising and acting upon early signs of dementia assists in diagnosis and treatment. NHWO's 1,2,4,9.
Implement podiatric aspects into falls prevention strategy.	Chris Hamer	October 2015	Expert and evidenced based interventions for those patients at risk from falls. NHWO's 1,2,3,4,5,7,9.
Contribute to savings targets by triaging orthopaedic referrals.	Chris Hamer	October 2015	Ensuring referrals are directed to the appropriate clinical service. NHWO's 2,3,4,5,7,9.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.	Chris Hamer	October 2015	Working across primary and secondary care to produce an effective and efficient vascular care pathway. NHWO's 2,3,4,5,7,8,9.

Key Risks to Delivery

Risk	Mitigation
Staff absences (sick and annual leave)	Continual engagement with staff, rapid onward referral to OH when necessary. Monitoring of safe work practices. Flexible leave arrangements.
Staff retention and recruitment	Engagement with staff. Staff able to input into service changes and improvements.
Continued savings	Efficient use of service resources. Use of PECOS and national contracts. Investigation of potential efficiencies.
Clinical facility availability	Efficient use of clinical rooms, sharing use where practicable. Use of alternative clinical facilities.

Performance Targets with links to National Outcomes

Performance Target	National Outcome
AHP MSK 4wRTT	NHWO 1
18w RTT	NHWO 9
Reduce DNA rate to 5%	NHWO 9

Contact Details

Mr Chris Hamer, Podiatry Manager,

01595 743021 or c.hamer@nhs.net

Orthotic Service Plan

Policy context

The main policy context for Orthotics is the Allied Health Profession's National Delivery Plan. This emphasises the requirement for people with musculoskeletal problems to be treated within four weeks of receipt of referral. In addition, the works within the integration framework and therefore aims to achieve the nine Health and Wellbeing Outcomes and national indicators.

Current Services

The Orthotic Department provides Orthotic services to NHS Shetland and the local community. The Orthotic service is multifunctional with diagnostic and treatment services for people with Musculoskeletal (MSK) issues. It is aimed at, avoiding pain, returning function, preventing deformity and protect "at risk" body parts. This is achieved using Orthotic devices and/or advice on self help. The department's aim is to keep patient's mobile and pain free. This can be achieved by working closely with community services to keep patients in their home environment for as long as possible or to help patients return to work earlier via appropriate interventions. The service also holds the budget for Breast prostheses services, Wig services and is involved in the wheelchair services in Shetland.
With integration embedding itself, it is planned that Orthotic Services technical side will be able to prevent wastage by servicing and repairing community seating equipment.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
ORTHOTIC SERVICE	2			143,363	4212

Needs/Unmet needs/Drivers for change

There will be an increasing need for Orthotic services with an aging population requiring increased support for mobility to keep them safe (e.g. avoiding falls) and in their home environment. With this comes a need for further protection to prevent pressure injuries which are expensive to heal both in nursing time and dressings.
There is currently an Orthotic service redesign plan submitted to move the service to the Independent Living Centre. This move is part of the Ambulatory Care Service changes being developed with acute services at the Gilbert Bain Hospital. This will include a move to new clinical and technical technology which will release time to improve the service (improving the patient experience) and also to be close to and responsive to community services so that equipment can be serviced rather than disposed off as is currently the case.
In addition, reducing employment cost is a driver for change. If either the Orthotist or technician were to leave then a reorganisation of staff could be carried out. Such things as administration support being brought into the service could mean a part time Orthotist or technician being employed in future, reducing the wages expenditure.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Overseeing the departments move to the Independent Living Centre (ILC), as part of the Ambulatory service redesign. Introduction of new technologies which will improve service delivery times and release time for service improvement.	Laurence Hughes	July 2016	Improved service integration between Orthotic services and community services. H&WB 3 improving patient experience. H&WB9. Resources are used effectively and efficiently.
Increase speed of treatment by moving to modern treatment techniques. This will allow patients from outer lying islands to be treated on the same day and avoid a return visit.	Laurence Hughes	July 2016	H&WB5. Reducing inequality. H&WB 2. Keeping at risk patients independently at home.
Review service and implement actions to reduce the rate of non-attendees (DNAs) to below 5%, thereby making better use of professional resource	Laurence Hughes	July 2016	H&WB3. Improved patient experience
Continue to review and revise technician's activity to release time to service community equipment, thereby reducing spend on community equipment	Laurence Hughes	October 2015-16	H&WB 9. Resources are used effectively and efficiently.
Development of referral criteria and introduction of self referral in line with the Allied Health Professional National Delivery Plan.	Laurence Hughes in conjunction with Scottish Orthotic Clinical Lead (ScOL) group.	April 2016	H&WB 1 and 9
Implement appropriate appointment booking procedure to ensure equity of access to service.	Laurence Hughes	July 2016	H&WB5. Reducing health inequalities.
Ensure access to service operates in line with other services in Scotland by adopting consensus documents under development by ScOL	Laurence Hughes	July 2016	H&WB5. Reducing inequalities. And 9 Effective and efficient services

Key Risks to Delivery

Risk	Mitigation
Loss of key staff in single handed department	Business Continuity Plan in place which is reviewed on a yearly basis
Insufficient budget to respond to demand	Budget is carefully monitored. Access to service criteria under review
Continuity of service whilst move to new building takes place	Suitable plans in place to ensure service continuity
Unable to meet 4 week referral to first contact target due to lack of staff availability (sickness, annual leave etc)	Discussion has taken place with national AHP directors group about achievability of target in very small services.

Performance Targets with links to National Outcomes

AHP MSK 4wRTT	NHWO 1, 3
18w RTT	NHWO 3, 9
Reduce DNA rate to 5%	NHWO 9

Contact Details

Orthotic service is situated in the Gilbert Bain Hospital, South Road Lerwick. Shetland.
Contact Laurence Hughes 01595743023.
Email laurencehughes@nhs.net

Further Reading

- Ambulatory Care Services redesign plan
- Orthotic dept Business case

Physiotherapy

Policy context

National:
AHP NDP – particularly 4 week wait for MSK conditions, 18 week wait for others, self-referral, work status, falls prevention
AHP Musculoskeletal pathway minimum standards
Integration of Health and Social Care
Local:

Current Services

Physiotherapy helps restore movement and function when someone is affected by injury, illness or disability. Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice.

The NHS Shetland physiotherapy team covers a wide range of specialties: musculoskeletal, neurology, respiratory, elderly, adults with learning disability, chronic pain, paediatrics and inpatients (medical, surgical, rehabilitation and maternity). The service is based at the Gilbert Bain Hospital, where the majority of patients are seen; but patients are also seen at home, or in care centres, schools and leisure centres if appropriate.

Unscheduled Care:
Physiotherapists work on all wards at the Gilbert Bain Hospital and, with the exception of the rehabilitation ward, the majority of the work is related to unscheduled care. Physiotherapists are available for A&E during the working day to assess/advise as required. There is physiotherapist availability for patients receiving Intermediate Care input who have a physiotherapy need. Our core hours are 0830-1700 Monday to Friday and respiratory on-call cover is provided 0900-1700 at weekends and Public Holidays.

Planned Care:
This covers all other aspects of physiotherapy.

Older people:
There is an older people's specialist within the physiotherapy team, however she has a broad caseload which, although predominantly elderly, includes all age groups. There are no elements of the physiotherapy service exclusive to older people; with the exception of paediatrics all physiotherapists have a high proportion of older people on their caseloads.

Workload and caseload are defined by specialty, area or individual practitioner – there is no split between planned and unplanned care or older people.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Physiotherapy				602,664	

Needs/Unmet needs/Drivers for change

From August 2014 to July 2015 the physiotherapy service received 2553 referrals (11.6% of the population). Referral rates continue to increase year-on-year – since 2011 referrals have increased by 31%. The increase in referral is proportional from all sources; i.e. self, GP, secondary care and community and across specialties. This increase in referral rates has been absorbed into existing staffing levels. Additional staffing resources allocated have been for specific service developments, e.g. chronic pain and telehealth.

Self-referral is considered best practice and is a target within the AHP NDP. From August 2014 to July 2015 self-referral accounted for 46% of all referrals. Self-referral has, in part, replaced GP referral. In the MSK service where throughput is highest this has given additional challenges – particularly around time taken to triage referrals, seeking additional information and dealing with people presenting with multiple or complex problems.

As a result of high demand with unchanged staffing levels waiting times have increased. Projects are underway in musculoskeletal (MSK) and neurology looking at all aspects of the service, with a view to reducing the workload by referral management and promoting self-management.

Due to the small numbers of staff and range of specialties covered it is not possible to cover absence within current resources. Waiting times rise during periods of absence, particularly unplanned or long-term absence. The current savings targets and financial climate may cause difficulty recruiting to vacancies, which would have a negative impact on appointment availability and waiting times.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Review of neurophysiotherapy service (PID attached)	Fiona Smith Margaret Gear	Underway: completion August 2016	See PID
Review of physiotherapy musculoskeletal outpatients service	Paula Wishart	Underway: ongoing	Self management Referral management Reduce waiting times (links to AHP NDP and MSK pathway minimum standards)
Multi-disciplinary Falls Pilot (within current resources)	Elaine Campbell		Evaluation of results and recommendation regarding future falls programmes (links to AHP NDP)

Key Risks to Delivery

- High referral rates: The risk of rising waiting times if we are not able to keep up demand. This is being addressed through the projects detailed above.
- Complex conditions: Across all specialties we are seeing an increasing number of people with complex conditions. This requires an increased amount of therapist time, clinically and administratively (including liaising with other health professionals or other agencies)
- Staffing:

Performance Targets with links to National Outcomes

AHP NDP
AHP MSK minimum standards

Contact Details

Address: Gilbert Bain Hospital, Lerwick, ZE1 0TB
Phone: 01595 743323
Email: shet-hb.physiotherapy@nhs.net

Further Reading

Chartered Society of Physiotherapy: www.csp.org.uk
Health and Care Professions Council: www.hcpc-uk.co.uk
NHS Inform MSK zone (self-management): www.nhsinform.co.uk/MSK/
AHP National Delivery Plan: http://www.gov.scot/resource/0039/00395491.pdf

AHP MSK pathway minimum standards:
http://www.gov.scot/Resource/0047/00476937.pdf

Adult Occupational Therapy

Policy context

Occupational Therapy service development is informed by a number of national and local strategies which includes but is not limited to these. Integration and the National Health and Wellbeing Outcomes are particular drivers. Scotland's National Dementia Strategy 2013-16 is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. Maximising Recovery & Promoting Independence describes the provision of intermediate care service whilst the Rehabilitation framework promotes reablement and rehabilitation strategy and Realising Potential describes OT input into mental health services. The See Hear Strategy guides the development of sensory impairment services. The AHP National delivery plan is currently under review but once published will contain actions that need to be implemented.

Specific areas of legislation are described below:

- The Social Work (Scotland) Act 1968 places a general duty on local authorities to promote social welfare (Section 12 of the 1968 Act) by making available advice, guidance and assistance. There are also specific duties to assess needs and decide whether those needs call for the provision of services, which essentially means services under part II of the 1968 Act. There is a duty under the National Assistance Act, Section 2 of the Chronically Sick & Disabled Persons Act 1972, Social Work Act to assess need including that of support or instruction within the home. Occupational therapists particularly have a key role in carrying out these assessments of need and prescribing appropriate advice, treatment programmes, equipment or adaptations.
- Local authorities have specific duties under the Health and Safety at Work etc. Act 1974; Manual Handling Operations Regulations 1992, the Management of Health and Safety at Work regulations 1999 - Occupational Therapists are qualified to carry out moving and handling risk assessments, assess for and provide suitable equipment to meet the employer's responsibilities.
- The local authority has duties under the Disability Discrimination Act 2005 to ensure disabled people have equal access to opportunities, which Occupational Therapists assist in achievement through treatment, advice, adaptations and equipment provision. This includes the needs of people with sensory impairment.
- The Housing (Scotland) Act 2006 describes an obligation to provide financial assistance with a range of structural adaptations attracting a mandatory grant. The guidance notes that applications for assistance should be referred to a suitable specialist, usually an occupational therapist employed by the local authority Guidance on this is found in the Implementing the Housing (Scotland) Act 2006, Parts 1 and 2: Statutory Guidance for Local Authorities: Volume 6 Work to Meet the Needs of Disabled People.

Current Services

GBH: Adult inpatient and outpatient occupational therapy service with a focus on rehabilitation, reablement and adaption to impairment thereby supporting a timely return home and their community, and to people's occupations

SIC: Community based service primarily for adults with impairments, including sensory loss, with a focus on rehabilitation and enablement enabling them to remain at home and engaged in their occupations. Home adaptations and specialised equipment support the process.

SIC Telecare: Uses technology to enable older and more vulnerable people to live independently and securely in their home through a range of electronic monitoring equipment

SIC Independent Living Centre: Community resource with information and a range of equipment for people to view and trial. The Bluer Badge Clinic is run from this facility

SIC Equipment Store: Manages, maintains, delivers, installs and collects, maintains and repairs all occupational therapy equipment used in the community and in hospital. The Community Nursing store is also held here

Funding and Resources

To be finalised once budgets are approved

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Occupational Therapy (not broken down by adult/children)				1,644,149	

Needs/Unmet needs/Drivers for change

Identified need includes:

- Mental health occupational therapy services, both inpatient and community. The Mental Health Strategy for Scotland identifies that 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.
- Neurological out patient service to provide treatment to maximise people's potential once discharged
- Provision of rapid response to A&E to facilitate discharge directly home wherever possible

Drivers for change include Government strategies especially Integration, responding to internal and external pressures and seeking further efficiencies within the services. Telecare advancements provide greater opportunity for people to stay at home, but require constant updating of knowledge. Health and safety requirements and considerations must be adhered to with regard to very large quantities of equipment deployed.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate	Jane Pembroke	April 2016 onwards	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 effective resource utilisation
Explore need for specialisation in Dementia services and implement as appropriate	Jane Pembroke	April 2016 onwards	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 effective resource utilisation

Increase number of people in receipt of technology enabled care	Jane Pembroke	April 2016 onwards	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 effective resource utilisation
Provide rapid response to A&E in order to facilitate discharge straight home	Jane Pembroke	April 2016 onwards	2- people able to live at home 4 -quality of life 8- staff are supported to feel engaged and continuously improve their service 9- use resources effectively and efficiently
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community	Jane Pembroke with Jo Robinson	Commenced April 2015, ongoing development	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 -resource are used effectively
ILC Equipment Store- review, and refresh all procedures and protocol that ensure the supply of appropriately maintained equipment. Integrate district nursing equipment into establish integrated system.	Jane Pembroke/ Ian Sandilands	October 2015 and ongoing	3- people have positive experience of our service 7 -people who use our service are safe from harm 9- resources are used effectively

Key Risks to Delivery

Risk	Mitigation
Lack of staff resource to implement and maintain quality initiatives	Self assessment and self management techniques are implemented wherever possible to do so safely
Recruitment to hospital posts continues to present challenges	Continued redesign to ensure posts are varied and satisfying
Poor management and deployment of equipment due to competing pressures	Ensure risks assessments, protocols and procedures are in place and implementation monitored
Large geographical area and increasing need to provide wider range of services, to respond to a wide variety of government and professional initiatives	Continued redesign of services to ensure most effective and efficient use of resources
Potential conflict between needs of health board and statutory responsibilities of local authority within limited resources	Ensure prioritisation of needs of both services and potential conflicts are raised with managers
Need for staff to have wide ranging generalist and specialist skills	Ensure personal development plans are up to date and CPD opportunities are taken. Ensure quality control mechanisms are in place

Performance Targets with links to National Outcomes

Performance target	National Outcome
National Eligibility Criteria timescales	NHWO 2
Increasing number of people are supported by technology enabled care	NHWO 1,2, 7

Contact Details

Occupational Therapy Service, Independent Living Centre, Gremista 01595 744319
Occupational Therapy Service, Gilbert Bain Hospital 01595 743022

Further Reading

- Principles for Planning and Delivering Integrated Health and Social Care
- Draft Older People Health and Wellbeing Strategy
- **Scotland**'s National **Dementia** Strategy 2013-2016
- National Health and Wellbeing Outcomes Framework
- AHP National Delivery Plan: http://www.knowledge.scot.nhs.uk/ahpcommunity/national-delivery-plan.aspx
- Core Suite of Integration Indicators: http://www.gov.scot/Resource/0047/00475305.pdf

Child Occupational Therapy

Policy context

Current Services

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Occupational Therapy Paediatric service: Our priority is to use early intervention and preventative interventions to address the health and wellbeing needs of children enabling them to participate in their occupations as fully as possible	.8 OT .53 OTA	Budget for 2106 just been set- , can include in next document?			
Occupational Therapy (not broken down by adult/children)				1,644,149	

Needs/Unmet needs/Drivers for change

- Increasing focus on early intervention (under 5's) in line with government policy. Presents risk to over 5's in system who have not had this start and require ongoing OT input to maximise their potential and lessen potential reliance on funded services
- Paediatrician shortage has meant some work is being transferred to OT eg routine developmental screening of babies with onward referral

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Internal plan under way to review service, check for relevance to current environment and facilitate change	Marc Beswick	Under way	1.people improve their health and well being 2- people are able to live at home 4- quality of life 5- reduce health inequalities

Key Risks to Delivery

- Band 7 OT has expressed that he is beginning to think about a change. Based on experience recruitment will be problematical. Fostering interest in existing staff to build skills and confidence and a move to Paediatrics

Performance Targets with links to National Outcomes

Assessment completed within 14 days

Contact Details

Jane Pembroke Team Lead 744319
Marc Beswick 743022

Further Reading

National Health and Wellbeing Outcomes Framework

AHP National Delivery Plan:
http://www.knowledge.scot.nhs.uk/ahpcommunity/national-delivery-plan.aspx

Core Suite of Integration Indicators:
http://www.gov.scot/Resource/0047/00475305.pdf

Shetland NHS Autism Strategy and Action Plan

Support Services Plans

Information & Communication Technology

To follow

Finance

Policy context

The organisation has a statutory duty to break even and the directorate role is to ensure efficient stewardship of resources and delivery of the government best value programme for public funds.

Current Services

The Finance Directorate includes the Board Finance Department, the Finance Department, the Patient Travel Department and the Central Stores Department.

Board Finance – This department represents the Board's Director of Finance and central corporate expenditure such as insurance costs, legal expenses and audit fees.

Finance Department – Responsible for the financial stewardship of the Board and has a statutory obligation to produce annual accounts and associated reports. The department provides timely, accurate financial information to heads of departments to aid them in their organisational decision making. Through service level agreements with NHS Grampian provides the Board's Payroll Service and Accounts Payable/Receivable functions.

Patient Travel – Responsible for the booking of all patient travel to and from various mainland health Boards particularly NHS Grampian. The department manages the Highlands & Islands Travel Scheme (HITS) and all relevant reimbursements to patients.

Central Stores Department – Responsible for the five rights of procurement to ensure goods/equipment/services are available of the right quality, in the right quantity, in the right place, at the right time, at the right price. Being an Island Board the department must ensure there are adequate stock levels across the Board to deal with adverse weather conditions frequently experienced in Shetland.

Funding and Resources

Table of budget and savings targets, including workforce details

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Board Finance	1.0			£384,483	
Finance	6.8			£349,548	
Patient Travel	3.0			£2,827,823	
Central Stores	5.50			£181,658	
Directorate Savings Target					£25,200

Needs/Unmet needs/Drivers for change

Drivers for change include reducing budgets combined with a greater appetite for financial information in the current climate. With demand increasing on the department it will be very difficult to maintain the level of service whilst continuing to find additional savings year on year.

There is also a shared services initiative under way where Finance/Stores may be merged with other Boards or nationally into central hubs.

Plans for change

With demand for financial information increasing ideally the Finance Department would like to recruit a band 4 Finance Officer to assist with the monthly closedown process. This would allow us to achieve an 8 working day closedown which corresponds to best practice in the NHS. To fund this additional recurring savings will be found within the directorate.

Service levels in Shetland have now been reduced to a minimum with Payroll, Accounts Payable & Receivable outsourced to NHS Grampian through a Service Level Agreement.

As a result of outsourcing these services, the Finance Directorate has achieved all of its savings target up to and including the financial year 2016/17.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Recruit a B4 Finance Officer	Head of Finance & Procurement	Oct 2015	

Key Risks to Delivery

Budget constraints may result in a lower level of service and there is ongoing difficulty in recruiting and retaining staff.

Performance Targets with links to National Outcomes

No performance targets as such but regular scrutiny by External & Internal Audit which results in continuous improvement of the service.

Contact Details

NHS Switchboard 01595 74 3000

Human Resources and Support Services

Policy context

Service changes are currently being driven by the introduction of a National IT platform EESS. NHS Shetland commenced implementing the system in 2012 at Phase 2 of the National programme. There have been numerous setbacks and delays, involving developments to the system in order for it to be fit for purpose. Successful implementation will support the National HR Shared Service (HRSS) Agenda.

Current Services

The department provide the following services:

- Job Evaluation
- Recruitment planning and advertising
- Coordination of recruitment interviews
- On Boarding Administration for new starts
- Pre-employment checks
- Relocation monitoring
- Exit interviews
- Professional Registration monitoring
- Issue of ID badges
- Absence monitoring / promoting attendance
- Employment law / employee relations /case management advise, conduct , capability, grievances, whistle blowing, bullying and harassment From informal to formal investigation / hearing / appeal / tribunal
- TUPE guidance and due diligence administration
- Consultation on change
- Workforce data monitoring / returns (vacancy, WTE/ turnover/FOI's/ Junior Doctor)
- Workforce planning – projections and reports
- Redeployment
- Policy and procedure development
- Training delivery
- Equality and Diversity – policy, monitoring, action plans

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target across directorate / contribution 2016/17
Personnel: Pay	5.5 WTE	214,078	0		3000
Personnel: Non Pay		189,838	0		7000
Human Resources overall				689,685	

We have been carrying a 0.5 wte band 4 vacancy, that we have filled on a temporary basis through bank to support the delivery of workloads. We anticipate £3k recurring saving by using Band 2/3 with additional responsibilities distributed across substantive staff.

Needs/Unmet needs/Drivers for change

Following the implementation of EESS in 2013, a 1wte Band 3 vacancy was released to savings. Reduction in 1 wte was planned following successful implementation. National delays in advancing the initial implementation of EESS and the lack of clarity regarding the impact of HRSS locally have resulted in staff increasing responsibilities to cover workload demands. The current substantive admin staff Job descriptions will need to be reviewed to reflect changes in responsibilities. Following the review / evaluation of Job Descriptions any remaining budget outstanding from the current vacancy 0.5 wte band 4 will go to savings.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
National HR Shared Services for Recruitment and Medical staffing	HRSM	Likely to proceed in the next 2-5 years	Redeployment of HR Recruitment staff as applicable - still to be identified

Key Risks to Delivery

HRSS is nationally driven, Recruitment administration is likely to be centralised in the next 2-5 years. There is likely to be some discretion to determine what staff are required locally to support service delivery. Staff and Manager's will require training on the EESS system to enable them to self administer current HR recruitment administration activities within the system, including vacancy and candidate administration / coordination of short listing, interview and on boarding. If the demand for administration support across clinical services increases, the savings anticipated nationally will not be achieved and local pay costs will likely increase and local expertise reduce.

Performance Targets with links to National Outcomes

Reduction in administration demands will enable remaining HR resource to refocus responsibilities on supporting resource planning, redesign, integration of services, effective performance management and management of change, policy development and training delivery. This will include monitoring and reporting of absence / attendance against the 4% HEAT target.

Contact Details

Lorraine Allinson, HR Services Manager 01595 743071, Lorraine.allinson@nhs.net.

Further Reading

HRSS project Initiation document
http://www.qihub.scot.nhs.uk/media/611088/hrss%20-%20pid%20-%20may%202014.pdf
Quality Improvement Hub
http://www.qihub.scot.nhs.uk/quality-and-efficiency/shared-services.aspx

Occupational Health

Policy context

Service changes are currently being driven by external / NHS local demand for services, and nationally with the introduction of the Fit for Work Service Scotland and requirement for accreditation via SEQOHS.

Current Services

The department provides a range of services including:

- Management referrals for absence / performance case management
- Self Referral -NHS Staff
- CBT relating to personal or workplace issues / change
- Health Surveillance
- Immunisations
- Pre-employment screening
- Health Checks
- Work related Vaccinations
- Workplace/ workstation assessments
- Night Worker assessments
- Needle stick Injury response
- Stress management
- Medicals
- Ill Health Retirement
- Staff Training

In addition to local OH service- the department are set up to support the delivery of the Fit for Work Service Scotland as this is rolled out.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target across directorate / contribution 2016/17
OH: Pay	3 WTE	144,042			£4000
OH: Non Pay		17,300			
OH Income			57,430	99,912	

Pay budget includes Visiting Consultant from NHS Highland. 4K recurring saving has been agreed from pay budget for 2016/17. Line management and business management including SLA with NHS Highland is via the HRSM for which costs are included in Personnel plan & not included in above.

Key Drivers for change

- Legislation: Equality Act provides an increasing need for assessment and supportive adjustments in the workplace
- Demographics - Ageing workforce - complex health needs
- Increase in stress & MSK related absence
- Need to work more efficiently within reduced budgets
- Local business demand for services has increased following the retirement of an alternative provider. This has also enabled our consultant to become an approved Doctor for the MCA, so we can offer ENG1 medicals to our customers
- Requirement for SEQOHS national accreditation for which the department are working towards
- National Fit For Work Service implementation programme – Local participation in national implementation plan

Plans for change

The introduction of the FFWS in Scotland, funded through the Department of Working Pensions (DWP) may reshape external customer service demands as this service will focus on referral from the GP / employer into a national service, for those with 4 or more week sickness absence from work. NHS Shetland will participate in this service delivery but allocation of referrals will be via call a central call centre for the service (NHS 24). The service level will be managed separately via a defined SLA.

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
Introduction for Fit for Work Service	Senior OH Nurse	2015/16	23, 500 income

Key Risks to Delivery

- The FFWS set up costs to be recovered from DWP January 2016 – awaiting confirmation of ongoing funding / service demand. Service Level Agreement is in place for FFWS for 0.5 wte Band 6, £23,500. Current lead nurse Band 7 with additional Bank support Band 5 have been utilised for set up and readiness for commencement of service. Local start delayed, awaiting training from NHS Lanarkshire, FFWS lead.

- There is a risk that we may lose 70% of income if Shetland Island Council participate in a collective procurement process for a regional OH service provider with Highlands Local Authority – tender to cover service for Highlands and Islands. NHS Shetland occupational health is not resourced to bid for the work in its entirety and process may not permit us to bid for the Shetland work in isolation. Due to location we may be able to subcontract the work required to be delivered locally in Shetland. TUPE is unlikely to apply as service is not delivered by a defined resource. Failure to generate replacement income would result in a reduction in staffing required to deliver remaining demands.

- The department are set up to participate in the delivery of the Fit for Work Service Scotland. Reimbursement from DWP is outstanding for set up arrangements / training costs. Service

level agreement is for £23,500 to provide 0.5wte Band 6. No funding has been received and unlikely until January 2016.

- Increasing demand from local businesses provides potential to increase current income generation; this is without any marketing due to the retirement of an alternative local provider.

- Retention of skilled staff will be key to maintain service delivery levels – local availability of skill is very limited therefore national recruitment or specialist agency would be required to fill any turnover or any increase in resource requirements.

Performance Targets with links to National Outcomes

In the event there was a reduction in income and OH staff, service would continue to support NHS staff in maintaining health, wellbeing and fitness for work. Service would continue to support achievement of the 4% HEAT target for absence and reduce risk in relation to the Equality Act 2010 and the requirement for adjustments. Without a local service we would unlikely achieve 4% absence target or national average.

Contact Details

Lorraine Allinson, HR Services Manager
Telephone: 01595 743071,
Email: Lorraine.allinson@nhs.net.

Further Reading

- FFW: http://www.fitforworkscotland.scot/
- Equality Act http://www.legislation.gov.uk/ukpga/2010/15/contents
- NICE Guidelines https://www.nice.org.uk/guidance/ng13
- Procurement Highland local authority http://www.google.co.uk/url?url=http://www.highland.gov.uk/download/meetings/id/40290/item20res7710pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBQQFjAAahUKEwi9qeTamMLIAhXCPxQKHTxaAIw&usg=AFQjCNHoPUDGtqKdggY1JgymN0NA7RSdOw
- Previous OH tender http://www.publictenders.net/tender/349150

Staff Development

Policy context

- Joint Development Review (JDR) and Personal Development Planning (PDP)
- Staff Development Policy
- Fire Safety Policy
- Manual Handling Policy
- Policy and Guidelines for the Prevention and Non-Physical Management of Aggression and Violence (PMAV) in the Workplace
- Volunteering Policy

Current Services

- **The Staff and Organisational Development Team** is responsible for: the delivery and the co-ordination of key personal and professional training to enable employees across the workforce including those in training to deliver safe and effective care. The department also has a service improvement lead that provides training and project support across Health and Social Care. The Staff and Organisational Development Team are responsible for offering wide range of training covering all areas required by the Board ensuring compliance with statutory requirements. The staff and Organisational Development Team are also responsible for assisting teams achieve targets and objects through specific interventions and for supporting staff with the KSF and JDR programme.
- **The Clinical Education Team** is responsible for creating and maintaining a clinical learning environment for all students. The team also delivers and coordinates a range of clinical training events and programmes to support the aim of appropriately trained staff.
- **The Service Improvement Team** is responsible for providing training and project support across the organisation. The team utilises a range of tools and techniques that are fundamental to getting to grips with the challenges of everyday service delivery and trialling and measuring ideas for change.

Funding and Resources

Updated workforce plan below.

Service	Number of Staff (WTE)	Gross Expenditure	Income	Net Budget	Capital Budget
Management	2.2	2.2 Band 7	.2 Ext		
Staff and Organisational Development	2.1	1 Band 3 1.1 Band 5	.24 Band 3 Ext		
Service Improvement and AHPs	.7	.3 Band 6 .4 Band 7	0.4 Band 7 Ext		
Clinical Education	1.5	.4 Band 3 1.1 Band 6	.5 Band 6 Ext		
Total	6.5				

The Staff and Organisational Development Department receives external funding for a range of posts including the Clinical Development Facilitator and Staff Development Administrator by Robert Gordon University. The Practice Education Facilitator for Nursing, Practice Education Lead for AHPs, Post-Graduate Medical Administrator is all or partially funded by NHS Education for Scotland.

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target across directorate / contribution 2016/17
Staff Development				344,918	

Needs/Unmet needs/Drivers for change

The Organisational and Staff Development Department delivers high quality education, organisational development and continuous service improvement across NHS Shetland supporting the Board achieving it Corporate Objectives.

Service Aims/Priorities	Objectives/Actions
To support the continued mainstreaming and embedding of the NHS Knowledge and Skills Framework (KSF) and Personal Development Review (PDR) process	Update Learning materials to support the continued use of e-KSF and effective JDR processes.
Corporate Induction and Compulsory Refresher Training.	Monitor attendance rates and ensure quality and currency of induction and refresher training.
Support the delivery of Service Improvement within the Board.	Provide support for projects as requested by the Senior Management Team eg localities and pathways projects. Establish a Service Improvement Forum where staff can share knowledge, skills and experiences in a safe learning environment.
iMatter Staff Experience Tool Implementation	Support the implementation of the programme with Cohort 1 staff in line with SGHD plan. This includes: Finance, Human Resources and Support Services, Public Health and Performance.
Board Quality Group	Actions carried out by Quality Working Group - Currently under review

Previous Actions Completed in 2014/15

Description	Delivered Early/on-time/late	Achieved original intention?
Restructure of the Staff and Organisational Development Team.	On time	Savings were made based on change in structure which now does not include and overall service lead (3 team leads).

Support and embed service improvement delivery within the Board.	On time	Provide 3 internal secondment opportunities within the Board which will enable staff to deliver improvement methods via work based projects.

New Planned Actions Due to Start in 2015/16

Description	PRINCE *	Start	Expected Outcome
Move to Eess learning management system	No	Due to start in Jan 2016	Completed 2016

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery

The team is small and carries out a diverse range of actions across the organisation. Risks associated with the outcomes of these actions are,

- Leave
- Vacancies not being filled
- Posts not being renewed
- Capacity

Performance Indicators

Ref	HEAT Measure	Data Available	Period of latest value	Target	Target date	Performance Previous Period
Key: E - Efficiency and Governance -						
BSC8	Knowledge and Skills Framework – Personal Development Plan Review (rolling 12 month figure)	M	2015 Aug	70	31/03/2016	28
BSC9	Staff Survey completion rate	A	2014	50	31/12/2015	38
BSC10	iMatter implementation	A		100	31/05/2015	
BSC12	Number of staff attending mandatory update training sessions 2014-16	M	2015 Aug	540	31/03/2016	314
E.2S	NHS Boards to Achieve a Sickness Absence Rate of 4%	M	2015 Aug	4	31/03/2016	4.18

Contact Details

Sally Hall Staff and Organisational Development Manager Montfield (Lower) Hospital Burgh Road Lerwick ZE1OLA 01595-743-081	Mhairi Roberts Clinical Education Montfield (Lower) Hospital Burgh Road Lerwick ZE1OLA 01595-743-204	Bruce McCulloch Service Improvement Montfield (Lower) Hospital Burgh Road Lerwick ZE1OLA 01595-743-202

Medical Records

Policy context

Current Services

The Medical Records Department provides various functions within NHS Shetland.
Our purpose is to provided, secretarial cover for local and visiting consultants, ward clerks, patient focus booking with outpatient receptionist, clinical coding, and main hospital reception cover.
We do this by booking patient appointments, inpatient and outpatient in a timely fashion in accordance with the rules set down by the Scottish Government, ensuring that clinic letters, discharge letters are processed in a timely fashion. Procedures are coded correctly and within the time scales provided so that statistics can be provided on a monthly basis to the Scottish Government on the performance of NHS Shetland.
The main hospital reception is the centre for greeting the general public coming into to the Gilbert Bain, it also the main point for internal and external mail, Telephone exchange for the Gilbert Bain. It also acts as the first point of contact for emergency services in the hospital.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Secretarial Administration Ward Clerks Receptionists Supervisors Manager	27.99	420,186 first 6 months 2015		819,956	2%

Needs/Unmet needs/Drivers for change

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Succession Planning for Health Records Manager	Kathleen Carolan	October 2015	N/A

Key Risks to Delivery

Health Records Manager, retiring at end of 2015, succession planning currently being discussed with staff.
The Reception supervisor will be going off long term sick, cover is in place but this could be fragile and lead to additional spend on the budget.

Performance Targets with links to National Outcomes
N/A

Contact Details
Health Records Manager 01595 743033
Health Records Supervisor 01595 743015
Clinical Coder & PFB Team Leader 01595 743223
Reception Supervisor 01595 743000

Spiritual Care

To follow

Estates and Facilities

Policy context

The Estate & Facilities service is designed to support the overall vision of NHS Shetland.
It therefore aspires to provide and maintain ***sustainable, high quality properties and facilities services*** that allow the effective delivery and continuous improvement of healthcare across Shetland.

Current Services

A detailed summary of the physical assets supported by the Estates department are included in the PAMS (see link). These include the Gilbert Bain Hospital, the Montfield site including Dental services, Staff development and Board HQ and 10 Health centres and 4 clinics spread across the Shetland mainland and outer isles. There are also a number of other small owned properties (i.e. St Olaf Dental practice) and privately owned premises from which NHS contractor services are provided (i.e. Pharmacies and Opticians).
All the NHS Shetland owned buildings, Health centres and Medical equipment assets are supported by an Estates function that carries out planned and reactive maintenance, capital planning, minor repairs and schemes and a Medical Physics function.
The facilities services provided by the Directorate include Domestics, Catering, Porters and Laundry and Linen services.
The service is obliged to maintain compliance with a range of indicators. A number of these are national KPIs and others link to legislative requirements (e.g. Legionella, Hospital Gases, Building regulations, Fire safety, etc, etc.)

Funding and Resources

The total budgets and workforce for the department are:
Estates: Revenue - £ 1.99M, Capital - £1.1M; Staffing – 15.5 WTE
Facilities: Revenue - £1.66M Staffing – 71.12 WTE

The savings target for 2014/15 was £202k
The savings target for 2015/16 is a further target of £122k and outline plans have been identified to achieve this.
The savings target for 2016/17 is a further target of £177k and outline plans have been submitted to achieve this.
Future year on year targets are anticipated to be 3%

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Estates & Facilities				1,681,400	

Needs/Unmet needs/Drivers for change

The savings target for 2014/15 was £202k
The savings target for 2015/16 is a further target of £122k and outline plans have been identified to achieve this.
The savings target for 2016/17 is a further target of £177k and outline plans have been submitted to achieve this.
Future year on year targets are anticipated to be 3%

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Property and Asset Management Strategy 2015 (PAMS) sets out the list of priorities over next year ,five years and 10 years	Lawson Bisset	2015	Refer to PAMS

Key Risks to Delivery

The key risks, as identified above are the availability of adequate resources to support the services required. This includes both staffing, linked to recruitment and retention and finances (revenue and capital budget). Along with other support services the E&F directorate is currently working to deliver a 25% efficiency target over a 5 year period.

Agreement has already been reached to provide recruitment & retention "premia", linked to Agenda for Change T&C's for key trades staff and this has been agreed for a period of 3 years until March 2017.

In addition work a joint project is also underway to maximise opportunities from joint working with Shetland Island Council.

Performance Targets with links to National Outcomes

The PAMS sets out a range of KPIs and mechanisms for performance monitoring. This includes indicators on:

- Energy Efficiency (HEAT)
- Property : SCART (quality indicators); Backlog maintenance etc
- Facilities: Patient Satisfaction (IP survey); Cleanliness Audits;
- Within the SAFR all Estates & Facilities services across Scotland are also measured for efficiency and comparative cost

Contact Details

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HEALTH IMPROVEMENT

Policy context

External and national drivers for taking a new approach to health improvement include:

- Increasingly challenging national targets (e.g. HEAT target for smoking cessation which is now focussing on the hardest to reach groups)
- Increasing emphasis on doing things 'with' people rather than 'for' them, including using co-production[2], enablement, and asset based[3] approaches
- Fewer public sector resources to meet increased demand due to factors such as changing demographics (the aging population) and global economics. This was the focus of the recent Christie Commission
- Changes in lifestyle and culture (for example more sedentary work and leisure pursuits, and the use of games consoles and portable devices)
- Changes in diet (for example increased consumption of processed and convenience food, and larger portion sizes)
- A persisting, and possibly worsening, inequality gap between the most advantaged and the most disadvantaged in our society

Current Services

There are a range of health improvement services and resources available for people and communities in Shetland, most of which are open access. There are also a number of training programmes, usually for staff and volunteers, but some are also open to members of the public. Many of the services listed below are delivered by the Health Improvement Team, but there are other providers including the voluntary sector, primary care and other NHS departments. Services include:

- '**Help Yourself to Health'** information and resources based in the Shetland public library
- **Keep Well** Health Checks workplaces and primary care
- **Smoking Cessation** Services in primary care; community pharmacies; and drop in sessions
- **Weight Management** including Counterweight in primary care (for adults) and a range of Child and Family healthy weight interventions
- **Drug and Alcohol** services delivered by Community Alcohol & Drug Services Shetland and the NHS prescribing Clinic
- **Sexual Health and Wellbeing** Clinic; a Monday evening drop-in clinic at the Gilbert Bain Hospital
- **A pre-conceptual care** service for people planning pregnancy, which is provided through the maternity department by a specialist midwife.
- **Exercise on referral** as part of cardiac rehabilitation programme (with Shetland Recreational Trust)
- **Falls prevention work** including Chair-Based Exercise
- **Healthy Working Lives**: includes advice, resources and training for employers and workplaces
- **ASIST (Suicide Prevention)** and **Mental Health First Aid training**

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[2] **Co-production is a new vision for public services based on recognising the resources that citizens already have, and delivering services** *with* **rather than** *for* **service users, their families and their neighbours.**

[3] Asset based approaches are based on the principles of appreciating and mobilising individual and community talents, skills and assets, rather than focussing on problems and needs

- **Improving Health: Developing Effective Practice** Training for healthcare and other workers

Other health improvement activities often delivered in partnership: including awareness raising and campaigns; preventative work (often with children and young people); other training events.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Health Improvement				353,794	

Needs/Unmet needs/Drivers for change

Needs assessment undertaken through locality profiling, and analysis of current service delivery. There is a more detailed assessment of need within the overarching health improvement strategy and within each of the individual health improvement strategies. Key statistics for Shetland include:

- There are still approximately 3000 people who smoke
- According to GP figures, smoking rates are higher in the practices covering the more disadvantaged areas of Shetland
- In 2011 10% of pregnant women were smoking at booking
- In 2011/12 23.4% of primary 1 children in Shetland were overweight or obese (Body Mass Index - BMI on 85th centile or above)
- 220 people were discharged from hospital with alcohol related diagnoses in 2011-12
- Seven people died through suicide or deaths of undetermined intent in 2011

Whilst there is a wide range of health improvement services and activities available in Shetland, many of these are still centred in Lerwick (e.g. the drop in clinics, community pharmacy services and many of the training events) and people in the more remote and rural areas need better access to the same opportunities.

As well as geographical limitations, there are other restrictions on the services that can be provided because of our very small scale. This can result in widening the health inequalities gap by excluding some of the most vulnerable and disadvantaged groups from being able to access services. There is therefore an unmet need in making health improvement services and activities more accessible to all communities and groups that need them.

There are some specific areas of unmet need that have been identified, and these have not changed in the past year, including:

- Exercise on prescription for more groups (currently just for cardiac rehabilitation patients).
- Greater range of weight management interventions, particularly for those needing a more intensive intervention than Counterweight.
- Psychological interventions and support for individuals with complex needs struggling with behaviour change.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
• Increasing capability, capacity and the contribution of non specialist staff: including work with the wider workforce through the Health Promoting Health Service programme to embed health improvement in routine practice; increasing community based work and the use of volunteers. • 'invest to save' to support accelerated health improvement programmes tackling key risk factors and positive lifestyles with a focus on physical activity, reductions in smoking and alcohol misuse; utilising the increased capacity and capability as above. • community capacity building and work in partnership with voluntary sector partners.			

Key Risks to Delivery
Workforce/capacity issues mean that other professional staff don't have the time they would like in order to undertake preventative work.

The main risk is the requirement to achieve savings, which makes it harder to 'invest to save' in the way that we would like to do. We are addressing this through the use of volunteers, where at all possible, and think of ways to maximise the contributions of staff that we do have.

Performance Targets with links to National Outcomes
Single Outcome objectives under Outcome B: We live longer healthier lives.
Objective 1: To reduce alcohol consumption as a key risk factor for poor health outcomes; specifically focusing on the most vulnerable and disadvantaged individuals and communities.

Objective 2: To reduce smoking as a key risk factor for poor health outcomes; specifically focusing on the most vulnerable and disadvantaged individuals and communities
Objective 3: To increase physical activity, focussing on those who are currently inactive and the most vulnerable and disadvantaged individuals and communities
Objective 4: To reduce the suicide rate by identifying and tackling key risk factors at a local level
Objective 5: To support reducing health inequalities by increasing access to a healthy diet

Public Health Ten Year Plan Targets:

- To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s). The table illustrates Scotland-wide compared to Shetland rates of premature mortality.
- To reduce the percentage of adults who smoke from 15% in 2010 (as measured by Scottish Household Survey) to 10% by 2015, and 5% by 2022
- To reduce the percentage of adults who smoke in the two most deprived SIMD quintiles in Shetland to match the overall smoking rate for Shetland by 2015. Historical data based on GP practice shows that the practices that cover the most deprived areas in Shetland (as measured by SIMD) have higher smoking rates than other practices. However we need to determine the current baseline for this indicator, and set a trajectory to reach the target.
- To achieve the HEAT target of 104 inequalities related smoking cessation successful quits at 4 weeks by end March 2014 (35 achieved by March 2012)
- To reduce the number of alcohol related admissions (discharges) from a baseline of 761/100,000 discharges in 2009/10 to a target of 500 / 100,000 discharges by 2014/15, and 300/100,000 by 2021/22. (This target is based on the best performing Boards in Scotland)
- To increase the proportion of people aged over 65 who live in a housing rather than hospital or care setting: This is currently high at 974.7/1000 but needs to be maintained despite an increasing elderly population. The data presented in the table below illustrates how, working jointly, services are enabling more people to stay in their own homes with 36.3 per 1000 population living in a care or hospital setting in 2009 dropping to 23.6 for 2014.

Contact Details

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Phone: 01595 807484
Email: shet-hb.healthimprovementdepartment@nhs.net

Further Reading

- Public Health Ten Year Strategy 'Changing the World' (2012-2022)
- NHS Shetland Public Health Ten Year Strategy 'Changing the World' Update August 2014 'More than Targets'
- Mental Health Strategy
- Obesity Strategy
- Active Lives Strategy
- Shetland Sports Strategy
- Choose Life Action Plan
- Older People's Strategy
- CEL 01 (2012) Health Promoting Health Service

Public Health Service Plan

- **Policy context**
  Public Health covers the three domains of health improvement, health protection and population health in service planning and delivery.
  Further detail on Health Improvement is included in that separate section of the Strategic Plan. This section focuses on the core Public Health Team, and policy and service change etc in core public health, health protection and population health.
  However, financial targets for savings for public health come from the whole departmental budget, so the likely impact of these is included here.
  The Public Health team work to deliver the requirements of the Public Health Etc (Scotland) Act 2008, which governs the requirements and arrangements for public health in Scotland.
  There is currently a national review of public health in Scotland, and the service will need to take account of any change that results from that review (due to report later in 2015/16).

- **Current Services**
  The Public Health Department provides public health services to NHS Shetland and the local community. Our purpose is to promote, improve and protect the health and wellbeing of the people of Shetland, to prevent ill-health, and to reduce health inequalities.
  We do this by surveillance and response to communicable disease and environmental health threats, and oversight of immunisation and screening programmes; health improvement programmes targeted at lifestyle factors, working with individuals and communities on prevention and tackling inequalities; and technical support on population health through health intelligence work, needs assessment, health impact assessment and service evaluation.
  The team also provides support for the Strategic Planning function to the Board, and supports the Board's performance monitoring system.
  We consist of:
  Director of Public Health (F/T)
  Consultant in Public Health Medicine (P/T)
  Public Health specialist (P/T)
  Senior Planning & Information Officer (F/T)
  Information Analyst Public Health Intelligence (P/T)
  Public Health secretary & admin support (shared with Director of Pharmacy)

- **Funding and Resources**
  Table of budget and savings targets, including workforce details

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Public Health	14.6[i] 3.1[ii]			£548,214[i] £194,420[ii]	

i Includes Health Improvement staff
ii Core Public Health Team

- **Needs/Unmet needs/Drivers for change**
  Population health needs are changing with an increasing elderly population, and increasing demands on health and care services. Public health intervention offers the potential to change the pattern of demand, through prevention, early intervention and

health improvement for which a case can be made for 'Invest to Save' in Health Improvement activity. The challenge is to do this whilst meeting departmental savings targets by reducing budgets.
In addition the DPH is retiring at end March 2106, which gives both a challenge around sustainability and resilience within the team, and a potential efficiency / savings opportunity around team skill mix. The decision on this rests with the CE and the Board.

- **Plans for change**

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Retirement of DPH and succession planning	CE	June 2015 / end March 2016	
Team staffing restructure to achieve savings targets	DPH	Sept 2015 / March 2017	Efficiency savings achieved with minimal loss of service delivery. Links to National Outcomes 1.Improving Health & Wellbeing 5. Reducing health inequalities 7. Safe from harm 9. Resources used efficiently

The Public Health Team has achieved its savings targets to date consistently through savings in non-pay and staff turnover. In 2016/17 for the first time this will not be possible. The team is therefore planning redesign with any future staff leaving - to not replace or replace with budget savings to achieve the savings targets for 16/17 and 17/18.
We can achieve our future savings targets if we have staff turnover and our workforce plan for 2016/17 will set out how we might achieve that. Without natural turnover we can only achieve savings by a restructuring that would displace staff to achieve the savings. The workforce plan for 16/17 will therefore also show the plan for restructuring the dept to achieve savings through staff redeployment.

- **Key Risks to Delivery**

Increasingly we use national programme budgets to fund core staff which brings two risks: around achieving savings - some programmes require performance monitoring to government which needs to show spend in programme areas, this limits our flexibility to make savings or reduce services in these programme areas;
if national programme funding ends, unless it is replaced with new programme funding we reduce staffing to remain in budget. This has been managed to date through the use of short term contracts and natural staff turnover. These opportunities have now all come to an end, so future reductions in programme budgets will result in loss of staff, and the dept budget will need to absorb any associated costs.
If we are faced with restructuring and staff redeployment, we will need a lead-in time to achieve savings, and we will need to add to our savings targets with any associated costs unless the Board reaches Board-wide agreement on supported funding. The workforce plan will detail our management of this risk.
There is a risk of reduced service delivery with reduced staffing levels, which we will aim to minimise through reducing unnecessary activity, best use of skill mix, and focus on effective practice.

This includes failure or delays in re-recruitment to the DPH role, or reduced staffing resource in any replacement redesign.

- **Performance Targets with links to National Outcomes**
  Health Improvement HEAT targets are detailed in the Health Improvement section. Public Health also leads and supports delivery against the Single Outcome Agreement objectives on
  Living Longer, Healthier Lives (with targets on alcohol, physical activity, smoking and suicide prevention); Reducing Inequalities; and Being the best place for children and young people to grow up.

- **Contact Details**
  The Public Health team are based in Upper Floor Montfield in Board HQ, Burgh Road, Lerwick ZE1 0LA.
  Contact via the department secretary on 01595 743340 or on email to shet-hb.publichealthshetland@nhs.net

- **Further Reading**
  Public Health Annual Report 2014/15 including Appendices on progress against the Work Programme and the Public Health Ten Year Plan - add in web link

Child & Family Health

Policy context

The Scottish Government's ambition is that Scotland should be the best place in the world for children and young people to grow up. There are a number of national policies and local strategies that we link with to help achieve this ambition and ensure that children and young people who live in Shetland will have the best possible start in life and achieve the best outcomes.

The Refreshed Maternity Framework (2011) has been designed to address all care from conception, throughout pregnancy and during the postnatal period. This document clearly outlines the strategic direction for maternity services in Scotland and NHS Shetland is delivering on this Framework. It has been well recognised that maternal health and wellbeing has a significant impact on future child development and resilience.

The Children and Young People (Scotland) Act 2014 , which was passed by the Scottish Parliament in February 2014 combines proposals to improve the delivery of children's rights and services for children and young people. It is wide-ranging in its focus, building on the foundations of Getting it Right for Every Child (GIRFEC) particularly with the responsibilities outlined for the Named Person/Lead Professional.

GIRFEC is more than the framework supporting inter-agency assessment and planning. It provides the overarching principles and values for everything we do for our children and young people. In order to further embed these into our thinking and practice, we have formulated our practice around the GIRFEC National Practice Model SHANARRI outcomes. All our partner services have adopted this principle. The aim is to bring a common language and framework to all children and young people's services planning.

The Early Years Framework published in December 2008, signified an important milestone in encouraging partnership working to deliver a shared commitment to giving children the best start in life and to improving the life chances of children, young people and families at risk.

The objective of the Early Years Collaborative (EYC) is to accelerate the conversion of the high level principles set out in GIRFEC and the Early Years Framework into practical action.
The aim is to:

- Deliver tangible improvement in outcomes and reduce inequalities for Scotland's vulnerable children
- Put Shetland squarely on course to shifting the balance of public services towards early intervention and prevention by 2016
- Sustain this change to 2018 and beyond

The EYC is premised on the fact that we know there is strong evidence about costs and outcomes of current and desired practice, but much of this is not being used in daily work. Where we have taken on board the evidence, practice does not always reliably recreate what the evidence tells us, and there is inconsistency and patchy implementation.
The EYC will help us close that gap by:

- Creating a structure in which partners can easily learn from each other and from recognised experts in areas where they want to make improvements.
- Supporting the application of improvement methodology to bridge the gap between what we know works and what we do.

There are key change areas identified and the Shetland EYC Group are working with individual teams to deliver improved outcomes for children as described in SOA and Integrated Children's

Plan. These include addressing child poverty, family engagement and parenting skills amongst others.

Current Services

The Child Health Team was created in 2012 as a result of bringing together child health services across the community, hospital and specialist settings. The team includes: 1 GPwSi (Paediatrics), 1 team leader, 5.3 Health Visitors, 2 Children's Nurses, 1 School Nurse and a Public Health Staff Nurse who work across Shetland. They are supported by 2 support staff. There are a number of staff who support and work alongside this core team.

- **Health Visitors**
  Health visitors (HVs) support and educate families from pregnancy through to a child's fifth birthday or entering school. Health visitors are trained to recognise the risk factors, triggers of concern, and signs of abuse and neglect in children. HVs also maintain contact with families while formal safeguarding arrangements are in place; ensuring families receive the best possible support during this time.

  Children's' Nurses
  Children's nurses have a broad casemix from caring for a neonate to supporting a child following trauma e.g. accident or bereavement. Children's nurses also play a key role in the care and support needed by the wider-family, including the parents. The team includes two Registered Children's Nurses – one with a focus on hospital care and the other is based in the community and provides holistic child centred care to children and young people up to the age of 18 years of age for a wide range of health issues and conditions. The Community Children's nurse may be the Lead professional for children and young people who are identified as needing a Child's Plan as defined by Getting Right for Every Child.

- **Out-Patient Services**
  Our Children's Outpatient Department operates as required and enables children to be seen within Shetland by General Practitioner with Special Interest in Paediatrics and by visiting paediatricians and visiting specialists. Our healthcare support worker works within this department half time and in the school nursing service the rest of her time.

- **School Nurses**
  School nurses are public health nurses who work within a variety of settings but principally within schools. A child-centred public health approach enables the school nurse to work at community level with public health programmes, with whole schools, with group work within schools and with individual children, young people and their families.

- **Children's Physiotherapy**
  The paediatric physiotherapy service is based at the Gilbert Bain Hospital and served by 1.6 WTE staff (made up of 1 WTE Band 7, 0.5 Paediatric band 6, and 0.1 Outpatient Band 6). It provides a service to children and young people aged 0-16 (19 if additional needs) in a variety of settings including: inpatients, outpatients, community and schools.
  The service takes referrals from health, education and also from parents and children themselves via self-referral. It provides advice, assessment and treatment in all areas of paediatric physiotherapy such as development, orthopaedics and musculoskeletal problems, respiratory illness and neurology. It is also able to refer directly into paediatric and orthopaedic clinics for children on the caseload which minimises the impact on GP's.

- **Speech and Language Therapy Service**

This service provides assessment, diagnosis and treatment for children and adults with speech, language and communication needs, and those with eating, drinking swallowing problems (dysphagia). Children are seen with a range of speech, language and communication needs, including language delay and disorder, difficulties with speech production, voice problems, dysfluency and social communication difficulties. There are 2.56 speech and language therapist and 0.7 support worker. There is currently 243 children on the caseload with 104 referrals in 2013.

- **Child and Adolescent Mental Health Service**
  This multi disciplinary team provides a CAMH service to the population of Shetland. The team consists of 1 WTE Psychiatric Nurse, 1 WTE Primary Mental Health Worker, 0.7 WTE Clinical Associate in Applied Psychology and two visiting specialists – a Consultant Psychologist and a Consultant Psychiatrist – who hold monthly clinics over 4 sessions. It provides consultations, assessments and interventions; treatment can include different types of individual therapy: behavioural; cognitive; systemic; psychodynamic, family work of various kinds, and where needed prescribed medication. Referral for 2014 has seen a 30% increase in numbers from the same time period in 2013.

- **Children's Occupational Therapist (OT)**
  This service is involved in the assessment and development of the practical skills necessary for children's everyday life. An OT will aim to enable a child to be as independent as possible by analysing the following areas functional abilities, school skills, play skills sensory abilities fine motor gross motor, movement abilities and behavioural responses during your child's day. The staff consist of a specialist children's OT (0.8) Assistant Practitioner (0.5).

- **Medical Care**
  Medical services on island are provided by a local GP with Special Interest in paediatrics and sessional paediatrician providing a community child health clinic, and joint clinics with visiting paediatricians offering a combination of general paediatric sessions and specialist clinics e.g. cardiac, respiratory. Most in-patient children's services are provided through NHS Grampian or to more specialist regional or national paediatric services.
  Children, who are acutely ill, will present through Accident and Emergency, be assessed and given initial treatment by the medical or surgical teams, in consultation with specialist paediatric services in Grampian as appropriate. Children may stay overnight in GBH but if they need longer term inpatient care they will be transferred to a specialist Children's Hospital. There is also a paediatric retrieval service for transporting seriously ill children to specialist units off island.

Funding and Resources

Service	Number of Staff (WTE) [4]	Expenditure	Income	Net Budget	Savings target [5]
Maternity	16.02			£777,938	£4,538
Child Health & Health Visiting	11.98			£581,731	£17,452

[4] Establishment is taken from 2015/16 workforce plans

[5] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

Sexual Health	NA			£38,137	£1,144
CAMHS	2.5[6]			£181,995	£5,460
Medical Staffing - Child Health Consultants	NA			£250,049	£7,501
Medical Staffing - Consultant Gynaecologist/Obstetrician & GPwSI	1.66			£324,446	£4,155
Management Costs	1			£74,000	£2,220
Total	**29.66**			**£2,228,296**	**£42,470**

The indicative savings target for planned care services in 2016-17 is **£42,470.** This is equivalent in staffing costs to a reduction of WTE 1.3 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- review skill mix including advanced practice NMAHP role development and other skill mix changes
- Repatriating services e.g. obstetrics and gynaecology to reduce patient travel and the cost of off island services

Needs/Unmet needs/Drivers for change

- Due to the changes in medical training recruiting medical consultants who have the expertise to care for children may be problematic in the future.
- A national shortage of Health Visiting staff and the implementation of the Children and Young Peoples Act have led to a government-led initiative to increase the number of health visiting posts Scotland wide with a new training programme starting and an increase in the number of Health Visiting posts rising over the coming years.
- In terms of the Shetland workforce, 60% of Health Visitors in post are due for retirement in the 3-5 years
- Modernisation of the school nursing role is at an early stage and the outcome of that consultation may have an impact on the service we provide in the future
- CAMHS require redesign options discussed to ensure the service can accommodate the increase and diversity of the children being supported by the staff
- Advance Practice models for AHP is being discussed nationally. We need to look at the potential of advanced practice NMAHP roles to support children's services locally

Plans for change

- The impact of the Children and Young Person's Act 2014 and the new HV pathway needs to be quantified and evaluated over the next few years – including the workforce needed to deliver the legal requirements of the act
- Redesign of the CAHMS team and links to specialist services is a key priority
- On-island paediatric outpatient care is fragile. A review of the options available to sustain input from medical specialist team will be required over the next 1-2 years

[6] Increasing to 3.5 in 16-17

- Joint commissioning and joint budgeting discussions are being tabled at the Integrated Children and Young Person's Strategic Planning group (ICYPSPG). We will be engaging with this work over the coming years
- The move to an electronic child's record will allow the secure sharing of information between services when required under the Children and Young Person's Act (2014)

Key Service Indicators - HEAT and other Local Targets

ID Code	Target Description
H.9	3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year (percentage)
H.10	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours. (percentage)
BSC4	Immunisation Uptake - MMR1 at 2 yrs (percentage)
BSC7	Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter) (percentage)
HI.3	Percentage of mothers smoking during pregnancy
HI.4	Reduce the proportion of children with their Body Mass Index outwith a healthy range (>=85th centile) (percentage)
HI.6	Reduce teenage pregnancy rate (13-15 year olds) Rate per 1,000 population (3 year rolling average) (rate)

Service Performance Measures from the Shetland Single Outcome Agreement

Single Outcome Agreement objectives:

- Effective early intervention and prevention to enable all our children and young people to have the best start in live.
- Effective early intervention and prevention to get it right for every child.

Other Performance indicators

National Performance Framework strategic objectives:

- Our children have the best start in life and are ready to succeed.
- We have improved the life chances for children, young people and families at risk.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

EYC aims are:

- To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1000 births in 2010, to 4.3 per 1000 births in 2015) and infant mortality (from 3.7 per 1000 live births in 2010, to 3.1 per 1000 live births in 2015). This objective has been achieved and a review is underway to establish further aims in this area.
- To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016.

- To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.

Local outcomes (as agreed by the Integrated Children and Young Peoples Strategic Planning Group in the Multiagency Children's Plan):

- Shift from crisis intervention to prevention and early intervention.
- Promote resilience and wellbeing of children, young people, families and communities.
- Timely engagement with children and young people to ensure their views shape current and future planning.
- Continue development of our workforce in delivering the best outcomes for children and young people through their multi-agency working.

Contact Details

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Further Reading

GIRFEC website: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp

EYC website: http://www.scotland.gov.uk/Topics/People/Young-People/early-years

Shetland Integrated Children and Young People Plan

Acute & Specialist Services

Planned Care

Policy Context

Planned care is an umbrella term used to describe services which are planned and pre-booked by appointment. This includes access to elective procedures in Day Case and Ambulatory Care settings, access to diagnostic tests and outpatient consultations.

The overarching aim of services aligned to planned care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services for pre-booked assessments, tests, care and procedures. Planned care takes place across community, hospital and specialist settings.

The national policy context is very broad and includes: the Public Bodies (Joint Working) (Scotland) Act (2014); 20:20 Vision (2011) and the Patients Rights Act (2011).

Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The importance of planned care services is described in local strategies and plans e.g. the older people's strategy (2015), dementia strategy (2015), mental health strategy (2013), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of planned care services, which are also aligned to local policy context, include:

- Streamlining referral and diagnostic pathways
- Active management of admissions so that only patients who need specialist care are admitted to hospital (implementing alternative models, reducing length of stay)
- Active management and redesign of outpatient services (e.g. developing multi-disciplinary models, introducing telehealth to support remote access etc) to promote pre-admission assessment and follow up in localities
- Creating pathways to support day surgery and ambulatory care as the norm for planned procedures (reducing reliance/pressure on inpatient services)

Current Services Provided

The majority of healthcare services have a planned care pathway, but the main ones can be defined[7] as:

- Day Surgery Services
- Out Patient Services (local and visiting)
- Pre-Operative Assessment Services
- Chemotherapy Services
- **Renal Services**
- **Elective Inpatient Medical Services**
- Elective Inpatient Surgical Services
- **Elective Rehabilitation Services**
- Planned Critical Care Services (e.g. pre-operative optimisation and post operative care)

[7] The services shown in bold are part of the joint service planning arrangements set out in the Integration Scheme – known as part B 'set aside' services.

- Elective Theatre Services
- Elective Obstetric Services e.g. pre and post natal care, planned c-sections
- Elective Service provision at NHS Grampian for patients requiring specialist interventions
- Allied Health Professionals - AHPs (planned clinics are in place across all seven AHP disciplines)
- Diagnostic Services (e.g. Medical Imaging, Laboratory Services, Audiology, Physiological Measurements etc)

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of planned care, including the provision of tele-health services to support long term conditions and self management as well as transporting patients between health and social care settings.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery. Child and Family Health Services and specialist off island services are also shown in separate plans.

Funding & Resources

Jointly Commissioned Services (that include a planned care component)

Service	Number of Staff (WTE)[8]	Expenditure	Income	Net Budget	Savings target [9]
Acute Medical Ward (Ward 3)	26.62			£910,654	£27,320
Rehabilitation Unit (Ronas)	12.89			£524,671	£15,740
Medical Staffing - Consultant Physicians & Junior Doctors in Training	8			£1,007,037	£30,211
Renal	3.57			£144,699	£4,341
Total	**51.08**			**£2,587,061**	**£77,612**

Other Planned Care Services & Support Functions in the Acute & Specialist Services Directorate

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Surgical Services (Surgical Ward, DSU & HDU)	27.38			£1,066,022	£ 21,320
Theatre Services	15.19			£929,032	£18,581
Decontamination Services	4.64			£166,759	£3,335
Out Patient Services	7.42			£283,942	£5,679

[8] Establishment is taken from 2015/16 workforce plans

[9] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Visiting Services (NHS Grampian and other providers)	Not Applicable			£267,632	£31,981
Pre- Assessment	2.2			£103,669	£27,871
Oncology/Chemotherapy	3			£151,259	£5,003
Specialist Nurses	2.73			£138,499	£8,518
Medical Staffing - Consultant Surgeons & Junior Doctors in Training	7			£883,751	£8,029
Medical Staffing - Consultant Anaesthetists	4			£666,556	£3,110
Maternity Services	16.02			£777,938	£4,538
Medical Staffing - Consultant Gynaecologist/Obstetrician & GPwSI	1.66			£324,446	£4,155
Medical Imaging	8.96			£663,449	£26,513
Laboratory Services	9.62			£761,461	£19,997
Physiological Measurements	1			£66,616	£23,338
Audiology	1.6			£132,659	£9,733
Health Records & Reception	27.99			£896,660	£19,903
Hospital Management	3			£239,559	£22,844
Total	**143.41**			**£8,519,909**	**£255,597**

Drivers for Change

Over recent years, services that provide planned care have been under increasing pressure. There are a number of factors which are associated with the increase in planned care activity including:

- A response to demands associated with demographic changes and patterns of ill health
- Increased public expectation of equity of access to health and social care services
- Advancement in technology, diagnostic capabilities and surgical techniques has made many interventions safer and less invasive resulting in an increase in the number of patients eligible for treatment
- Progressive shift towards the delivery of day case surgery, interventions and diagnostic tests in ambulatory care units and out with the hospital setting
- Successful delivery of services within the national waiting times treatment guarantee (TTG) and other access targets

Another important factor impacting on planned care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways.

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies
- Managed Clinical Networks (MCNs) to support people with long term conditions e.g. diabetes, cancer, neurological conditions, sensory impairment
- Promoting personal and community level resilience and accountability for health and wellbeing
- Effective health and care pathway design across primary, secondary and specialist care
- Delivering Outpatient Integration Together (DO IT)
- The Patients Rights Act – Treatment Time Guarantee (TTG)
- Making ambulatory care and day care services the norm
- Effective models of unscheduled care delivery

Plans for Change

The indicative savings target for planned care services in 2016-17 is £333,209. This is equivalent in staffing costs to a reduction of WTE 10.5 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Reducing our reliance on expensive inpatient beds and focusing on ambulatory care models
- Increase efficiency and productivity e.g. by delivering more services locally using affordable methods such as tele-health
- Streamlining pathways – reducing the reliance on outpatient services and delivering more complex assessments with practitioners in the community
- Reduce inefficiency and short term spending on locum/supplementary staffing

Our strategic priorities for planned care as set out in the Corporate Action Plan (2015-16 and beyond) and the various strategies referenced above can be summarised as follows:

- Managing patient flow - balancing planned and emergency care and separating flows wherever it is possible to do so
- Developing new models of supported rehabilitation, discharge to enhance recovery and reduce length of stay in hospital
- Repatriating services where it is safe to do so – providing person centred care and maximising the efficiency of local services
- Developing ambulatory care and day care models as a safe alternative to inpatient care and increasing activity through investment in ambulatory care and day surgical facilities
- Using technology and tele-health to avoid unnecessary follow up/review in hospital
- Role development to support planned care service delivery – particularly the positioning of advanced NMAHP practitioners in ambulatory care and outpatient settings
- Reducing the number of people who are delayed in hospital

Some of the specific change management plans/actions/impact and timescales are shown here.

Description	Lead Officer	Start/Target	Expected Outcome(s)	National Outcomes
Increasing access to tele-health appointments to avoid unnecessary follow up and travel	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review progress September 2016 and annually thereafter	Increase in use tele-health delivered appointments Increase in electronic triage of referrals Reduction in the cost of patient travel	Public services contribute to reducing health inequalities Resources are used effectively and efficiently
Increasing capacity in the renal unit to meet demand	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review progress September 2016 and annually thereafter	Additional renal dialysis stations – to meet growing service demand Reduced patient travel through the provision of teleheath	Resources are used effectively and efficiently
Identifying appropriate clinical pathways for repatriation to Shetland in collaboration with NHS Grampian – e.g. local surveillance instead of specialist service oversight, shared pathways with specialists in Grampian	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review progress September 2016 and annually thereafter	Reduction in the number of patients travelling to NHS Grampian and other hospitals for follow up Reduction in the number of procedures undertaken in NHS Grampian hospitals Reduction in the cost of the SLA (at a sub speciality level)	Public services contribute to reducing health inequalities Resources are used effectively and efficiently
Developing an enhanced Day Surgical Unit (DSU) and ambulatory care facility	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – if funding is successful then construction will be complete mid 2017	Increase in the number of day case surgical procedures (through repatriation of clinical services from Grampian) Increase in the number of ambulatory care procedures (as an alternative to admission) Reduction in the number of inpatient attendances and outpatient attendances Reconfiguration of inpatient services/beds (medium term)	Public services contribute to reducing health inequalities Resources are used effectively and efficiently

Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)	Director of Nursing & Acute Services (DNAS)	Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards	Increased role development for NMAHPs with advanced practice skills Increased number of NMAHPs supporting planned care e.g. in outpatient setting Reduced length of stay (LoS) for patients due to increased availability of enhanced recovery models Reduced LoS linked to nurse led discharge Reduced locum costs (e.g. for junior doctor vacancies)	Resources are used effectively and efficiently H&SC services are centred on helping to maintain or improve quality of life People using services are safe from harm
Put in place a managed service contract for Laboratory Services (joint arrangement with NHS Grampian and NHS Orkney)	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review implementation in September 2016	Fixed costs for revenue requirements for lab reagents Reduced capital costs for laboratory equipment replacement and maintenance Reduced cost of on call for BMS staff (moving towards point of care testing and sample analysis automation)	Public services contribute to reducing health inequalities Resources are used effectively and efficiently
Reviewing the management structure for Acute & Specialist Services	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review implementation in September 2016	Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs	Resources are used effectively and efficiently

Key Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Planned care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a 'whole system' strategic exercise with all partners working to shared objectives
- Pace of change – e.g. developing primary care and locality based alternatives to outpatient assessment, review clinics and early supported discharge will take time. We

need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented

- Viability of alternative models – we will need to work closely with specialist services and NHS partners to ensure that pathway redesign is realistic and deliverable. There are considerable challenges ahead for succession planning generalist clinical roles and we are already starting to see the impact of this on some visiting services
- Increase in demand for acute services due to demographic changes and case complexity
- Rising costs associated with increases in demand and inflation reduce the impact of the redesign plans

Targets/Outcomes

There are a number of HEAT targets that specifically relate to quality or performance markers for effective planned care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

E.4.2S	Total Delayed Discharges (count)	M	2015 Aug	2	2015 Jul	2	**R**	→	0	2016-03	0	
E.9	No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0	
A.9aS	Urgent Referral With Suspicion of Cancer to Treatment Under 62 days (percentage)	M	2015 Jul	83	2015 Jun	100	**R**	↓	100	2016-03	95	
A.9bS	Decision to treat to first treatment for all patients diagnosed with cancer - 31 days (percentage)	M	2015 Jul	100	2015 Jun	100	**G**	→	100	2016-03	95	
A.10.2Sa	Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (consultant led services) (count)	M	2015 Jul	38	2015 Jun	21	**R**	↓	0	2016-03	0	
A.10.2Sb	Inpatients/Day Cases Waiting Over 9 Weeks (count)	M	2015 Jul	11	2015 Jun	9	**R**	↓	0	2016-03	0	
A.10.2Sba	Treatment Time Guarantee - 12 weeks	M	2015	0	2015	0	**G**	→	0	2016-	0	

	from being added to Inpatient waiting list to having procedure (count)		Jul		Jun					03		
A.10.2Sc	Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (Orthodontic Service) (count)	M	2015 Jul	1	2015 Jun	0	**R**	↓	0	2016-03	0	
A.10S	18 Weeks Referral to Treatment: Combined Performance (percentage)	M	2015 Jul	93.5	2015 Jun	94.8	**G**	↓	90	2016-12	90	
Acc1	Number of cases where the Upper GI endoscopy waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	1	**G**	↑	0	2016-03	0	
Acc2	Number of cases where the Lower endoscopy (excluding colonoscopy) waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0	
Acc3	Number of cases where the colonoscopy waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0	
Acc4	Number of cases where the cystoscopy waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0	
Acc5	Number of cases where the ultrasound scan waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0	
Acc6	Number of cases where the CT scan waiting time was greater than 6	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0	

	weeks (count)											
Acc7	Number of cases where the Barium enema test waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0	
BSC16	Quarterly Hospital Standardised Mortality Ratios (HSMR) (count)	Q	2015 Jan-Mar	0.61	2014 Oct-Dec	1.27	**G**	↑	1	2016-03	1	
T.12	Emergency bed days rates for people aged 75+ (rate))	M	2015 Aug	361	2015 Jul	421	**G**	↑	500	2016-03	3497	
T.14	To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%. (percentage)	A	2014	19.2	2013	16.4	**R**	↑	26	2016-03	29	
CCB1	Average length of stay for critical care patients discharged per month (days)	M	2015 Jul	2	2015 Jun	1.9	**G**	↓	2	2014-12	2	
CE02a	% of people who say they got the outcome (or care support) they expected and needed on Ward 3 (percentage)	M	2015 Jul	100	2015 Jun	100	**G**	→	90	2016-03	90	
CE02b	% of people who say they got the outcome (or care support) they expected and needed on Ward 1 (percentage)	M	2015 Jul	100	2015 Jun	100	**G**	→	90	2016-03	90	

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Further Reading (available at http://www.shb.scot.nhs.uk)

Older Peoples Strategy
Corporate Action Plan
Unscheduled Care Strategic Plan

Unscheduled Care

Policy Context

Unscheduled care is an umbrella term used to describe services which provide an emergency or unplanned service response. The majority of unscheduled care takes place in the community setting and is managed by community health and social care teams.

The overarching aim of services aligned to unscheduled care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services 'in an emergency'. Unscheduled care takes place across community, hospital and specialist settings.

The national policy context is very broad and includes: the Public Bodies (Joint Working) (Scotland) Act (2014); 20:20 Vision (2011) and the Patients Rights Act (2011).

Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The importance of planned care services is described in local strategies and plans e.g. the older people's strategy (2015), dementia strategy (2015), mental health strategy (2013), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of unscheduled care services, which are also aligned to the unscheduled care collaborative essential actions include ensuring that we deliver:

- Clinically Focussed and Empowered Hospital Management
- **Hospital Capacity and Patient Flow (Emergency and Elective) Realignment**
- **Patient Rather Than Bed Management – Operational Performance Management of Patient Flow**
- **Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway**
- **Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working**
- **Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting**

Current Services Provided

The majority of healthcare services have an unscheduled care pathway, but the main ones can be defined[10] as:

- **Out of Hospital Services – e.g. community nursing and primary care services 'out of hours'**
- **Accident and Emergency Services**
- **Acute Inpatient Medical Services (including admission of renal patients)**
- Acute Inpatient Surgical Services
- Critical Care Services
- Theatre Services
- Obstetric Services
- Emergency Service provision at NHS Grampian for patients requiring specialist interventions

[10] The services shown in bold are part of the joint service planning arrangements set out in the Integration Scheme – known as part B 'set aside' services.

- Diagnostic Services (e.g. Medical Imaging, Laboratory Services)

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of unscheduled care, including the provision of air transfer and critical care retrieval for adults, children accessing tertiary care centres and patients accessing specialist mental health facilities.

The services which are shown in bold are part of the integrated commissioning arrangements.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery. Child and Family Health Services and specialist off island services are also shown in separate plans.

Funding & Resources

Jointly Commissioned Services

Service	Number of Staff (WTE) [11]	Expenditure	Income	Net Budget	Savings target [12]
A&E	14.66			£741,083	£14,822
Acute Medical Ward (Ward 3)	26.62			£910,654	£27,320
Rehabilitation Unit (Ronas)	12.89			£524,671	£15,740
Medical Staffing - Consultant Physicians & Junior Doctors in Training	8			£1,007,037	£30,211
Renal	3.57			£144,699	£4,341
Total	**65.74**			**£3,328,144**	**£92,434**

Other Planned Care Services & Support Functions in the Acute & Specialist Services Directorate

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Surgical Services (Surgical Ward, DSU & HDU)	27.38			£1,066,022	£ 21,320
Theatre Services	15.19			£929,032	£18,581
Medical Staffing - Consultant Surgeons & Junior Doctors in Training	7			£883,751	£8,029

[11] Establishment is taken from 2015/16 workforce plans

[12] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Medical Staffing - Consultant Anaesthetists	4			£666,556	£3,110
Maternity Services	16.02			£777,938	£4,538
Medical Staffing - Consultant Gynaecologist/Obstetrician & GPwSI	1.66			£324,446	£4,155
Medical Imaging	8.96			£663,449	£26,513
Laboratory Services	9.62			£761,461	£19,997
Hospital Management	3			£239,559	£22,844
Total	**92.83**			**£6,312,214**	**£129,087**

Drivers for Change

Over recent years, services that provide unscheduled care have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs
- Increasing public expectation of and access to health and social care services
- Delays in accessing up-to-date patient information - impacting on or slowing down clinical decision making
- Need for improved team working and better co-ordination of care between NHS partners (primary care, SAS, NHS 24, secondary care and tertiary care)
- Need for greater collaborative working to reduce delays particularly at the health and social care interface
- Need for closer working between health and social care services to develop integrated models of anticipatory and community based care
- Challenges in training, recruitment and retaining of staff

Another important factor impacting on unscheduled care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways. Our winter planning arrangements as well as a local focus on the strategic development of primary care services and medical staffing models help to support the sustainable delivery of unscheduled care and planned care services.

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies
- Promoting personal and community level resilience and accountability for health and wellbeing

- Developing an integrated approach for older peoples services delivery across health and social care
- Developing robust models for dementia care and community mental health services
- Effective health and care pathway design across primary, secondary and specialist care
- Effective models of planned care delivery e.g. Delivering Outpatient Integration Together (DO IT)
- Strategic plans to support Living and Dying Well

Plans for Change

The indicative savings target for unscheduled services in 2016-17 is £221,521. This is equivalent in staffing costs to a reduction of WTE 7 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Deliver care closer to home through locality based teams and services (reducing reliance on hospital and care home resources)
- Invest in patient education, self care and self management
- Use technology more to support people at home e.g. telecare, tele-health
- Working collaboratively with the third sector to provide services which help people to access services/support in the community
- Streamlining pathways – reducing the reliance on outpatient services and delivering more complex assessments with practitioners in the community
- Reduce inefficiency and short term spending on locum/supplementary staffing by changing the skill mix in teams

Our strategic priorities for planned care as set out in the Corporate Action Plan (2015-16 and beyond) and the various strategies referenced above can be summarised as follows:

- Managing patient flow - recognising the increase in admissions and demographic changes meaning patients with more complex needs are presenting through emergency care services and discharge planning models need to be revised
- Implementing a joint strategic approach to the delivery of older peoples care across health and social care sectors – particularly our objective to develop a locality based approach to provide more community assessment and support options
- Focus on ensuring that we can provide appropriate care settings/resources/pathways (jointly) to ensure that clinical and care needs are met in the community, whenever it is safe to do so
- Reducing the number of people who are delayed in hospital
- Reviewing the current provision of Out of Hours (OOHs) services to ensure they are sustainable
- Developing ambulatory care and day care models as a safe alternative to inpatient care
- Role development to support unscheduled care service delivery – particularly the positioning of advanced NMAHP practitioners in Acute and Community based care settings

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)	Director of Nursing & Acute Services (DNAS)/ Director of Community Health & Social Care	Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards	Increased role development for NMAHPs with advanced practice skills Increased number of NMAHPs supporting unscheduled/primary care e.g. OOHs Increased anticipatory care plan development/access Increased access to care to OOHs care packages Reduced locum costs (e.g. for GP vacancies)	Resources are used effectively and efficiently H&SC services are centred on helping to maintain or improve quality of life People using services are safe from harm
Reviewing out of hours service provision (including medical staffing, primary care configuration and locality based services)	Ralph Roberts (Chief Executive)	Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards		Resources are used effectively and efficiently
Reviewing the management structure for Acute & Specialist Services	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015	Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs	Resources are used effectively and efficiently
Reviewing the management structure for Community Care services		Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards	Improvement management capacity to support service delivery at a locality level Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs	Resources are used effectively and efficiently

Key Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Unscheduled care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a 'whole system' strategic exercise with all partners working to shared objectives
- Pace of change – developing robust community based models will take time and resources. We need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented
- Increase in demand for acute services due to demographic changes and case complexity

Targets/Outcomes

There are a number of HEAT targets that specifically relate to quality or performance markers for effective emergency care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

E.4.2S	Total Delayed Discharges (count)	M	2015 Aug	2	2015 Jul	2	R	→	0	2016-03	0	
E.9	No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes (count)	M	2015 Aug	0	2015 Jul	0	G	→	0	2016-03	0	
A.7S	A&E 4 Hour waits (percentage)	M	2015 Aug	94.1	2015 Jul	96.2	A	↓	98	2016-03	98	683 out of 726
A.8.1S	48 hour Access - GP Practice Team (percentage)	A	2014	93.5	2013	89	G	↑	90	2016-03	90	
A.8.2S	Advance booking - GP Practice Team (percentage)	A	2014	73.2	2013	73	R	↑	90	2016-03	90	
BSC17	Level of Older People with Complex Care Needs Receiving Care at Home (percentage)	Q	2015 Apr-Jun	48	2015 Jan-Mar	40	G	↑	39	2016-03	39	
T.10	Rate of attendance at A&E (rate)	M	2015 Aug	3094	2015 Jul	3021	A	↓	3061	2015-12	3061	

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Further Reading

Older Peoples Strategy, Corporate Action Plan, Unscheduled Care Strategic Plan

http://www.isdscotland.org/Health-Topics/Emergency-Care/

Renal Service

Policy context

To ensure the renal patients receiving renal replacement therapy are meeting the guidelines set by the Renal Association clinical standards.

Current Services

The Renal unit provides renal replacement therapy for the people of Shetland. In addition the service provides pre-dialysis education and monitoring and post transplantation care liaising with Aberdeen Renal Unit and Renal Consultant .The unit provides the opportunity for holiday dialysis whenever possible.
In addition, the renal nursing provide education and support for patients to enable them dialyse at home and provide respite care for these patients as required.
The service cares for patients following peritoneal dialysis and provides home visits if necessary and monitor their adequacy.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
RENAL				144699.00	2%

Needs/Unmet needs/Drivers for change

There has been an increase in demand over 2015 and moving forward into 2016, the staff have adjusted working times and days to support the increase in demand for the service. This increase in demand for the longer term will require a staffing review and service provision review.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
To extend the renal unit by 2 more stations making 6 in all.	Michael Gray	unknown	unknown

Key Risks to Delivery

- **Water quality**- water testing/ monitoring and result analysis, testing criteria and plan in place.

- **Water failure**- Estates monitoring, adjustment to service provision, and transportation of patients to NHS Grampian for dialysis if required in major water failure.

- **Dialysis machine failure**- 3 new dialysis machines and reverse osmosis machines have been purchased, a spare machine available which will support service continuity. The other two are for the new dialysis stations once the unit has been extended. Servicing of current machines undertaken by NHS Grampian. Major failure would instigate transfer of patients to ARI.

- **Weather related risks** - due to location of patients, if needs be, patients individual dialysis sessions can be changed to accommodate the patients or patients receive their dialysis in Aberdeen.

- **Specialists staffing resource** - staff work flexibly, hours extended where possible to meet services demand .Continued support is required to sustain the renal service and annual training plans are submitted to ensure staff receive the required updates. There are associated risks with staff sickness / absence and additional resilience is needed within the team to ensure service delivery.

- **Increase in demand for service**- The staff have reviewed their hours and days of work to accommodate the patients and are now full to capacity. This creates an impact on other services in terms of staffing (renal clinics, IV iron etc) which remains a challenge and consideration is required to further expansion of service in terms of staffing. To allow for increased demand for the service it is envisaged the extension to the unit will commence when all plans have been agreed year to allow for additional Shetland patients to receive their dialysis on island.

- **Performance Targets with links to National Outcomes**
  There are a number of standards that specifically relate to adult renal service:
  - Annual audit is carried out using the Quality Improvement Scotland (QIS)
  - Standards for Adult Renal Services.
  - Renal Association clinical standards.

Adequacy takes place with the data submissions to NHS Grampian

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Further Reading

Useful links:
Renal web : http://www.renalweb.com/
National Kidney Foundation: www.kidney.org.uk
UK National kidney foundation: www.kidney.org.uk
The Nephron information centre: www.nephron.com
Kidney patient guide: www.kidneypatientguide.org.uk/contents.php
Royal Infirmary of Edinburgh: www.edren.org

Medical Imaging Department

Policy Context

The AHP national plan (2012) and the Healthcare Science National Plan (2015) are key policies which shape the scientific professions aligned to healthcare. Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The contribution of clinical support services is described in local strategies and plans e.g. the older people's strategy (2015), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of clinical support services, which are also aligned to the AHP and Healthcare Science National Plans include ensuring that we deliver:

- Clinically Focussed and Empowered Diagnostic/Clinical Support practitioners
- **Ensure clinical pathways are evidence based and diagnostic tests are evidence based**
- **Seven day services are appropriately targeted to reduce variation in weekend and Out of Hours working**
- **Sustainable services and develop our local workforce – including fellowship and development posts to build resilient local teams**

Current Services Provided

The team consists of 6 Radiographers, 1 Sonographer, 1 Imaging Assistant and 1 Imaging Services Administrator.

The medical imaging department[13] undertakes approximately 14,000 imaging examinations per year. There is no local Consultant Radiologist and Radiologists at NHS Grampian, Aberdeen Royal Infirmary carry out reporting, where the Clinical Director is also based. Consultant Radiologists visit the department once a month to carry out specialised examinations. Role extension is actively encouraged within the department.

Key modalities available locally include plain film imaging/fluoroscopy/mobile/CT scanning & Ultrasound. There is out of hours emergency cover provided by a single on call radiographer. Modalities therefore available out of hours are dependent on the scope of practice of the radiographer on call.

The department operates highly efficiently by offering plain film imaging on demand; not only for A&E referrals, but for all primary & secondary care referrals where possible. Appointment systems operate for ultrasound and CT scanning due to the nature of the examinations which require preparation.

[13] Medical imaging is a clinical support service and one of the 'visible other' services out with the Integration Scheme strategic remit but provides services to practitioners which are part of 'side aside' and 'managed services'.

Funding & Resources

Service	Number of Staff (WTE) [14]	Expenditure	Income	Net Budget	Savings target [15]
Diagnostic Imaging Service	8.9			£522,829	£15,685
Ultrasound	NA			£2,700	£ 81
CT Scanning	NA			£137,920	£4,138
Total	8.9			£ 663,449	£19,903

Drivers for Change

Over recent years, services that clinical support and diagnostics have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs
- Increasing public expectation of and access to health and social care services
- Increasing demand for diagnostic tests and the need to ensure that there is a clear evidence base for test requests
- Challenges in training, recruitment and retaining of staff

Plans for Change

The indicative savings target for unscheduled services in 2016-17 is £19,903. This is equivalent in staffing costs to a reduction of WTE 0.5 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Streamlining pathways – reducing the number of diagnostic tests by creating a more consistent approach and evidence based pathways for diagnostic testing
- Increasing the number of diagnostic tests available locally – reducing off island service level agreement costs (e.g. looking at the potential to bring MRI to Shetland)
- Reduce inefficiency and short term spending on locum/supplementary staffing by changing the skill mix in teams

Our strategic priorities for medical imaging services as set out in the Corporate Action Plan (2015-16 and beyond) and the Capital Plan (2015 and beyond) as well as the various strategies referenced above can be summarised as follows:

[14] Establishment is taken from 2015/16 workforce plans

[15] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

- Role development to diagnostic/clinical support service delivery – particularly the positioning of advanced NMAHP practitioners to support local and regional shared services as well as looking at the development of the Assistant Practitioner role
- Ensuring that there is appropriate investment in medical imaging technology to support the repatriation of diagnostic tests from specialist services and ensure that we can sustain the delivery of local services

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
Reviewing the medical imaging staffing skill mix and team structure	Head of Medical Imaging/ Director of Nursing & Acute Services (DNAS)	Ongoing from 2015	Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs	Resources are used effectively and efficiently
Diagnostic Imaging Equipment Replace Programme - Replacement of x-ray equipment (2017-18) Replacement of CT scanner (by 2021) Replacement of current ultrasound machine (by 2018)	Head of Medical Imaging	Ongoing from 2015	Increased opportunity for new technologies/modalities of diagnostic testing which might be less invasive or potent (e.g. radiation levels) Increased opportunity to provide local diagnostics to support clinical pathways in Shetland (including repatriation of services)	Resources are used effectively and efficiently People using services are safe from harm

Key Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Impact of local HB plans to repatriate services locally and increases in diagnostic testing generally have put pressure on all clinical support services and diagnostic modalities such as ultrasound have seen significant increases in demand

- A recent needs assessment for ultrasound services depicted a requirement to increase sonographer staffing to meet current demand and we have trained additional staff to help match this demand. However, we will need to keep a watching brief on increasing demand in terms of workforce planning and development and expansion of the service. A

business case has been put together proposing expansion of the existing ultrasound facilities which will be progressed if no other solution to meet service needs is identified

- Expectations towards delivery of 7 day working in remote and rural services – we have reviewed the models of clinical support service delivery and an oncall model is the most sustainable way of providing 24/7 access to diagnostic tests. However, this may not align with national standards for the delivery of 7 day services, but alternative models for remote and rural service provision might not be available (e.g. reporting can be part of a shared service model with remote decision making, but a Radiographer is still required to undertake the diagnostic test and where services have diseconomies of scale, moving to 7 day service delivery for ultrasound would be challenging).

Targets/Outcomes

There are a number of HEAT targets that specifically relate to quality or performance markers for effective medical imaging services and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

Acc5	Number of cases where the ultrasound scan waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	G	→	0	2016-03	0	
Acc6	Number of cases where the CT scan waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	G	→	0	2016-03	0	
Acc7	Number of cases where the Barium enema test waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	G	→	0	2016-03	0	

Contact Details

*ANN SMITH, 01595 743000 EXT. 3158, **ANNSMITH5@NHS.NET***

Further Reading

Medical imaging Department intranet page.

Royal College of Radiologists https://www.rcr.ac.uk/

Society of Radiographers https://www.sor.org/

Grampian Radiation Protection Service/website

http://www.gov.scot/resource/0039/00395491.pdf

Healthcare Science Delivery Plan (2015), http://www.gov.scot/Resource/0045/00453441.pdf

Physiological Measurements

Policy context

Following the Healthcare Sciences Delivery Plan it is hoped that resource will become available to help streamline the current demand led service.

Current Services

Physiological Measurements provides mainly cardiac physiological measurement services to NHS Shetland and the local community.
The service is multifunctional with diagnostic services in the main along with treatment services for patients with implanted cardiac devices.
The service aims is to provide physicians with data to guide treatment as well as treating patients with implanted cardiac devices to maximise their function.

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
PHYSIOLOGICAL MEASUREMNTS SERVICE	1	69,725	0	69,725	0

Needs/Unmet needs/Drivers for change

National changes in the patient demographic not only result in an increase of patients surviving to an older age but also result in an increase of patients with conditions of older age along with technology that can treat these patients. For example Aortic Stenosis – in the past a simple echocardiogram to determine the condition and measure a single number to guide treatment took about 20 minutes. Today that test requires more parameters such that 60 minutes is not unusual. That and in the future , more information will be required as there are now surgical treatments for those older patients who were just treated palliatively.
While numbers may not increase dramatically in Shetland, the time per patient will.

Reducing employment cost is a massive driver for change. The nominal retirement of the present incumbent is the end of 2016/17. And while this is an opportunity to redesign the service it is against a background of shortages of appropriately qualified and sufficiently skilled cardiac physiologists in the UK

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
SERVICE REDESIGN AS PART OF RETIREMENT OF PRESENT INCUMBENT	KATHLEEN CAROLAN	JAN 2015 ONWARDS	CONTINUED SAFE AND APPROPRAITE CARDIAC PHYSIOLOGY SERVICE FOR SHETLAND

Current draft model: Grampian to provide implanted cardiac device follow-up service Employ a BSE accredited echocardiographer Move community services dome in the hospital to the community eg Spirometry and ABP Investigate arrhythmia service		To be in place end 2016	Seamless service provided by appropriately qualified and experienced cardiac physiologists Community testing closer to the patient

Key Risks to Delivery

Financial risks are involved with requiring increased investigations for an aging population. Eventually capacity will overwhelm supply and further practitioners may be needed.
Already bank staff are being used to supply chaperoning services to avoid females having a longer wait time than males for echocardiography

The shortage of appropriately qualified and experienced echocardiographers.: A package to recruit and retain will most likely be higher financially than for the present incumbent.

Weather and travel costs for the visiting implanted cardiac devices service.

Still a single-handed practitioner.

The present incumbent is paediatric trained and it may not be possible to source a future clinical physiologist with a broad skill base.

Contact Details

Physiological Measurements is situated in the GBH.
Contact Chris Brown 01595743053.
Email chrisbrown3@nhs.net

Laboratory

Policy context

Current Services

Funding and Resources

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Medical diagnostic laboratory services comprising Biochemistry, Haematology, Transfusion Medicine and Microbiology. Provided 24/7 by a combination of rostered shifts and OOH on-call service to NHS Shetland acute services (GBH) and primary care providers (GPs) Service levels are defined by NHS Scotland – Remote & rural district general hospital.	9.62			770654	(-3%)

Needs/Unmet needs/Drivers for change

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
1. Severe difficulties in recruitment of specialist BMS staff 2. Obsolete and archaic equipment, well beyond expected economic life 3. No effective POCT capability 4. Restricted governance capability/capacity 5. Limited use of IT connectivity: – lab-lab & lab order-comms	Director Acute Services & laboratory manager	1. Ongoing 2. Jan 2016 3. Mar 2016 4. Ongoing 5. Not known	

Key Risks to Delivery

Performance Targets with links to National Outcomes

Contact Details

Further Reading

Audiology Service

Policy context

SENSORY IMPAIRMENT STRATEGY (SEE HEAR) -
http://www.scotland.gov.uk/Resource/0044/00448444.pdf

Scottish Audiology Quality standards -
http://www.scotland.gov.uk/Resource/Doc/270517/0080557.pdf

Locally a 2014 patient survey shows that lack of deaf awareness amongst staff is an issue for patients. (Kathleen Carolan – holds an action plan for this survey). Through 2015 additional funding from SIC to increase support hours from WTE0.6 to WTE 0.4 has allowed for deaf awareness and hearing aid care training to be supplied to SIC and NHS staff. A hearing aid care box has been supplied to each GHB Ward and SIC care home facilities along with other care facilities. Funding for this will stop at the end of December 2015 and impact greatly on the service plans going forward.

The Scottish Healthcare Science National Delivery Plan (2015-2020)
http://www.gov.scot/Resource/0047/00476785.pdf the programme has 5 deliverables.

1. Streamlining health technology management – implement by end of 2020
2. Point-of-care testing – implement by end of 2020
3. Demand optimisation – implement by end of 2019
4. Developing sustainable services – implement by end of 2019
5. A new integrated model for clinical physiology services – implement by end of 2020

The key deliverables for Audiology are 3, 4 and 5.

Current Services

The Audiology service provides Audiological support to NHS Shetland, visiting ENT clinics and the local community.
Hearing assessment, hearing aid provision, hearing aid follow up, hearing aid maintenance and other hearing aid related services. Hearing aid repairs by appointment or by post or drop box at main reception.
Paediatric hearing assessment clinic , hearing aid fitting when required generally for school age children. Babies and pre-school children requiring hearing aid fitting would be seen in Aberdeen with specialist paediatric Audiologists.
Support to the visiting ENT service with the Audiologist working at advanced practitioner level to triage and pre-assess ENT referrals.
Deaf Awareness training to staff of all levels both NHS and SIC
Work with SIC to implement the Sensory Impairment Strategy which has come from the SEE HEAR consultation.
Maintain and improve the services for hearing impaired people both adults and children with a growing elderly population with increasingly complex needs.
Aim to routinely re-design the service to meet changing clinical and financial demands whilst maintain quality of service to patients.

Funding and Resources

Table of budget and savings targets, including workforce details

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target 2% of budget
Audiology	1.6	161,001		137,001	2,740.02

As of month 6 (2015) budget statement the non pay part of the budget (61,900) is over spent by £12,815. Due to being a demand led service although efforts are being made to reduce costs it is likely that the service will have an over spend of around £24,000. This will mean not being able to meet the 2% savings target.

Savings plans

5% saving on hearing aid costs from Oticon as main supplier

Recurrent saving of WTE 0.4 Band 4 support post

Redesign of reassessment criteria to reduce the number of self referrals of current hearing aid users. But this may turn out to be futile as time goes on a patients genuinely need re-test and hearing aid upgrade due deterioration in hearing.

Needs/Unmet needs/Drivers for change

There is a growing elderly population with the number of people in the UK rising from 1 in 7 around 20 years ago to 1 in 6 currently. This compares to 1 in 30 who have sight impairment. So, there are a significant number of people in the local population with some degree of hearing impairment. Not all will seek help and some will access hearing aids privately but the majority of those suitable for hearing aid provision will be referred for NHS hearing aid provision. We keep a register of active NHS hearing aid users and currently (29th Oct 15) it is 1,108 people. In 2005 there was a list of around 200 Shetland patients supplied from the Aberdeen Audiology service. But this quickly proved to be an underestimate of the those using NHS hearing aids at the time. As with all NHS services in recent years who deal with **older people** the demand has begun to increase sharply.

As permanent hearing impairment is a progressive condition the “Scottish Audiology Standards” recommend that this group require review every 3yrs. The Audiology service has not been able to provide this for several years due to lack of capacity within the service.

This group of patients has begun to self refer for review as they notice hearing deterioration which puts them in to the 18wks pathway. Further demand comes from the general increase in the older population and increased demand from the ENT service for both Adults and Children. The demand for Paediatric hearing assessment has been steadily increasing for several years.

There is increasing difficulty in supporting elderly hearing aid users who are more likely to have additional complex needs such as dementia and sight loss.

Unmet need

Many hearing aid users do not represent for testing as described above as they may not be aware of the slow deterioration of hearing. Studies have shown that hearing loss can increase problems with dementia and some people have been misdiagnosed with dementia due to hearing loss. Untreated hearing impairment can cause an already elderly person to become more vulnerable and require more support.

Lack of a second soundproof room to meet demands is becoming more of an issue going forward. This reduces the services ability to re-design and meet the HCS deliverables, 18wks RTT and local targets.

We do not offer an unscheduled service but patients do still turn up without prior arrangement or a scheduled appointment. This can impact on other nearby services such as Physiotherapy and GBH reception staff if patients are no able to access a member staff from Audiology.

Plans for change

Headline actions including service redesign, lead officer, target dates and links to national outcomes.
Please reference any Action Plans already in existence.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
1. Staffing/Training Assistant Audiological Practitioner post From Sep 2014 funding secured from NES to support all or most of the costs of training this post holder to Associate Audiologist level. Therefore increasing the skill mix	Jackie Haywood	Sep 14 – Jun 16	Diploma in Hearing Aid Audiology (2yrs) online and blocks of study at QMU, Edinburgh. **HCS Deliverable 4** Developing sustainable services
2. Accommodation/Equipment It has **not been possible** to secure a permanent second clinical room and associated equipment for the Associate Audiologist to work from when qualified. As per previous plan.	Jackie Haywood	ongoing	But measures are in place to use the OH dept room with soundproof booth at most once a week. Along with room availability in outpatients 1 day a week over 2 1/2day sessions. The OH room use is currently on hold due to a new round of direct supervision and log book completion for the 2nd year of diploma. We should be able to utilise the OH room again from May/Jun 2016 but this will be of limited use if the newly qualified Associate Audiologist is still on WTE0.6 rather than WTE1.0 **HCS Deliverable 4** Developing sustainable services
3. Changes to Directorate management structure	Kathleen Carolan	2015-16	Creating a diagnostics lead and therefore a diagnostic group within the directorate. This groups **Audiology**, **Cardiology**, Labs and Medical Imaging. This is a step towards **HCS Deliverable 5** "...develop a

			sustainable integrated service model to enhance **clinical physiology** service delivery and quality."
4. Advanced practitioner The Audiologist works as an advanced practitioner with support to ENT clinics. From Jan 2014 an extended triage of ENT referrals was piloted to help reduce ENT waits/demand.	Jackie Haywood	Pilot from Jan – Jun 14 and now ongoing. Suspended from January 2016 Due to the TAA dropping back to WTE 0.6 there will not be the capacity within Audiology to continue these clinics**. This will impact on the ENT service.**	Outcomes Jan – Apr 14 Discharged 2% (no ENT apt needed) ENT apt needed 65% Hearing aid/Audiology apt needed 33% There is some overlap of patients who need to see ENT after extended triage and also need Audiology input. **HCS Deliverable 4** "...explore new and developing healthcare science roles that support areas of service pressure and have the potential to free-up medical capacity,..."
5. Cochlea implant reviews We have a small number of Shetland patients who have been fitted with cochlea implants at the mainland cochlea implant centre, Lanakshire.	Jackie Haywood /Diane Coleman (outpts)	From early 2016	These patients have previously travelled to the mainland for assessment/fitting/review. After a pilot in Orkney to offer a review clinic there, we are to set this up for Shetland in early 2016. This will reduce the cost of patients travelling to the mainland. The cochlea implant team will pick up the costs of their travel/accommodation and plan to set this up as a yearly VC type review clinic from 2017 (using the VC facilities in outpatients.) Linked to local aims **of reducing travel costs off island for treatment** which can be provided via telemedicine.

As the Trainee Associate Audiologist (TAA) is still in training and will from January 2016 be going back to WTE 0.6 after a temporary period of WTE 1.0 Jan-Dec 15 as noted in "policy contex". The plans for change are limited as the Audiologist will have to pick up routine clinical tasks formally supported by the TAA from January 2016 at a time of high demand.

Key Risks to Delivery

As per "Drivers for change" the NHS as whole is dealing with **an increasing elderly population who are living longer** and requiring assistance with **more complex needs**. As most of the

Audiology service users are older/elderly people this is and will continue to be a risk to delivery of Audiology services.
The service has **1.0WTE Audiologist** who works at advanced practitioner level and so this can make the **service fragile** when this person is not available. Currently demand is regularly outstripping capacity and although the TAA is training to take on more of the clinical work we **only have one permanent clinical room**.
The new TAA role is increasing the clinical role but the consequence of this is reduced clerical support for the service. We do not have a proper point of contact for patients trying to access the service for unscheduled care. This impacts on other services such as Physiotherapy and main reception.
Costs will rise with **increasing numbers of patients seen and hearing aids fitted**.

Performance Targets with links to National Outcomes

National outcomes/targets
18wks RTT
Scottish Audiology quality standards
Sensory impairment strategy (SEE HEAR)
The Scottish Healthcare science national delivery plan 2015-2020

Service indicators of quality locally – Patient satisfaction survey (usually annually) part of Scottish Audiology quality standards

Contact Details

There is no reception or clerical staff so sometimes people need to leave a message on the answer phone. This can be very difficult for hearing impaired people to be able to use but we also have an email contact.
Audiology Department, Gilbert Bain Hospital, Lerwick, Shetland, ZE1 0TB.
Telephone: 01595 743231 (Audiology office)
Fax: 01595 692184
Email: shet-hb.audiology@nhs.net

We are piloting a link with outpatients to transfer the Audiology phone to them when Audiology staff are seeing patients and not able to answer the phone. (From October 2015)

Further Reading

SENSORY IMPAIRMENT STRATEGY -
http://www.scotland.gov.uk/Resource/0044/00448444.pdf

Scottish Audiology Quality standards -
http://www.scotland.gov.uk/Resource/Doc/270517/0080557.pdf

The Scottish Healthcare Science National Delivery Plan (2015-2020)
http://www.gov.scot/Resource/0047/00476785.pdf the programme has 5 deliverables

http://www.hearingreview.com/2014/01/update-on-dementia-and-hearing-loss/

http://hub.jhu.edu/2014/01/24/hearing-loss-brain-size

Central Decontamination Unit

Policy Context

CDU provides sterilization and decontamination services from a Unit based at the Gilbert Bain Hospital. The Unit was built in 1996 and has been completely refurbished to meet the current statutory requirements. It is supported by a robust Quality Management System which helps meet ever changing customer requirements in what is a very specialist field.
The Unit provides sterilization and decontamination services for Primary and Secondary Care covering a number of specialities that include Orthopaedics, General Surgery, ENT, Obstetrics, Gynaecology, Ophthalmology, Dental, Maxilla-facial and podiatry.

Staff in CDU provide expert advice on all aspects of sterilization and disinfection, taking great pride in the quality and reliability of the service provided.

Funding and Resources

Service CDU	**Number of staff (WTE)**	**Expenditure**	**Income**	**Net Budget**	**Savings Target**
Staffing funded by NHS Shetland	B4 1.6 B3 3.04	£127,638	NA	£127,638	2% across pay/ non pay budget = £3161
Staffing funded by Dental, NHS Shetland	B3 1.36	Available from Dental services/ Finance	NA	Available from Dental services/ Finance	NA
Non pay	NA	£30,440	NA	£30, 440	As above

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Central Decontamination Unit				166,759	

Needs/ Unmet needs/ Drivers for change

£5000 removed from non pay budget for year 2015/2016 as recurrent savings.
Savings targets of 2% for 2016/2017 from April = £3161 across pay/ non pay budget to be achieved.

Plans for change

Description	**Lead officer**	**Start date/ target date**	**Expected outcome**
Reduction in non pay budget by £5000	Carol Barclay	April 2015	To be taken as recurrent savings
Reduction in B4	Carol Barclay	April 2016	To meet target

Quality Supervisor post by 0.1 WTE to release £2961			savings of 2%
Reduction in non pay budget by £200	Carol Barclay	April 2016	To meet target savings of 2%

These saving targets have already been submitted to Finance as part of projected savings for NHS Shetland for the year 2016/ 2017.

Key Risks to Delivery

There is one washer disinfector in the unit that is now eleven years old and spare parts can no longer be obtained for this. This machine needs to be replaced and a request for replacement has been submitted as part of the Capital Management Programme.

The duplex reverse osmosis steam generator for the two sterilizers has had numerous operational issues since installation and commissioning. A bid to link the existing reverse osmosis plant which already supplies the washer disinfectors to the sterilizers to overcome these issues has also been made to the Capital Management Programme.

Both these issues mean that the reliability of decontamination/ sterilization services provided can be interrupted due to breakdowns. Business continuity plans are in place with NHS Grampian for any prolonged breakdowns in service provision.

Performance Targets

NHS Shetland submits data as part of HFS national benchmarking project. This project is still in the early stages of development.

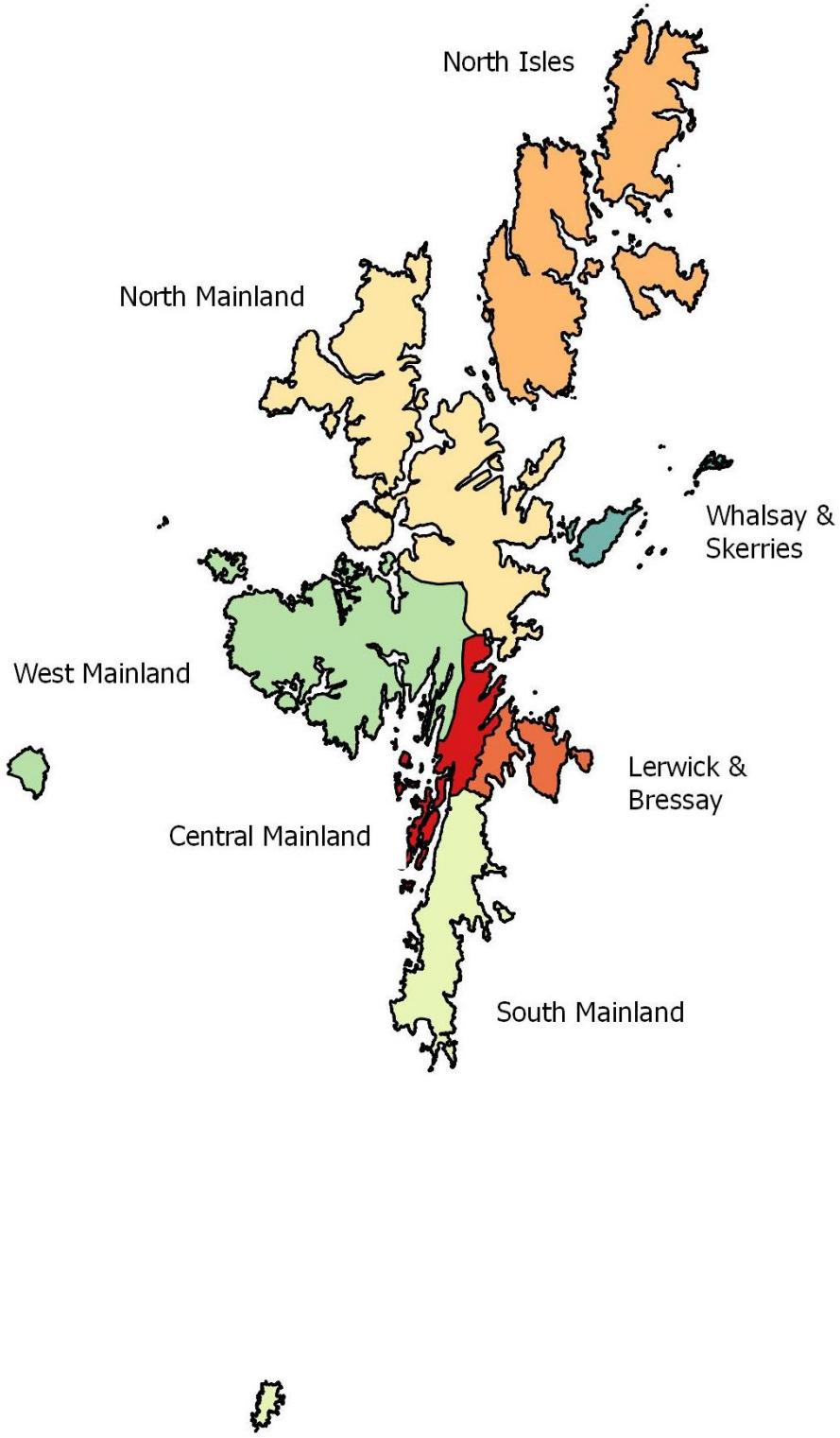
Contact Details

Carol Barclay, Decontamination Lead – GBH Ext 3190
Ruth Black, Production Supervisor – GBH Ext 3191
Angela Hall, Quality Supervisor - GBH Ext 3191

Further Reading

CDU is audited by an external notified body, SGS on an annual basis to ensure conformity to the Medical Devices Directive 93/42/EEC and to the requirements of 2007/47/EC as well as EN ISO 13485:2012.

Appendix 1: Localities Map



Agenda Item

X

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Community Health & Social Care Directorate Plan 2016-17
Reference Number:	CC-56-15-F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

1. Review and discuss the contents of the draft Directorate Plan and make any suggestions for amendment or further update
2. **Approve** the Directorate Plan

High Level Summary:

To present the final edit of the Community Health & Social Care Directorate Plan for 2016-17.

Corporate Priorities and Joint Working:

Shetland's Joint (Commissioning) Plan 2015/16 is the Commissioning Strategy for Shetland's Health and Social Care Partnership. The Joint Strategic (Commissioning) Plan for 2016/19 is being developed jointly in partnership with stakeholders, for adoption by the Integration Joint Board. It will be compliant with Strategic Commissioning Plans Guidance issued by Scottish Government:
http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

The Directorate Plan reflects the Councils Corporate Priorities and Health Boards vision and values.

Key Issues:

Effective performance management and continuous improvement are important duties for all statutory and voluntary sector partners in maintaining appropriate services for the public.

Implications :	
Service Users, Patients and Communities:	The Directorate Plan will help ensure its role in monitoring and directing health and social care services; and ensure the best possible outcomes for service users, patients and the community.

Human Resources and Organisational Development:	Monitoring of the directorate plan will be within existing resources.
Equality, Diversity and Human Rights:	The Council and Health Board are required to make sure that systems are monitored and assessed for any implications in this regard. Shetland's Joint Strategic (Commissioning) Plan supports and promotes equalities, health and human rights.
Legal:	The IJB is advised to adopt the Directorate Plan, but there are no legal requirements to do so.
Finance:	Any costs associated with the development and maintenance of the Directorate Plan will be met from within existing budgets of the Council and the Health Board.
Assets and Property:	There are no implications for major assets and property. Risks associated with the need for and use of assets and property will be recorded in the appropriate risk registers maintained by the Council and the Health Board and reported to the IJB where relevant to the delegated functions.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Embedding a culture of continuous improvement and customer focus are key aspects of the Council's and Health Board's improvement activity. Effective performance management is an important component of that which requires the production and consideration of these reports. Failure to deliver and embed this increases the risk of the Council and NHS Shetland working inefficiently, failing to focus on customer needs and being subject to further negative external scrutiny.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015. The IJB has the authority to approve the Community Health & Social Care Directorate Plan 2016-17 as set out in this report.
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

X

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Community Health and Social Care Directorate Plan 2016-17
Reference Number:	CC-56-15-F
Author / Job Title:	Director Community Health & Social Care

1. Introduction

1.1 The purpose of this report is to present the final edit of the Community Health and Social Care Directorate Plan for 2016/17 which is aligned with the Councils Corporate Plan and NHS Shetlands Local Delivery Planning process

2. Background

2.1 The Directorate plan (Appendix 1 with Appendices A-E) sets out the key aims, objectives, actions, performance measures and targets and risk management activities of the Directorate.

2.2 Managers have developed detailed service plans which support the Directorate Plan and the development of the Strategic Plan 2016-19 that will be presented to the Integrated Joint Board.

2.3 Continuing community engagement on strategy development, particularly primary care, will be reflected in updates on the Directorate Plan during 2016/17.

2.4 The Directorate Plan is a working document for member and management business purposes. Once final versions are approved then further work will be done to produce versions that communicate key messages to the public, service users and partners.

2.5 The Directorate Risk Register (Appendix 2) is reviewed by the Directorate Management Team on a regular basis. Risks are managed up from services if appropriate to Directorate level, or down from Directorate level to a service Risk Register if the risk becomes more manageable.

3. Performance monitoring

a. Once adopted, the Directorate Plan will monitor progress through its performance monitoring systems.

Recommendations

3.4 **It is recommended that the IJB:**

3.4.1 Review and discuss the contents of the draft Directorate Plan and make any suggestions for amendment or further update;

3.4.2 **Approve** the Directorate Plan

4. Conclusions

4.1 The Community Health and Social Care Directorate plan for 2016/17 has been updated as part of the planning and budgeting work done over the previous months. The Committee is now asked for final comments on its layout and structure before recommendation to the Council and NHS Board.

Contact Details:
For further information please contact:
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simon.bokor-ingram@nhs.net *or* *simon.bokor-ingram@shetland.gov.uk*
18 November 2015

Appendices

Appendix 1 – Community Health & Social Care Directorate Plan 2016-17
Appendix A – Projects and Actions
Appendix B – Council-wide Indicators
Appendix C – Key Directorate Indicators
Appendix D – Directorate Performance Indicators from Local Government Benchmarking Framework
Appendix E – Statutory Performance Indicators

Appendix 2 – Community Health & Social Care Risk Register

Community Health and Social Care Directorate

2016-17 Directorate Plan

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Contents

Introduction
This Directorate Plan provides an overview of the Community Health and Social Care Directorate for 2016/17. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks. Detailed activities for each Service within the Directorate are included in their individual Service Plans.

The Public Bodies (Joint Working) (Scotland) Act 2014 required agencies to have set out by April 2015 detailed priorities on what Local Authorities and Health Boards will be expected to have in place and deliver with regards to integration. The Act removes Community Health Partnerships from statute and replaces them with Health and Social Care Partnerships. It places a requirement on Health Boards and Local Authorities to integrate adult health and social care budgets. The Directorate Plan for Community Health and Social Care will contribute to setting out Shetland's Joint Commissioning and Integration Strategy for Community Health and Social Care Services. This agreement sets the tone for strategic and operational objectives and is updated annually.

This Directorate plan will be presented for approval at Integration Joint Board, Full Council and Health Board as part of the budget setting process.

Vision Statement
The Community Health and Social Care Directorate is committed to the Vision of:

"Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community".

Drivers for Change

Government Policy and Legislation

Many of the drivers for change in the area of Community Health and Care are guided by government policy and legislation. The key themes of Scottish Government Policy at present are:

- Developing person-centred services, with personalisation driving the shape of all public services and a strong focus on developing a person centred approach to care and care planning;
- Delivering quicker, more personal care, closer to home;
- A shift of care from hospital to community;
- A shift towards prevention, with preventative care or anticipatory care rather than reactive management. The desire is to prevent problems before they occur and resolve problems effectively at an early stage when they do occur. By addressing the causes and not the symptoms of problems, for example, it is hoped to tackle rising demand and reduce inequalities;
- Targeting action in deprived areas (using anticipatory care approaches, for example) to prevent future ill health and reduce health inequalities;
- Developing a systematic approach to managing long term conditions;
- Increased use of Telecare, Telemedicine and Telehealth solutions to support local care delivery and diagnosis;
- Supporting people to lead more independent lives, have more personal control over their lifestyles, care and environment and to live at home for as long as they want to;
- Valuing older people as an asset;
- Improving support for carers;
- Greater involvement of patients and carers in the design of services and greater involvement of communities in developing sustainable local solutions;
- Developing an asset-based approach to health (which involves mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits), thus empowering individuals, enabling them to rely less on public services;
- Encouraging people to take greater control over their own health and support;

- Promoting 'co-production' (which involves delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours);
- Agencies working together more effectively, with an increasingly stronger focus on not just joint working but on the integration of services; and
- Using an outcome based approach to improve outcomes that are relevant to patients and their carers, with an increasing focus now on shared outcomes.
- Redesign of Community Justice Services

The Public Bodies (Joint Working) (Scotland) Act 2014 http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf is the key strategic driver for 2016/17. This Act contains nine "Integration" outcomes which are set out under the Aims and Objectives section. The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve, by working with individuals and local communities through integration and ultimately through the pursuit of quality improvement across health and social care. The section of this plan on Aims and Objectives demonstrates how these outcomes are aligned with objectives from both the Council and the Health Board to ensure a consistent and collaborative approach.

Workforce Planning

There are particular issues locally around workforce planning and development; these are addressed in individual service plans, however the NHS Shetland Workforce Plan 2014 – 17 notes the following:

> "There is high competition for local resources across public, private and voluntary sector when recruiting general and specialist skills. Unemployment is very low in Shetland; the current increase in demand for local resources by the oil industry has had an impact on turnover levels and a reduction in applicants. Remuneration packages are not always sufficiently competitive to attract and retain, with reliance on desire for long term stability, preference of work environment and location.
>
> For specialist roles (clinical and professional) it is generally necessary to advertise nationally in order to attract skills from off island. This incurs additional costs in respect of advertising, interview expenses, relocation expenses and increased time required to fill vacancies." (Source: Economic Workforce Plan NHS Shetland 2014-17)

The particular workforce challenges noted by NHS Shetland and common to both organisations, that will impact on future ability to provide quality services for the population, include:

- attracting and retaining suitably skilled staff , particularly in medical & specialist clinical and practitioner roles
- supporting staff working in isolated (single handed) roles and small teams
- implementing changes to services and our workforce to support the delivery of safe, efficient, sustainable services.
- developing and maintaining the skills of our current workforce
- maximising the cost effectiveness of our workforce so we also deliver financial balance

Finance

In addition to national drivers, local drivers include the Medium Term Financial plan for the council and required savings targets in NHS. The Directorate receives funding from both the Council and NHS Shetland. The efficiency target for the Council part of the budget for 2016/17 has been met in full as part of the budget setting process. For the Health Board part of the budget, efficiencies will need to be delivered in 2016/17, with detailed plans developed by March 2016.

Feedback/ consultation

Extensive engagements events have taken place during the course of 15/16 with particular focus on Locality Working and Primary Care Services. We have used existing planned meetings and professional groups to gather ideas and comments. We have used the feedback and engagement to drive service improvement. We have continues to work closely with the Patient and Public Forum on making improvements at the Lerwick Health Centre, including a redesign of the skill mix in the practice which has resulted in Advanced Nurse Practitioners having a greater role in clinical care. Action plans have been developed and are being implemented for Mental Health and Dementia Services where there was specific feedback from the community in response to work on strategy and development.

About Us

The Community Health and Social Care Directorate was created as a result of the Public Bodies (Joint Working) (Scotland) Act 2014. http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf. The Directorate comprises a number of regulatory and front-line functions.

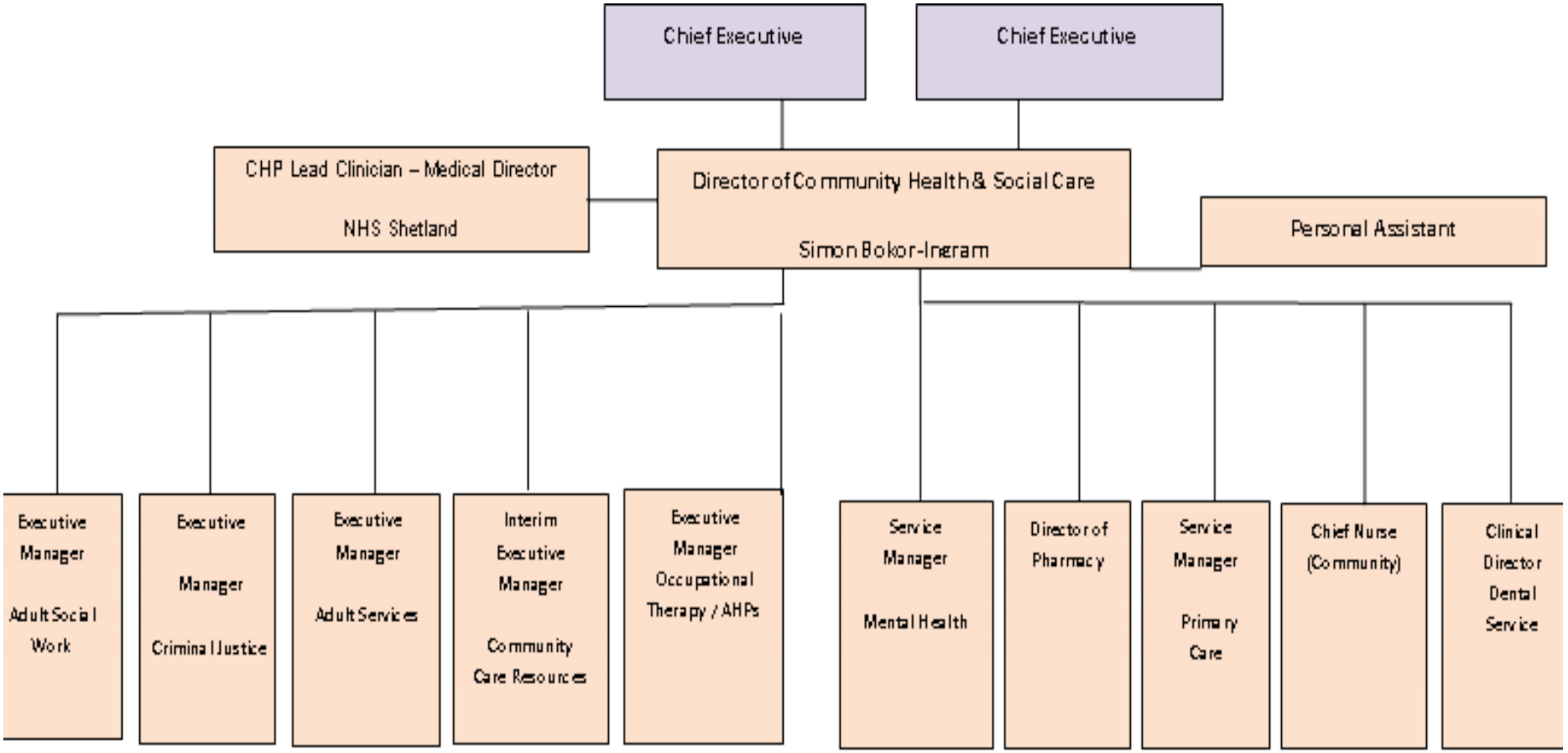
Who We Are

The Community Health and Social Care Directorate is led by the Director of Community Health and Social Care with an operational team of senior managers, and consists of 10 Services. The managers of these services are responsible for the strategic planning and commissioning in their area. These services are:

- Adult Social Work,
- Adult Learning Disability Service,
- Allied Health Professionals,
- Community Care Resources,
- Criminal Justice,
- Mental Health,
- Nursing in Community Settings
- Oral Health,
- Pharmacy and Prescribing
- Primary Care

The services work in partnership with other organisations including third sector agencies.

Organisational Chart



Locations

The Community Health and Social Care Directorate covers the whole of Shetland with specific facilities as follows:

Area	Facility	Area	Facility
Unst	Hillsgarth Surgery Nordalea Care Centre	**Yell**	Yell Health Centre Isleshavn Care Centre
North Mainland	Brae Health Centre Hillswick Health Centre North Haven Care Centre	**West Mainland**	Bixter Health Centre Walls Health Centre Wastview Care Centre
South Mainland	Levenwick Health Centre Overtonlea Care Centre	**Whalsay**	Whalsay Health Centre Fernlea Care Centre
Lerwick	Lerwick Health Centre Montfield, Gilbert Bain and St Olaf Street Dental Practices Edward Thomason and Taing Support Service Montfield Support Services Eric Gray Resource Centre NewCraigielea Independent Living Centre	**Outer Islands**	Foula – Community Nurse Fair Isle – Community Nurse Fetlar – Community Nurse Skerries – Community Nurse Bressay – Community Nurse

	Grantfield Office • Adult Social Work • Criminal Justice • Supported Living and Outreach		
Scalloway	Scalloway Health Centre		

In addition to the geographical locations above, the services make use of housing and community facilities across Shetland. These are described in more detail in individual service plans. Staff from Community Health and Social Care also use other facilities which are not part of the property portfolio of the Directorate e.g. Gilbert Bain Hospital.

Governance

The Community Health and Social Care Directorate reports to the Joint Integrated Board. The Directorate's performance is reported to this committee 4 times per year.

The Community Health and Social Care Strategic Group is responsible for the development and integration of all community health and care services. It is also responsible for developing and maintaining the Joint Commissioning Strategy.

Strategic team membership includes:

- Director of Community Health and Social Care
- Director of Nursing and Acute Services
- Medical Director
- Director of Voluntary Action Shetland
- Public Health Consultant
- Service Manager – Primary Care
- Clinical Director of Dental Services/ CADO
- Executive Manager – Community Care Resources
- Executive Manager – Criminal Justice
- Service Manager – Mental Health

- Executive Manager - AHPs
- Executive Manager – Adult Services
- Executive Manager - Adult Social Work
- Chief Nurse Community
- Executive Manager - Housing
- Directorate Projects Manager
- Human Resources SIC and NHS

Strategic groups

A number of strategic and planning groups are at the heart of policy and service development for the Directorate. Other short life working groups are established as required to take forward particular projects.

The Strategic planning groups and working groups in place in 2016 are:

	Lead Officer/ Chair
Strategic Planning Groups	
Shetland Mental Health Partnership	Director of Public Health
Housing Strategy Group	Executive Manager Housing
Shetland Alcohol and Drugs Partnership (SADP)	Director of Community Health and Social Care
Data Sharing Partnership	Executive Manager Schools
Community Health and Care Partnership Strategic Group	Director of Community Health and Social Care
Area Drugs and Therapeutic Committee	Director of Pharmacy
Scottish Ambulance Liaison Group	Hospital Manager

Psychological therapies Steering Group	Service Manager Mental Health
Health and Safety Forum	Director of Community Health and Social Care
Adult Protection Committee	Independent Convenor
Highlands & Islands MAPPA Management Group	Executive Manager Criminal Justice
Working Groups	
Local Partnership Finance Team	Director of Corporate Services
Joint Staff Forum	Chair of Social Services Committee and Employee Director (joint chairs)
Locality Governance	Chief Social Work Officer and Medical Director (joint chairs)
Locality Project	Chief Nurse Community
Directorate Team Meeting	Director of Community Health and Social Care
New Eric Gray Working Group	Executive Manager Adult Services

The Area Clinical Forum now involves the Chief Social Work Officer which gives a more integrated approach to clinical and practitioner practice. The Area Clinical forum is a multi-professional group who are tasked with providing advice, guidance and interpretation of policy. The Chief Social Work Officer chairs the Social Work Professional Team.

Regulation and Compliance

Social Work Services, Care Homes, Respite Providers and Care At Home Services are subject to inspection by the Care Inspectorate. http://www.scswis.com/ The Care Inspectorate are working more closely with Health Improvement Scotland and in 2015 it is likely that Adult Services will be subject to joint inspection.

Staff must be registered with and are regulated by the following bodies:

Professional Group	Professional Body
Social Care Workers Social Workers	Scottish Social Services Council http://www.sssc.uk.com/ http://www.socialworkscotland.org/
Allied Health Professionals	Health Care Professions Council http://www.hpc-uk.org/
Doctors	General Medical Council http://www.gmc-uk.org/
Nurses	Nursing and Midwifery Council http://www.nmc-uk.org/
Dentists and Dental Care Professionals	General Dental Council http://www.gdc-uk.org/Pages/default.aspx
Pharmacists	General Pharmaceutical Council http://www.pharmacyregulation.org/

What We Do

Service	Teams or Functions
Mental Health Service	Community Mental Health Support Service (Annsbrae House) – supported accommodation, short break/ respite, outreach service Psychological therapies – for example, in situations such as depression, anxiety, personality disorder General Adult Psychiatry – assessment and treatment of patients in the community and a range of care settings including hospital; emergency assessment and treatment short description (NHS) Dementia diagnosis and post diagnostic support

	Substance Misuse Recovery Service – support and treatment of substance misuse issues
Social Work Service	Provides a professional, regulated and protected function to assess people's circumstances to establish if they require support from local authority and/ or partners. Assessing such needs against agreed eligibility criteria. Specific duties include adult support and protection, adults with incapacity, mental health interventions.
Adult Learning Disability Services	Supported Living and Outreach Service – supports adults with a learning disability or autistic spectrum condition. Supported Vocational Activities – Eric Gray Resource Centre provides a range of educational, leisure and social activities Newcraigielea – Short break and respite facility offering 8 en-suite bedrooms and a self-contained bedsit for short breaks Learning Disability Nurse – Single handed post provides a service for children and adults who have specific needs associated with their learning disability.
Allied Health Professionals	Dietetics - assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Dieticians use public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. Occupational Therapy – provide Occupational Therapy Assessments at home, in the Gilbert Bain Hospital or as outpatient appointments, a rehabilitation and reablement service, advice, assessment and provision of Equipment and Adaptations; a Sensory Impairment Service, Telecare and Telehealth provision and advice, Wheelchair Assessments and Blue Badge Assessments. Orthotics - provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. They are able to design and provide orthoses that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They treat patients with a wide range of conditions including Diabetes, Arthritis, Cerebral Palsy, Stroke, Spina Bifida,Scoliosis, MSK, sports

	injuries and trauma. Physiotherapy - help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible. Physios use their knowledge and skills to improve a range of conditions associated with different systems of the body Podiatry - give advice on how to look after feet and what type of shoes to wear. They can also treat and alleviate day-to-day foot problems including toenail problems such as thickened, fungal or ingrown toenails, corns and calluses, flat feet and bunions. Speech and Language Therapy - provides services for anyone who has communication, swallowing or feeding difficulties of any age. For example, difficulty with: sounds of speech, understanding speech or using words and sentences meaningfully. The service works closely with families, carers and education staff.
Community Care Resources	The service has the following responsibilities, delivered from a number from a number of hubs around Shetland: • Residential care used for long term care or short breaks (respite) • Day services • Care at home • Domestic • Meals on Wheels
Criminal Justice Service	The service is responsible for the delivery and development of all criminal justice social work services throughout Shetland. Statutory functions include the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences. The service also manages the Social Work Substance Misuse Service and The Appropriate Adult Service. The Executive Manager also leads on the Out of Hours Standby System for statutory social work services.

Community Nursing Service	Community Nurses provide an acute, complex and end of life nursing service to people in their own homes or care homes on a 24 hours a day, seven days a week, 365 days a year basis. The service is pivotal in preventing unnecessary admission to hospital and supporting safe, early discharge from hospital back to the community. A nurse-led Intermediate Care Service is being trialled, currently funded and piloted through the Integrated care Fund to support early discharge from hospital and to prevent avoidable admissions. Community nurses work closely with specialist MacMillan nurses and social care workers to provide care and support for palliative care patients and their families.
Primary Care Service	The 10 General Practices across Shetland provide access to medical advice, treatment and prescriptions. They have a range of staff including GPs, Practice Nurses, Advance Nurse Practitioners and administrative staff who provide a service to a defined practice registered population. Practices carry out a range of interventions including minor surgery, family planning, chronic disease management and immunisations.
Oral Health Services	The Public Dental Service provides a complete range of NHS dental services for people who, for whatever reason, are unable to obtain these from local independent NHS dental practices, and currently also provides the same range of services to the entire local population to address the shortfall in local independent NHS practice provision. National oral health promotion schemes such as Childsmile and Caring for Smiles are delivered. Specialist oral health services such as maxillo-facial surgery and orthodontics are provided through a clinical network of visiting consultants
Pharmacy Service	The service provides a hospital dispensing service and actively participates in supporting patient management in the hospital. Primary care services are supported with an advice and liaison service, with pharmacists actively helping people to manage their medicines both through a presence in practices and in the community. This service also liaises with Community Independent Pharmacies and is the local commissioner for those services.
Directorate wide responsibilities:	Advocacy - Carers -

Our Customers

There are currently 22,500 people registered with a GP practice, whilst the dental service now has over 19,000 people registered. For some services, people will only access and become known to services when there is a need e.g. social care. Our population is ageing fast. In Shetland it is anticipated that by 2016, the number of people aged 65 or over will be 38% greater than in 2006 and 92% greater by 2031. This is higher than the national average and the fourth highest rate of change across Scotland's 32 local authorities

In terms of self-reporting of health status, the **2011 census** shows the following information:

Total Population of Shetland: 23,167		
	Percentage of population	No. of people
% With one or more long-term health conditions	29.9	6927
% With deafness or partial hearing loss	6.6	1529
% With blindness or partial sight loss	2.4	556
% With learning disability (for example, Down's Syndrome)	0.5	116
% With learning difficulty (for example, dyslexia)	2	463
% With developmental disorder (for example, Autistic Spectrum Disorder, Asperger's Syndrome)	0.6	386
% With physical disability	6.7	1552
% With mental health condition	4.4	1019

% With other condition	18.7	4332

Source: Scotland's Census 2011 http://www.scotlandscensus.gov.uk/ods-web/area.html#!

For local authority provided services, National Eligibility Criteria for older people are applied. These can be found at the following link: http://www.scotland.gov.uk/Resource/0039/00399040.pdf

For other service criteria please see individual service plans.

Our Costs and Income

The Directorate has around 818.69 full time equivalent staff, an annual net expenditure of £39,792,676 and a capital budget of £302,916 in the Council and £1.1M in the NHS with no confirmed Directorate split until NHS allocation process completed. As detailed below:

Community Health & Social Care Directorate	Number of Staff (FTE)	Net Budget	Capital Budget
Directorate	4.35	594,937	Nil
Adult Learning Disability Service	137.39	5,271,303	302,916
Adult Social Work	19.29	1,664,586	Nil
Allied Health Professionals	46.13	2,740,735	Nil
Community Care Resources	396.31	10,511,789	Nil
Community Nursing	47.45	2,312,966	Nil
Criminal Justice Social Work	7.37	29,149	Nil
Mental Health	59.99	3,398,956	Nil
Oral Health	67.73	3,382,294	Nil

Pharmacy and Prescribing	2.60	5,483,641	Nil
Primary Care	30.08	4,402,320	Nil
Community Health & Social Care Directorate Total	**818.69**	**39,792,676**	**302,916**

Funding and resources

The Medium Term Financial Plan 2014-2019 set a target budget reduction of 2% n the Directorate's budget for 2016/17, which has been met, this follows budget reductions of 10% in 2013/14, 2% in 2014/15, and 2% in 2015/16.

Aims and Objectives

National Health and Wellbeing Outcomes (Scottish Government)	**Aligned Shetland Islands Council Corporate Aims 2016/20**	**Aligned NHS Shetland Corporate Objectives 2015/16**
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.	People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer	To improve and protect the health of the people of Shetland
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Older people and people who are living with disabilities (including learning disabilities) or long-term conditions will be getting the services they need to help them live as independently as possible	To provide quality, effective and safe services delivered in the most appropriate setting for the patient
Outcome 3. People who use health and social care	More people will be able to get the	

services have positive experiences of those services, and have their dignity respected.	direct payments and personal budgets that they want, so they can make the best choices for their own lives Our Integrated Health and Social Care services will be providing the services people need in a more efficient way, improving standards of care and keeping people healthier for longer	
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer	
Outcome 5. Health and social care services contribute to reducing health inequalities.	The needs of the most vulnerable and hard-to-reach groups will be identified and met, and services will be targeted at those that need them most.	
Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer	To improve and protect the health of the people of Shetland
Outcome 7. People who use health and social care services are safe from harm.	Our Integrated Health and Social Care services will be providing the services people need in a more efficient way, improving standards of care and	To provide quality, effective and safe services delivered in the most appropriate setting for the patient

	keeping people healthier for longer	
Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Our staff will feel valued for their efforts and want to stay with us because they feel motivated to do their very best every time they come to work	To ensure sufficient organisational capacity and resilience
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.	Increased use of technology will be helping us provide care for the most vulnerable and elderly in our community	To provide best value for resources and deliver financial balance

Directorate Aims/Priorities	Objectives/Actions
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.	There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish. There will be ease of access to services, with clear understanding within the community of who to contact and where to go Information will be available to each household in Shetland which explains how to access services, what service standards they can expect and how each organisation is performing through an effective public performance reporting regime
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting	The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so

in their community.	
Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	There will be more flexible services and more choice for our customers, within available resources Systems, procedures and information will be shared between organisations wherever possible and there will be clarity in the decision-making process, thereby reducing bureaucracy and delays in decisions about service delivery.
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	
Outcome 5. Health and social care services contribute to reducing health inequalities.	There will be equity in access to services through better information, more locally based services and better transport arrangements where provision needs to be centralised. Everyone will be able to access services to meet their needs irrespective of their race, religion/faith, sexual orientation, age, disability, gender or socio-economic background.
Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	We will improve our identification of people who are carers and offer a carer's assessment so that the appropriate support can be put in place. We will continue to work with the Third Sector to develop strategies to support carers and to continue with training programmes and carer's events.
Outcome 7. People who use health and social care services are safe from harm.	We will build on our governance and quality assurance systems. Early reporting of incidents and near misses will help us to put in place actions that will improve procedures and processes.
Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the	There will be in place a system of team working which recognises and values individuals' skills and knowledge, encourages joint training and secondment

information, support, care and treatment they provide.	opportunities and works to meet the needs of our customers. There will be in place a seamless method of service delivery, not restricted by organisational or professional boundaries – modelled on a “one-stop-shop” methodology There will be an individual within Shetland who is publicly recognised as being the manager of each service area
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.	Financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions. Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system Resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need. Services are delivered to the best possible standard and quality, at the best possible price. The Directorate will have a single planning and design process with clarity in what they are trying to achieve in the short, medium and longer term. Services will be planned and designed in partnership with customers and the general public.

Detailed Actions/Plan for Change

Previous Actions Completed in 2015/16

Description	Delivered Early/on-time/late	Achieved original intention?

Implementation of findings outlined within 'Dementia Deep Dive' and Mental Health review to ensure quality and efficiency within these service areas.	In progress – on time	Implementation underway
Continue with Viewforth re-provision programme	Completed early	Yes
Continue with Development of a Primary Care Strategy	On-time	In progress at time of writing 2016 plan
Continue to review & redesign Drug & Alcohol services to cease duplication, drive efficiencies and achieve consistently better outcomes for customers.	On-time	In progress at time of writing 2016 plan
To review Shetland's single shared assessment process, With You For You and associated policies and procedures on care/case management and anticipatory care plans.	On-time	Implementation of action plan underway. On time
To continue to develop the implementation of Telecare & Telehealth care across all service areas in order to support more people to remain at home and to reduce the need for 'paid staff' and unnecessary intrusion into people's lives.	On-time	On-going action.
Develop and implement a Self Directed Support Strategy to implement the provisions of the SDS (Scotland) Act 2013.	Completed on time	Yes
Develop Integrated Locality Service Plans	In progress – on-time	
Assist Shetland Partnership with implementing the redesign of community justice.	In progress – on-time	

New Planned Actions Due to Start in 2016/17

See Appendix A

Risks to Delivery/ Risk Register

See Appendix 2

Contact Details

Adult Learning Disability Service Upper Floor Montfield Burgh Road Lerwick ZE1 0LA community.care@shetland.gov.uk 01595 744308	Allied Health Professionals Upper Floor Montfield Burgh Road Lerwick ZE1 0LA community.care@shetland.gov.uk 01595 744308	Community Care Resources Upper Floor Montfield Burgh Road Lerwick ZE1 0LA community.care@shetland.gov.uk 01595 744308	Community Nursing Upper Floor Montfield Burgh Road Lerwick ZE1 0LA maureen.stewart4@nhs.net 01595 743339
Mental Health Upper Floor Montfield Burgh Road Lerwick ZE1 0LA david.morgan4@nhs.net 01595 743697	Oral Health Montfield Dental Services Burgh Road Lerwick ZE1 0LA raymondcross@nhs.net 01595 743610	Pharmacy Upper Floor Montfield Burgh Road Lerwick ZE1 0LA christophernicolson@nhs.net 01595 743697	Primary Care Lerwick Health Centre South Road Lerwick ZE1 ORB e.watt1@nhs.net 01595 743209
Criminal Justice Unit Grantfield Offices LERWICK ZE1 0NT criminaljustice@shetland.gcsx.gov.uk T: 01595 744400	Adult Social Work Grantfield Offices LERWICK ZE1 0NT community.care@shetland.gov.uk T: 01595 744457		

Appendix A - Projects and Actions - Community Health & Social Care Directorate Plan

Shetland Islands Council

Generated on: 18 November 2015

OUR PLAN 2016-2020

B) OLDER PEOPLE

1) Technology

Increased use of technology will be helping us provide care for the most vulnerable and elderly in our community.

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP032 Develop framework based around accurate data collection and analysis	Develop a comprehensive quality assurance framework based around accurate data collection and analysis		Planned Start	01-Apr-2015	80%	Currently reviewed through the quarter performance report	Community Care - Resources; Health & Social Care Director's (Direct) Section; Health & Social Care Services Directorate
			Actual Start	12-Nov-2015			
			Original Due Date	31-Mar-2016			
			Due Date	31-Mar-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP121 Home monitoring	Increase the number of people receiving home monitoring for health and social care (technology enabled care)	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	not yet started	Community Care - Resources
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

4) Support

People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer.

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP024 Develop Integrated Locality Service Plans	Develop Integrated Locality Service Plans		Planned Start	07-Nov-2014	50%	Locality Planning Conversations 1st round completed. Drafting of Strategic Commissioning Plan for 2016/17 scheduled for Sept/Oct, to take account of Locality needs.	Community Care - Resources; Health & Social Care Services Directorate
			Actual Start	02-Nov-2015			
			Original Due Date	31-Mar-2015			
			Due Date	31-Mar-2016			
			Completed Date				

5) Integrated Health and Social Care services

Our Integrated Health and Social Care services will be delivering the services people need, improving standards of care and keeping people healthier for longer.

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP019 Continue with Development of a Primary Care Strategy	Continue with Development of a Primary Care Strategy		Planned Start		80%	First draft of strategy developed, about to be issued for consultation. Steering Group continues to refine narrative and data.	Community Care - Resources; Health & Social Care Director's (Direct) Section; Health & Social Care Services Directorate
			Actual Start	01-Apr-2014			
			Original Due Date	31-Mar-2015			
			Due Date	31-Mar-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP026 Work with both HR departments to develop joint workforce planning	Work with both HR departments to develop joint workforce planning		Planned Start	01-Apr-2015	20%	Development of joint policies where possible. Joint management team developing strategic plan for 2016/19 which will involve workforce planning with both HR departments	Community Care - Resources; Health & Social Care Services Directorate; Simon Bokor-Ingram
			Actual Start	11-Nov-2015			
			Original Due Date	31-Mar-2016			
			Due Date	31-Mar-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP030 Implement the Integrated Care Fund	Implement the Integrated Care Fund		Planned Start	01-Apr-2015	80%	A number of initiatives now in progress. Third sector Welcome Home from Hospital scheme commissioned.	Community Care - Resources; Health & Social Care Director's (Direct) Section; Health & Social Care Services Directorate
			Actual Start	11-Nov-2015			
			Original Due Date	31-Mar-2016			
			Due Date	31-Mar-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP116 Primary Care Strategy	Implement agreed actions from the Primary Care Strategy to create a sustainable primary care offering across Shetland that drives high quality and good access.	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	Not yet started	Community Care - Resources
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP117 Review residential base costs	Review the cost base of residential care and create options for a sustainable service	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	Not yet started	Community Care - Resources
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP119 Mental Health Care accessability	Ensure Mental Health service is able to respond appropriately to need on a 7 day a week basis	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	not yet started	Mental Health
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP120 Oral Health	Implement actions from the Oral Health Strategy	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	not yet started	Health & Social Care Services Directorate
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP123 Single Shared Assessment	Carers are identified through single shared assessment process to ensure they are supported and empowered to manage their caring role	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	Not yet started	Community Care - Resources
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP124 Review of Adult Learning Disability Service	Review of Adult Learning Disability Services and delivery of findings from review	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	Not yet Started	Adult Services
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP125 Community Nursing Review	Review of capacity and demand in Community Nursing services	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	Noy yet started	Health & Social Care Services Directorate
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

F) OUR "20 BY '20"

02) Staff value & motivation

Our staff will feel valued for their efforts and want to stay with us because they feel motivated to do their very best every time they come to work.

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP118 Recruitment and retention	Improve recruitment and retention of staff to ensure services remain sustainable	Likely to meet or exceed target	Planned Start	01-Apr-2016	0%	Not yet started	Health & Social Care Services Directorate
			Actual Start				
			Original Due Date	31-Mar-2017			
			Due Date	31-Mar-2017			
			Completed Date				

Appendix B - Council-wide Indicators - Community Health and Social Care compared with Whole Council

Shetland Islands Council

NOTE: 2015/16 figures are "to date"

Generated on: 19 November 2015

Code & Short Name	Date Range 1				(past) Performance & (future) Improvement Statements
	2012/13	2013/14	2014/15	2015/16	
	Value	Value	Value	Value	
OPI-4A Staff Numbers (FTE) - Whole Council	2474	2248	2190	2168	
OPI-4A-E Staff Numbers (FTE) - Community Health & Social Care Directorate	642	530	517	510	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4C Sick %age - Whole Council	4.1%	3.6%	4.2%	3.6%	
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	5.7%	Team Leaders are working with HR to ensure consistent application of the Council's Maximising Attendance policy
OPI-4E Overtime Hours - Whole Council	71,644	56,552	64,738	40,284	Overtime and Overtime budgets are devolved to departmental level. Overtime is often the most cost effective way to utilise existing teams and ensure prompt service to our customers.
OPI-4E-E Overtime Hours - Community Health & Social Care Directorate	2470	1856	5675	3684	Recent recruitment will reduce Q3 & Q4 overtime
E01 FOISA responded to within 20 day limit - Health & Social Care Services	93%	79%	91%	96.5%	Continue to strive to meet target.

Appendix C - Key Directorate Indicators - Community Health and Social Care Directorate Plan

Shetland Islands Council

Generated on: 17 November 2015

Code & Short Name	Previous Years		Current year (to date)		(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16		
	Value	Value	Value	Target	
E1 Percentage of adults able to look after their health very well or quite well					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E2 Percentage of adults supported at home who agree that they are supported to live as independently as possible					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E4 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E5 Percentage of adults receiving any care or support who rate it as excellent or good					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E6 Percentage of people with positive experience of care at their GP practice					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E8 Percentage of carers who feel supported to continue in their caring role.					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E9 Percentage of adults supported at home who agree they felt safe					It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E10 Percentage of staff who say they would recommend their workplace as a good place to work					Under development. To be included in NHS and LA Staff Surveys
E12 Rate of emergency admissions for adults per 100,000			10,665	11,225	Target still to be met - new data will be provided going forward

Code & Short Name	Previous Years		Current year (to date)		(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16		
	Value	Value	Value	Target	
E13 Rate of emergency bed days for adults per 100,000			79,644	88,126	Under Development - available in 6-12 months
E14 Readmissions to hospital within 28 days of discharge					Under Development - part of GP practice indicators data- to be available in Summer 2015
E15 Proportion of last 6 months of life spent at home or in community setting	92.5%	92.5%			Just below Scottish average. Managed Clinical Network for Palliative Care established in 2015
E16 Falls rate per 1,000 population in over 65s					Under Development - no specific timescales for completion
E17c Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Care & Support			92%	100%	The majority of care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E17e Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Environment			100%	100%	The majority of care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E17s Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Staffing			92%	100%	The majority of care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E17m Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Management and Leadership			72%	100%	The majority of care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E18 Percentage of adults with intensive needs receiving care at home	46.1%	41%			Continue to focus on providing care at home where appropriate
E19 Number of days people spend in hospital when they are ready to be discharged		184	460		Area of focussed work. Latterly rates improving.
E20 Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency					
E21 Percentage of people admitted from home to hospital during the year, who are discharged to a care home					Under development
E22 Percentage of people who are discharged from hospital within 72 hours of being ready					Under development - new collection methods required which will take up to 12 months
E23 Expenditure on end of life care					Under development - final definition still to be agreed
LDP001 People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support		67.5%	45.05%	50%	There has been a change in local understanding of how the standard is to be recorded. The September report will demonstrate 100% of those diagnosed have PDS available to them and that the waiting list has been eliminated.

Code & Short Name	Previous Years		Current year (to date)		(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16		
	Value	Value	Value	Target	
LDP002 18 weeks referral to treatment for Psychological Therapies		57.7%	90.6%		The cCBT service introduced in September last year is now beginning to have a positive impact on COMPLETED wait reporting. NB This positive result masks the long ONGOING waits for those needing face-2-face therapy. See LDP002a
LDP002a 18 weeks referral to treatment for Psychological Therapies (percentage of ongoing waits less than 18 weeks)		57.7%	42.5%		Service under review since June 2015. Currently being restructured. Changes coincided with an extended period of absence by two therapists.
LDP003a Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery					Patient seen within three weeks but data input delayed
LDP003d Clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery					No drug clients in July/August
CCR003 Percentage of people 65 and over requiring intensive care package (over 10 hours per week) in their own home					We are continuing to work with reablement programme to enable people to remain at home
CCR007 Number of 65 and over receiving Personal Care at Home.		214	218	200	To enable people to remain at home we aim to increase independence which may result in less need for personal care at home
MH002 Admission rates to Psychiatric Hospitals			7	48	This will help us consider the effectiveness of our local service provision.
MH003 Dementia Diagnosis Standard - number of diagnoses exceeds 50% of prevalence			46.81%		More people have died or moved away than have been diagnosed in recent months. As most of those on the register were diagnosed in older age, this is an ongoing issue. Work is in hand to encourage people to seek earlier assessment
AHP006 Increased number of people receiving home monitoring for health and social care (technology enabled care)					Latest national performance figures (2012/13) show Shetland ranked in top quartile of local authorities in Scotland for its telecare usage by care at home clients (Source- Draft Joint Inspection of Adult Services 2014/15)."
CJ002 Percentage of offenders commencing supervision within 7 working days of being sentenced			89.3%	100%	Missed target as outwith service control
AS002 Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills					Adults with learning disability, autistic spectrum disorder and/or complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted.
AS003 Number of incidents of emergency respite provided for adults with Learning Disability/Autistic Spectrum Disorder			1		An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays. Source: Newcraigielea The risk of unscheduled care will be reduced.

Code & Short Name	Previous Years		Current year (to date)		(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16		
	Value	Value	Value	Target	
CCR001 Delayed discharge from Hospital - no delays exceeding 14 days			5		Intense work with acute services to work out delays in systems and processes
CJ001 Percentage of court reports submitted on time	Not measured for Years	Not measured for Years	Not measured for Years		Service consistently meets target
CJ004 Risk and need assessment completed and case management plans in place within 20 days			100%		Service consistently meets target
CJ005 Percentage of individuals showing a decrease in assessed risk and need at end of order		37.5%			New risk assessment system in place which will provide more accurate data
AS005 Number of Social Care staff trained to implement Positive Behaviour Support.					Long term absence of training provider - alternatives being sought
AHP001 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count)			8	9	To achieve the nationally agreed referral to assessment timescales we have initiated a number of initiatives including streamlining our referrals and screening processes, reviewing all processes, and reconfiguring the team into a north and a south team to gain staff efficiency
AHP002 Maximum Waiting Time from Referral to Treatment for Orthotics Services (18 weeks)			98.1%	90%	Each instance of missed target is analysed by line manager.
AHP003 Maximum Waiting Time from Referral to Treatment for Physiotherapy Services (18 weeks)			97.7%	90%	Service consistently meets target. Significant pressures due to long term sickness absence, and increased number of referrals.
AHP004 Maximum Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)			99.5%	90%	Each instance of missed target is analysed by line manager.
CCR005 Occupancy of care homes		88.65%			Under occupancy is a result of vacancies in respite beds.
CJ003 Unpaid Work commenced within 7 working days		84.2%	85.45%	100%	Increase in offenders attending as instructed

Directorate Performance Indicators from the Local Government Benchmarking Framework

Indicator	Scotland 2014/15			Shetland				Performance & Improvement Statement
	Min	Avg	Max	Year	Value	Rank	Target	
SW1 Older Persons (Over65) Home Care Costs per Hour				**12/13**	43.11	32		**Performance Statement:** We have been continuing to implement our reablement programme to enable people to live for longer in their own home increasing their independence. **Improvement Statement:** Continue to work closely with agencies and integrating services to reduce costs and still enable people to stay at home for longer.
				13/14	36.68	32		
				14/15				
SW2 SDS spend on adults 18+ as a % of total social work spend on adults 18+				**12/13**	1.89	16		**Performance Statement:** The figure above shows the spend on Self-directed Support (Direct Payments) as a percentage of total social work spend on adults (aged 18+). A much higher percentage of people were offered the choice of Direct Payments or Council provided support. **Improvement Statement:** As of April 2014, we now offer all people the four options of self-directed support. We will regularly monitor this.
				13/14	2.18	19		
				14/15				
SW3 % of people 65+ with intensive needs receiving				**12/13**	48.89	3		**Performance Statement:** Consistently deliver a high level of care into people's homes as an alternative to receiving residential care services. **Improvement Statement:** Continue to work closely with
				13/14	46.1	3		

Indicator	Scotland 2014/15			Shetland				Performance & Improvement Statement
	Min	Avg	Max	Year	Value	Rank	Target	
care at home				**14/15**				agencies and integrating services to enable people to stay at home for longer. It should be noted that reablement and telecare services also enable people to stay at home without necessarily delivering an 'intensive care' package.
SW4 % of Adults satisfied with social care or social work services				**12/13**	82	1		**Performance Statement:** This figure is taken from the Scottish Household Survey and we are pleased with our performance in this area. We aim to continue with such positive results. **Improvement Statement:** From April 2015 we will record satisfaction rates for all people receiving social care / social work services at the point of review. This will give us accurate local data to assist with performance improvement.
				13/14	81	2		
				14/15				
SW5 Average weekly cost per resident				**12/13**	1484	32		**Performance Statement:** As with other island authorities, we are one of the most expensive in terms of service provision. Mainland authorities run at a lower cost due to competitive private availability and larger residential units. **Improvement Statement:** Refurbishment and review of existing service provision should lead to more efficient delivery and related costs
				13/14	1056	32		
				14/15				

Appendix E - Statutory Performance Indicators - Community Health and Social Care Directorate Plan

Shetland Islands Council

Generated on: 17 November 2015

	Date Range 1			
Code & Short Name	2012/13	2013/14	2014/15	(past) Performance & (future) Improvement Statements
	Value	Value	Value	
SW1 Home care costs for people aged 65 or over per hour (£)	£43.10	£36.68		A full review of the LFR information has now been completed. The outcome of this review will be reflected in the Local Government Benchmark information going forward.
SW2 Self directed support spend for people aged over 18 as a percentage of total social work spend on adults	1.9%	2.2%		Self-Directed Support more accessible where individuals make that choice following implementation project
SW3 % of people aged 65 or over with intensive needs receiving care at home	48.9%	46.1%		Area of focus for a number of years to provide as much care in people's own homes
SW4 % of adults satisfied with social care or social work services	82%	81%		Satisfaction rates have remained high and service will continue to strive to meet expectations
SW5 Residential care costs for people aged 65 or over per week (£)	£1,484.00	£1,057.00		Costs are significantly high in Shetland

Risks to Delivery / Risk Register

Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5
	Insignificant	**Minor**	**Significant**	**Major**	**Catastrophic**

Rating	Descriptor	Description
5	**Almost certain**	I would not be at all surprised if this happened within the next few months
4	**Likely**	I think this could occur sometime in the coming year or so
3	**Possible**	I think this could maybe occur at some point, but not necessarily in the immediate future
2	**Unlikely**	I would be mildly surprised if this occurred, but cannot entirely rule out the possibility
1	**Rare**	I would be very surprised to see this happen, but cannot entirely rule out the possibility

Current risk details

What we are going to do to manage those risks

Target in one

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
01. Supporting Adults to be Independent										
EM 0031	Inability to deliver cost-effective, safe Mental Health Service	Inability to provide quality, effective and safe services, delivered in the most appropriate setting for the patient/client.	Almost Certain (5)	Major (4)	High (20)	Following reviews of mental health and dementia, there are action plans in place which are being closely monitored to ensure progress on	Possible (3)	Minor (2)	Medium (6)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
						strengthening the services. With the additional funding allocated from health, recruitment of staff has been progressed.				
EM 0018	NHS and SIC are required to comply with Scottish Social Services Council and National Care Standards	Poor inspections ratings, failure to comply with NC standards. Potential for closure of services, bad publicity and reputational damage	Possible (3)	Significant (3)	Medium (9)	Regular inspections. Staff aware of the standards required. Inspection results reported to Committee.	Rare (1)	Significa nt (3)	Low (3)	DCHSC
04. Health Economy										
EM 0030	The impact of demographic change on Shetland if it is unmanaged	Shetland's demographics are set to change significantly over the coming 20 years, at an even more pronounced level than Scotland as a whole. The main impacts for the Council will be a falling school roll across Shetland and an increase in demand for Care of the Elderly, Mental Health and Learning Disability services.	Likely (4)	Major (4)	High (16)	Community Health & Social Care Integration is driving further joint working and efficiencies. Joint commissioning planning process to create a sustainable, affordable care model for the future. Strategies in development for Older People's Care and Dementia.	Possible (3)	Significa nt (3)	Medium (9)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
05. Strong Communities										
EM 0022	To provide quality, effective and safe services delivered in the most appropriate setting for the residents of Shetland	Lack of access to services for those living in remote areas of Shetland	Likely (4)	Significant (3)	High(12)	Models for health and social care integration focusing on ensuring locality resilience and sustainability. Primary healthcare continues to be provided in existing localities.	Significant (3)	Rare (1)	Low (3)	DCHSC
EM 0021	Inability to provide consistent, high quality, sustainable Out of Hours Care	To provide quality, effective and safe services, delivered in the most appropriate setting for the patient/client	Likely (4)	Major (4)	High (16)	More use of Advanced Nurse Practitioners. Creating seven day week 24 hour intermediate care service as part of integrated care fund initiative. Active planning of rotas with GPs.	Unlikely (2)	Minor (2)	Low (4)	DCHSC
06. Working with Partners										
EM 0033	Effect of policy decisions	NHS and SIC required to provide services across all areas of Shetland	Likely (4)	Major (4)	High (16)	Performance reporting to provide early warnings. Localities project progressing. Services to be commissioned by locality.	Major (4)	Rare (1)	Medium (4)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
07.Vulnerable and Disadvantaged People										
EM 0004	Reduced response to an emergency situation on Remote areas of Shetland and the outer islands	Potential reduction in availability of helicopter for air evacuation of unwell patients	Unlikely (2)	Major (4)	Medium (8)	Coastguard Search and Rescue Helicopter will respond to life and limb threatening injuries/illness Memorandum of Understanding in place with Direct Flight for transfer of "walking wounded". NHS Shetland continuing discussions with SAS and GAMA regarding additional helicopter coverage, especially for urgent (rather than emergency) transfer. Temporary control measure (for managing situation short term) to ensure staff on NDI have increased stock of Oxygen and consumables. Longer term need to conduct training needs analysis and increase staff skill set to support ill patients for longer period of time (if timeliness of air evacuation options not enhanced). Continue to	Unlikely (2)	Significa nt (3)	Medium (8)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
						develop First Responder schemes on NDIs to support the nurse in caring for critically ill patient.				
EM 0034	Professional Errors and Omissions	NHS and SIC operate within a complex legislative, contractual and compliance environment. Clients/ patients are many and varied in age, vulnerabilities and needs.	Unlikely (2)	Significant (3)	Medium (6)	Monitoring by professional leads re skills and capacity. Staff training plan developed each year. Incidents fully investigated.	Significant (3)	Rare (1)	Low (3)	DCHSC
EM 0042	Harm to a vulnerable person in the care of the council and/or health board	Injury or harm to a vulnerable person due to a failure or lapse in professional standards could cause national press interest, impact on communities, litigation/ prosecution/ civil action.	Unlikely (2)	Catastrophic (5)	High (10)	Professional leads are tasked with ensuring that there are adequate levels of skill and capacity to manage protection issues. Training is a key requirement for staff working in services so they have the knowledge to raise issues. Policies and procedures in place.	Rare (1)	Minor (2)	Low (2)	DCHSC
EM 0044	Difficulty in ensuring sustainable provision of services and retention of skills in small and remote communities.	A number of single handed posts exist which can be hard to recruit to. Potential difficulties of recruiting staff on a retained	Likely (4)	Significant (3)	High(12)	Cover provided using permanent or temporary staff. Temporary cover provided by community and hospital staff banks. Use of agency locum staff	Unlikely (2)	Minor (2)	Low (4)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
		basis.				as a last resort. More focussed approach to supervision and performance management to aid staff retention.				
08. A Properly Led and Well-Managed Council										
EM 0002	Delayed Discharges	Failure to meet key HEAT targets and interim trajectories for delayed discharges.	Likely (4)	Significant (3)	High (12)	Create capacity through use of Integrated Care Fund with rapid access to resources which avoid unnecessary hospital admission and expedite timely discharge. Whole system approach to reducing bottlenecks in the pathway.	Possible (3)	Minor (2)	Medium (6)	DCHSC
EM 0006	Public Involvement	Public Partnership Forum (PPF) capacity to support public involvement in developing new services and improving health services.	Possible (3)	Significant (3)	Medium (9)	Various activities to increase membership being supported by local officer of Scottish Health Council. PPF reviewing ways of operating in order to increase contribution to Health and Social Care Partnership.	Possible (3)	Minor (2)	Medium (6)	DCHSC
EM 0007	Partnership Working Failure	Conflict of interest between roles of NHS and Council. Failure to agree on certain	Possible (3)	Significant (3)	Medium (9)	Development of joint strategies incorporated in Joint Commissioning Strategy signed off by	Unlikely (2)	Minor (2)	Low (4)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
		issues which does not allow delivery to progress.				both Council and NHS Board. Single outcome agreement in place.				
EM 0010	Lack of robust contracting arrangements	Contractual arrangements unclear between NHS and Council and external organisations providing services to NHS and Council. Failure to provide services and value for money.	Possible (3)	Significant (3)	Medium (9)	SLAs in place. Joint Commissioning Strategy is being implemented. Review processes in place.	Unlikely (2)	Minor (2)	Low (4)	DCHSC
EM 0011	Resources	Resource requirements for future plans exceed available resources: — human resources — revenue — capital Failure to reach agreement on changes required to deliver targeted savings in resource.	Likely (4)	Significant (3)	High (12)	Cash Releasing Efficiency Savings (CRES) targets set for both Council and NHS. Prioritisation systems put in place for service developments. External support procured for particular efficiency schemes.	Possible (3)	Minor (2)	Medium (6)	DCHSC
EM 0013	Adult Protection Issues	Failure to act appropriately with relation to Adult Protection Issues. Current challenges in	Possible (3)	Minor (2)	Medium (6)	The professional leads are tasked with ensuring that there are adequate levels of skill and capacity to manage protection	Unlikely (2)	Minor (2)	Low (4)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
		releasing staff to attend training due to overall capacity issues				issues. Training is a key requirement for staff working in services so they have the knowledge to raise issues. Training on Adult Protection being prioritised.				
EM 0015	NHS and SIC require management information and budgetary planning to allow good performance monitoring and service planning.	Failure of systems to provide information, Inequalities, diverse formats of data, data unavailable, other technical and skills mis-matches	Possible (3)	Significant (3)	Medium (9)	Budget monitoring reports available at each period end. Performance information used at service level and reported to Committee.	Unlikely (2)	Significa nt (3)	Medium (6)	DCHSC
EM 0016	Not achieving full use of the Integrated Care Fund	Pace of change required to implement the Integrated Care Fund programme is not achieved.	Likely (4)	Significant (3)	High (12)	Plans are reflected in Joint Commissioning Strategy. Early development of plans	Possible (3)	Minor (2)	Medium (6)	DCHSC
EM 0035	Maintaining and improving the oral health of the local population	Inability to provide sufficient dental services to meet local needs	Likely (4)	Major (4)	High (16)	Review taking place of current Dental Service staffing levels and skill mix to ensure the model in place is working effectively, with flexibility for the future. Encourage local development of independent NHS dental practices.	Possible (3)	Minor (2)	Medium (6)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
EM 0036	NHS and SIC are required to evidence that funding for initiatives has resulted in improvements to service	Poor record keeping, failure to recognise requirements at the outset, no methods or systems of identifying improvements in services.	Unlikely (2)	Major (4)	Medium (8)	Establish performance monitoring systems, develop KPIs for local measures and utilise national measures. Establish performance monitoring systems reporting to both agencies. Work with Information Services Division Scotland on the national programme to develop performance indicators for joint services. Develop local measures to complement national indicators.	Rare (1)	Significa nt (3)	Low (3)	DCHSC
EM 0039	Management capacity issues	Aspects of Community Health and Social Care have been managed on an interim basis by Executive Managers.	Possible (3)	Significant (3)	Medium (9)	The structure for CH&SC will ensure that there is adequate management capacity including professional leadership within the directorate. Full engagement of the operational management team to ensure any gaps are quickly identified and dealt with.	Unlikely (2)	Minor (2)	Low (4)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
EM 0045	Budgets/ Service planning	Availability of funding or lack of alternative immediate/achievable management options, determines priorities rather than service need.	Likely (4)	Significant (3)	High (12)	Joint Commissioning Strategy sets out strategic direction and more detailed plans on how to spend specific funds. Need to better co-ordinate service planning and budget setting across the Council and Health Board to ensure budget is aligned to agreed service priorities.	Possible (3)	Rare (2)	Medium (6)	DCHSC
EM 0046	Task Duplication	Duplication or triplication of tasks to satisfy requirements of both organisations.	Almost Certain (5)	Significant (3)	High (15)	Agreement for lead organisation for functions or on use of one template and/or system. Number of initiatives progressing as result of discussions at Transition Programme Board.	Possible (3)	Unlikely (2)	Medium (6)	DCHSC
09. Dealing with Challenges Effectively										
EM 0023	Existing staff pressures compounded by an emergency situation	Critical pressure on staff and resources in an emergency situation where services are unable to respond adequately.	Possible (3)	Significant (3)	High (9)	Business continuity plans in place for community health and social care services. Involvement in planning and exercises.	Possible (3)	Minor (2)	Medium (6)	DCHSC
EM 0014	Inability to recruit to key posts	Failure to recruit staff with the right skills and in sufficient numbers to meet the needs of	Likely (4)	Significant (3)	High (12)	Work closely with both HR departments on recruitment and retention. Develop schemes to	Possible (3)	Minor (2)	Medium (6)	DCHSC

No	Risk	Details	Residual Likeli-hood	Residual impact	Residual Risk Rating and Current Risk profile	Current and planned Control Measure	Target Likeli-hood	Target Impact	Target Risk Rate	Lead Officer
		an ageing population				attract people to health and care work. Develop dynamic joint health and care roles. Review options for redesign of job roles.				

KEY:

DCHSC = Director Community Health & Social Care

Agenda Item

9

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	2016-17 Budget Proposals
Reference Number:	CC-57-15-D1
Author / Job Title:	IJB Chief Financial Officer

Decisions / Action required:

That the Integration Joint Board makes recommendations regarding the budget allocations for the delegated functions to the Council and the Health Board. The budget proposals for 2016/17 included in this report are set out in detail in the Budget Activity Sheet (Appendix 1).

High Level Summary:

The purpose of this report is to enable the Integration Joint Board to consider and understand the controllable budget proposals for the services within their remit. The Joint Strategic Commissioning Plan 2016-2019 in its current format includes NHS non-integrated services in addition to the budgets included in this report.

Corporate Priorities and Strategic Aims:

S.I.C

The budget has been produced to deliver the Directorate Plan which will contribute to meeting the Corporate Plan's Vision that the Council wants to be known as an excellent organisation that works well with its partners to deliver sustainable services for the people of Shetland. The budget has also been produced bearing in mind the specific achievement in Corporate Plan of continuing to keep to a balanced and sustainable budget, and living within our means.

NHS

The Board's Local Delivery Plan sets out intended actions and the risks associated with delivering key national targets and is signed off by the Scottish Government. This includes a detailed one year financial plan and a five year plan that sets out the key financial risks to the Board. The Local Delivery Plan is aligned to the Board's five corporate objectives and the Scottish Government's 2020 Vision.

Key Issues:

This report aims to make it clear to members which budgets from both the Shetland Island's Council and NHS Shetland are controllable within their remit.

The draft Joint Strategic Commissioning Plan currently includes all NHS budgets and does not differentiate between integrated and non integrated services.

The budgets contained in this report represent the integrated services of the Strategic Plan and will be developed further as consultation of the plan progresses in line with the IJB's Participation and Engagement Strategy. These service plan headings and corresponding budgets will form the basis of the quarterly financial performance reports that will be presented to the IJB.

Implications : *Identify any issues or aspects of the report that have implications under the following headings*	
Service Users, Patients and Communities:	S.I.C Consultation and communication with relevant groups and individuals as appropriate to the proposals have been considered as part of this report, including the development of the Older Peoples Strategy; the Dementia Strategy; and the Strategic Plan 2016-19 for the Integrated Joint Board. NHS Changes to budgets will occur as efficiency schemes are developed between now and the end of March 2016. Service change will require a separate process for public and user engagement in line with NHS, S.I.C and IJB policies.
Human Resources and Organisational Development:	None
Equality, Diversity and Human Rights:	None
Partnership Working	Budgets are set to deliver partnership working across integrated services.
Legal:	None
Finance:	S.I.C This report presents budget proposals that are consistent with the budget strategy included in the proposed Medium Term Financial Plan for 2015-2020 which is being presented to Council for approval on 18 November 2015. The budget and charging proposals will be considered by the Policy and Resources Committee on 25 November 2015, any decision to recommend changes to the proposals in this report to the Council on 2 December 2015, will result in an increased or decreased draw on reserves, and may result in not meeting the targets in the proposed Medium Term Financial Plan. This will require a formal amendment and be fully quantified in the Committee decision. NHS This report presents budget proposals that are consistent with the budget strategy included in the proposed Local Delivery Plan for 2016-2020 which is being presented to the Board for approval on 15 December 2015.
Assets and Property:	S.I.C

	A risk based approach will be taken for the management of property assets to minimise the deterioration and potential failure of assets over the life of the Medium Term Financial Plan. Where possible unused assets will be disposed of to reduce ongoing revenue costs and maximise capital receipts for the Council. NHS The Board has developed a ten year asset replacement schedule, based on indicative capital allocations from the Scottish Government, which will minimise the deterioration and potential failure of assets. Where possible unused assets will be disposed of to reduce ongoing revenue costs and maximise capital receipts for the NHS.
Environmental:	None
Risk Management:	SIC Any failure to meet the reductions in overall budget spending levels will result in the Council using its reserves unsustainably. The main specific financial risks for the services in this Committee area are: • increased demand for care services as a result of the changing demographics of Shetland's population; • unexpected demand for care services which may be costly depending on the circumstances; • the level of charging income received can vary significantly, as it is dependent on the individual financial circumstances of those in care at any time. These risks are mitigated by the Directorates using a realistic approach and the latest data when setting the budget, and the inclusion in the overall Council budget of a corporate contingency budget to support cost pressures which may arise during the year. The Council also has a strong balance sheet and available usable reserves which ensures that the Council is prepared for significant unforeseen events. Any draw on reserves beyond the Council's sustainable level would have an adverse impact on the level of returns from the Council's long-term investments and this situation would require to be addressed quickly to ensure no long term erosion of the investments. NHS Any failure to meet the reductions in overall budget spending levels will result in the NHS using under spends, as a result of both recurrent and non recurrent efficiency schemes, from other directorates to underwrite the position. The main specific financial risks for the integrated services are: • increased demand for care services as a result of the changing demographics of Shetland's population; • GP Prescribing inflation;

	• Staff recruitment and retention issues resulting in the use of high cost locums. These risks are mitigated by the Directorates using a realistic approach and the latest data when setting the budget, and the inclusion in the overall NHS budget of a general contingency reserve to support cost pressures which may arise during the year.

Policy and Delegated Authority:	<u>IJB</u> In regard to budget setting the Integration Scheme sets out that the IJB will be invited to make recommendations regarding the budget allocations for the delegated functions to the Council and the Health Board. In accordance with the IJB financial regulations, the IJB is responsible for the production of a Strategic Plan – setting out the services for their population over the medium term (3 years). This should include a medium term financial plan for the resource within the scope of the strategic plan. Shetland NHS Board and Shetland Island Council will provide indicative three year rolling funding allocations to the Integration Joint Board to support the Strategic Plan and medium term financial planning process. Such indicative allocation will remain subject to annual approval by both organisations. This report is the first step in what financial process, covering 2016/17. <u>S.I.C</u> The Social Services Committee has delegated authority to advise Policy & Resources Committee and the Council in the development of service, objectives, policies and plans concerned with service delivery. Approval of the revenue budget requires a decision of the Council, in terms of Section 2.1.3 of the Council's Scheme of Delegations. <u>NHS</u> Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare a five-year financial plan linked to the Board's Local Delivery Plan. This financial plan will be reviewed by Strategy & Redesign Committee and approved by the Board.
Previously considered by:	This report has not been considered by any other formal meeting of the Council.

"Exempt / private" item	No

The main report is to be attached together with a list of the appendices and references to any background documents or material e.g. include web links.

Agenda Item

9

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	2016-17 Budget Proposals
Reference Number:	CC-57-15-D1
Author / Job Title:	IJB Chief Financial Officer

1. Introduction

1.1 The purpose of this report is to enable the Integration Joint Board to consider and understand the controllable budget proposals for the services within their remit. The Joint Strategic Commissioning Plan 2016-2019 in its current format includes NHS non-integrated services in addition to the budgets included in this report.

1.2 The summary budget proposals for the services under the remit of the Integration Joint Board are £43.194m, split by organisation and service area as follows:

	2016/17 Proposed Budget £000s		
Service	**S.I.C**	**NHS**	**NHS Set Aside**
Mental Health	1,060	1,513	0
Substance Misuse	257	568	0
Oral Health	0	3,382	0
Pharmacy & Prescribing	0	5,484	1,017
Primary Care	0	4,402	0
Community Nursing	0	2,313	0
Directorate	425	92	0
Pensioners	78	0	0
Sexual Health	0	0	38
Adult Services	5,201	70	0
Adult Social Work	1,665	0	0
Community Care Resources	10,512	0	0
Criminal Justice	29	0	0
Speech & Language Therapy	0	88	0
Dietetics	0	119	0
Podiatry	0	225	0

Orthotics	0	143	0
Physiotherapy	0	603	0
Occupational Therapy	1,371	192	0
Health Improvement	0	0	340
Unscheduled Care	0	0	3,183
Renal	0	0	145
Efficiency Target [1]	0	-1,057	-266
Total	**20,598**	**18,138**	**4,458**
Grand Total		**43,194**	

[1] The NHS will undertake a programme of work between now and the end of March 2016 to develop detailed efficiency schemes, with clear timeframes, that will create sustainability for 2016/17 and beyond.
The efficiency target for the set aside budget is purely notional based on the value of set aside budgets as a percentage of the total Acute & Specialist Services budget (26.45%).

2. Background

Shetland Islands Council

3.1 The proposed Medium Term Financial Plan, setting out an integrated budgeting and reserves strategy for the period 2015-2020, is to be considered by Council on 18 November 2015. This report has been written subject to approval of that Plan. The Directorate's proposed 2016/17 financial plan will be considered by the Policy and Resources Committee on 25 November 2015 and presented for Council approval on 2 December 2015.

3.2 As part of the budgeting strategy, each of the Council's directorates was provided with a target operating budget. Each Director has subsequently developed their directorate budget proposals within these targets for 2016/17. The proposals in this report show how this will be delivered.

3.3 The Target Operating Budget for 2016/17 was set as follows:

Directorate	Original Target 2016/17 £000	Cost Pressures £000	Revised Target 2016/17 £000
Community Health and Social Care Services	19,359	1,300	20,659

The cost pressure figures in the table above relate to the nationally agreed pay award and other nationally agreed pay related adjustments e.g. changes to employers' national insurance liabilities.

3.4 By adhering to the target operating budget, Members will ensure that the organisation is now achieving a financially sustainable budget for 2016/17 with the use of reserves at a sustainable level.

3.5 The Community Health and Social Care Services set its budget by undertaking an incremental budget approach, using previous years' outturns, and in year financial information, adjusted for anticipated changes in the coming year.

3.6 In August this year the Council undertook a building budgets engagement exercise, which included a series of public meetings throughout Shetland and the use of an interactive on-line budget planning model, to gauge the views of the public on where the 2016/17 budget savings should be made. There were 244 people who participated in this exercise which is approximately 1% of the Shetland public.

3.7 The Director has reviewed the results of the building budgets exercise and have taken the views submitted into consideration when creating their 2016/17 budgets.

3.8 Social Care Services have implemented overall savings of 2.3% and developed their budget in consideration of the following:

3.8.1 the new Corporate Plan priorities of:

- people will be supported to look after and improve their own health and well-being, helping them to live in good health for longer;
- our integrated Health and Social care services will be providing the services we need in a more efficient way, improving standards of care and keeping people healthier for longer;
- our staff will have the highest possible standards of leadership and management, helping to create a culture that makes sure we achieve the things set out in this plan;
- older people and people living with disabilities (including learning disabilities) or long term conditions will be getting services they need to help them live as independently as possible;
- increased use of technology will be helping us provide care for the most vulnerable and elderly in our community;
- the needs of the most vulnerable and hard-to-read groups will be identified and meet, and services will be targeted to those that need them most;
- more people will be able to get the direct payments and personal budgets that they want, so they can make the best choices for their own lives;

3.8.2 the desire of the building budgets exercise to see resources aimed at health, vulnerable groups, older people and children;

3.8.3 the proposed Medium Term Financial Plan recognising expected increased demand for care services arising from changing population demography;

3.8.4 to maintain the delivery of statutory service to a level that satisfies external scrutiny from regulators and inspectors.

3.9 The results of this detailed budget work have been captured in a detailed Budget Activity Sheet - Appendix 1.

3.10 The proposed charging structure included in the budget proposals for the Community Health and Social Care Services is attached as Appendix 2.

NHS Shetland

3.11 The Board's proposed 2016/17 financial plan will be reviewed by Strategy & Redesign Committee on 27 November 2015 and presented for Board approval on 15 December 2015. The approved 2016/17 plan will then be incorporated into the Board's five year Local Delivery Plan (LDP) which will be submitted to the Scottish Government in March 2016.

3.12 The pay budgets have been zero based for 2016/17 assuming a nationally agreed pay award, incremental drift and changes to employers national insurance liabilities.

3.13 Non pay budgets have been developed in conjunction with departmental managers and will be reviewed and finalised by Strategy & Redesign Committee on 27 November 2015.

3.14 Managers were presented with 2015/16 non pay budgets and asked to flag any known cost pressures that will arise in 2016/17. NHS Finance then reviewed these pressures based on historic spend patterns and decided on which of these to fund and which should be contained within current budgets.

3.15 The NHS balanced budget for 2016/17 and for the duration of the five year LDP remains reliant on an unidentified efficiency target. This challenging target is in the region of £7m from 2016/17 to 2019/20.

4.0 2016/17 Budget Proposals

Shetland Islands Council

The following section describes the changes proposed in the Community Care Services budget for 2016/17.

4.1 The Spend to Save Project which has enabled the linkage of Edward Thomason and Taing House and included the creation of one central kitchen will be completed in 2015/16. The budget reflects the closure of Viewforth Care Home, which was part of this project, showing the associated reduction in staffing and operating costs as a result of this.

4.2 Services formerly provided by Viewforth Care Home have now been re-provided, primarily within Edward Thomason House, and budgets to cover the additional staffing requirements at that location have been included.

4.3 A reduction in staffing within Supported Living and Outreach has been recognised. Furthermore the borrowing costs required for the new Eric Gray Building is also contained in the Community Health and Social Care Directorate budget in 2016/17.

4.4 Provision has been made for an additional 2 FTE posts to administer Self Directed Support.

NHS Shetland

4.5 Currently the 2016/17 efficiency target for the Directorate of Community Health & Social Care is £1.057m comprised as follows:

2014/15 unachieved recurring target b/f	£0.363m
2015/16 unachieved recurring target b/f	£0.343m
2016/17 target	£0.351m

4.6 High level efficiency schemes have been agreed in principle but the detail to these schemes will have to be developed between now and the end of March 2016.

4.7 As these schemes are developed the proposed budgets in 1.2 will change accordingly.

5. Recommendations

5.1 The Integration Joint Board is invited to make recommendations regarding the budget allocations for the delegated functions to the Council and the Health Board. The budget proposals for 2016/17 included in this report are set out in detail in the Budget Activity Sheet (Appendix 1).

6. Conclusions

6.1 This is the first presentation of the budgets which underpin the draft Joint Strategic Commissioning Plan for 2016/19. The report offers the IJB the opportunity to make recommendations to the Council and the Health Board regarding the budget allocations for the delegated functions.

Contact Details:

For further information please contact:
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18 November 2015

Appendices

Appendix 1 - 2016/17 Community Health & Social Care Budget Activity Sheet
Appendix 2 2016/17 Community Health and Social Care Schedule of Charges

END

2016/17 Community Health & Social Care Directorate Budget Activity Sheet

Appendix 1

					JOINT BUDGETS				
Service	**Activity**	**Links to Corporate Plan**	**FTE SIC**	**FTE NHS**	**Proposed Budget SIC** £	**Proposed Budget NHS** £	**Proposed Set Aside Budget** £	**Red Amber Green**	**Proposed Changes To Service Level**
Health and Social Care Integration Plans	Mental Health	People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer	28.94	21.50	1,060,488	1,513,469	0	**Green**	Closure of Viewforth Care Home has been recognised within the budget, with reprovision of some residential beds within Community Care Resources.
	Substance Misuse	Our integrated services will be providing the services we need in a more efficient way, improving standards of care and keeping people healthier for longer	1.05	8.50	257,163	567,836	0	**Green**	SADP to agree budget for 16/17, ensuring best value and to cover alcohol detox from within core allocation rather than through top up from NHS.
	Oral Health	Links to NHS Shetland's Board Objectives	0	67.73	0	3,382,294	0	**Green**	No change. The opening of an NHS committed independent practice is likely to result in a reduction to this budget.
	Pharmacy & Prescribing	Links to NHS Shetland's Board Objectives	0	9.08	0	5,483,641	1,017,083	**Green**	Budget to be uplifted in 16/17 as local prescribing costs follow the national 15/16 upwards trend.
	Primary Care	Links to NHS Shetland's Board Objectives	0	30.08	0	4,402,320	0	**Green**	Efficiency targets in 16/17, but no change in base budget allocation at this stage.
	Community Nursing	Links to NHS Shetland's Board Objectives	0	47.45	0	2,312,966	0	**Green**	Efficiency targets in 16/17, but no change in base budget allocation at this stage.
	Directorate	Our staff will have the highest possible standards of leadership and management, helping to create a culture that makes sure we achieve the things set out in this plan.	3.35	1.00	424,680	92,228	0	**Red**	SIC No Change. The savings target for the NHS will sit with the Director in this budget.
	Pensioners	N/A Statutory provision	0	0.00	78,029	0	0	**Green**	No Change
	Sexual Health	Links to NHS Shetland's Board Objectives	0	0.56	0	0	38,137	**Green**	No Change
	Adult Services	Older people and people living with disabilities (including learning disabilities) or long term conditions will be getting the services they need to help them live as independently as possible	136.39	1.00	5,201,063	70,240	0	**Green**	No overall change. Budget savings identified within Support Living and Outreach staffing to cover the expected borrowing costs for the new Eric Gray Resource Centre

	Adult Social Work	More people will be able to get the direct payments and personal budgets that they want, so they can make the best choices for their own lives	19.29	0.00	1,664,586	0	0	**Green**	No overall change. Proposed increase of 2 FTE to deliver Self Direct Support. These posts were previously funded by Reshaping Care Fund and carry-forward.
	Community Care Resources	Older people and people living with disabilities (including learning disabilities) or long term conditions will be getting the services they need to help them live as independently as possible	396.31	0.00	10,511,789	0	0	**Green**	Closure of Viewforth Care Home has led to reprovision of some residential beds within ET/Taing House, with staffing levels increased.
	Criminal Justice	The needs of the most vulnerable and hard-to-reach groups will be identified and met, and services will be targeted at those that need them most	7.37	0.00	29,149	0	0	**Green**	No change.
Allied Health Professionals	Speech & Language Therapy	Links to NHS Shetland's Board Objectives	0	3.29	0	88,135	0	**Green**	Efficiency targets in 16/17, but no change in base budget allocation at this stage.
	Dietetics	Links to NHS Shetland's Board Objectives	0	2.84	0	118,839	0	**Green**	Efficiency targets in 16/17, but no change in base budget allocation at this stage.
	Podiatry	Links to NHS Shetland's Board Objectives	0	4.40	0	224,917	0	**Green**	Efficiency targets in 16/17, but no change in base budget allocation at this stage.
	Orthotics	Links to NHS Shetland's Board Objectives	0	2.00	0	143,363	0	**Green**	Efficiency targets in 16/17, but no change in base budget allocation at this stage.
	Physiotherapy	Links to NHS Shetland's Board Objectives	0	12.89	0	602,664	0	**Green**	Efficiency targets in 16/17, but no change in base budget allocation at this stage.
	Occupational Therapy	Increased use of technology will be helping us provide care for the most vulnerable and elderly in our community and links to NHS Shetland's Board Objectives	16.29	4.42	1,370,630	192,187	0	**Green**	No Change
	Health Improvement	Links to NHS Shetland's Board Objectives	0	6.13	0	0	340,494	**Green**	No Change
	Unscheduled Care	Links to NHS Shetland's Board Objectives	0	58.19	0	0	3,183,445	**Green**	No Change
	Renal	Links to NHS Shetland's Board Objectives	0	3.50	0	0	144,699	**Green**	No Change
			608.99	284.56	20,597,577	19,195,099	4,723,858		

2016/17 Community Health & Social Care Directorate Schedule of Charges

Appendix 2

Activity	Charge	Unit	2015/16 Charge £	2016/17 Charge £	Variance %	VAT*
Social Work Establishments	Permanent Residents - All Establishments - single room	per week	1090.00	1144.00	5.0	NB
	Temporary Residents - All Establishments - single room	per week	272.00	277.00	1.8	NB
	Financial Assessment for Temporary Residential Care - Disregarded Home Commitments Allowances: - Person Living Alone		37.25	38.00	2.0	NB
	Financial Assessment for Temporary Residential Care - Disregarded Home Commitments Allowances: - Person Sharing a Home		24.80	25.30	2.0	NB
	Financial Assessment for Temporary Residential Care - - Disregarded Home Commitments Allowances: - Sheltered Housing Tenant Living Alone		24.80	25.30	2.0	NB
	Financial Assessment for Temporary Residential Care - - Disregarded Home Commitments Allowances: - Sheltered Housing Tenant Sharing a Home		18.63	19.00	2.0	NB
	Supported Living - Supported Living Service	per week	56.00	56.00	0.0	NB
	Supported Living Transition Experience Flat	per night	11.00	11.00	0.0	NB
	Personal Care Charge (under 65s)	per hour	16.77	17.53	4.5	NB
	Domestic Home Care Charge	per hour	11.78	12.33	4.7	NB
	Day Care Attendance Charge	per day	5.00	5.00	0.0	NB
	Day Care Meal Charges	per meal	6.00	6.00	0.0	NB
	Meals on Wheels	per meal	6.00	6.00	0.0	NB
	Community Alarm Response Service	per week	1.05	1.15	9.5	NB
	Social Work Premises - room hire rate	per hour	10.00	10.25	2.5	NB
Cross Reach	Negotiated price inclusive of enhancements for all client groups		848.00	880.00	3.8	NB
Mainland Placements	Negotiated price will be on an individual basis in line with COSLA's benchmark figures		Negotiable	Negotiable	n/a	NB
Direct Payment Rates	Personal Care	per hour	16.77	17.53	4.5	NB
	Domestic Tasks per hour (including Laundry and Meal preparation)	per hour	11.78	12.33	4.7	NB

*** VAT code explanation**

ZR = Zero Rated (VAT Code 0)

SR = Standard Rated (Vat code 1)

NB = Non Business (VAT code 3)

EX = Exempt (VAT code 2)

OS = Outwith Scope (VAT code 8)

Agenda Item

10

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Appointment of Members to the Shetland Partnership Board
Reference Number:	GL-52 *Cover*
Author / Job Title:	Jan-Robert Riise, Executive Manager – Governance and Law (SIC)

Decisions / Action required:

That the Integration Joint Board (IJB) appoints, from amongst its voting members, one substantive and one substitute member to the Shetland Partnership Board (SPB).

High Level Summary:

The purpose of this report is to consider a request to appoint a member and a substitute to the Shetland Partnership Board (SPB).

Corporate Priorities and Joint Working:

Work of the IJB is essential in ensuring the efficient and effective performance of Shetland's Health and Social Care Partnership in order to deliver the outcomes set out in the Integration Scheme.

Under the terms of the Public Bodies Joint Working (Scotland) Act 2014, the IJB has become a statutory partner in relation to community planning. The approved Integration Scheme requires the IJB to work closely with Shetland's Community Planning Partnership, as required by the Scottish Government.

Key Issues:

In order to ensure strong and effective links between the Shetland Partnership and the IJB, the IJB is being asked to formally take up membership of the SPB, which would ensure compliance with the Integration Scheme.

Implications :

Service Users, Patients and Communities:	None.

Human Resources and Organisational Development:	None.
Equality, Diversity and Human Rights:	None.
Legal:	The IJB is advised to take up the offer of a place on the SPB in order to demonstrate compliance with the Integration Scheme and as a statutory Community Planning partner organisation.
Finance:	Any costs associated with attendance at meetings will be met from within existing budgets of the Council and the Health Board.
Assets and Property:	None.
Environmental:	None.
Risk Management:	There are no risks associated with acceptance of membership of the SPB, but not accepting membership could cause reputational damage to the IJB, the Council or the NHS.
Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The appointment of members to the SPB complies with the requirement of the Integration Scheme to ensure the IJB works closely with Shetland's Community Planning Partnership, as required by the Scottish Government.
Previously considered by:	This report has not been considered at any other meeting.

END

Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	Appointment of Members to the Shetland Partnership Board
Reference Number:	GL-52 Report
Author / Job Title:	Jan Riise, Executive Manager – Governance and Law

1. Introduction

1.1 In the process of discharging their functions, both the Council and NHS Shetland contribute to the membership of the Shetland Partnership Board and, along with other organisations, to a number of other national and local organisations.

1.2 As a statutory Community Planning partner, the Integration Joint Board, now being fully established and operational [assuming approval of the Strategic Commissioning Plans], is being asked to take up membership of the Shetland Community Planning Board.

2. Background

2.1 At its meeting on 4 June 2015, the Shetland Partnership Board (SPB) agreed to invite the Integrated Joint Board (IJB) to appoint a member to the Shetland Partnership Board.

2.2 Also, under the revised Partnership guide, the partners can arrange a substitute member with appropriate authority to represent and take decisions on behalf of their organisation.

2.3 The IJB may therefore also wish to appoint a substitute member, should the substantive member be unable to attend a Partnership Board meeting.

2.4 The SPB is comprised of members from other organisations who may either be executive board members or officers carrying delegated powers. Given the statutory Scheme that established the IJB, it is recommended that consideration be given to appointing voting members for the purposes of this appointment.

2.3 The next meeting of the SPB is 3 December 2015.

3. Conclusions

3.1 In order to ensure strong and effective links between the Shetland Partnership and the IJB, the IJB is being asked to formally take up membership of the SPB, which would ensure compliance with the Integration Scheme.

Contact Details:
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17 November 2015

Appendices

None.

Background Documents

H&SCI Integration Scheme Integration Scheme

Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	IJB Business Programme 2015/16
Reference Number:	GL-49 *Cover*
Author / Job Title:	Jan-Robert Riise, Executive Manager – Governance and Law (SIC)

Decisions / Action required:

The Integration Joint Board is asked to consider its business planned for the remaining quarters of the current financial year to 31 March 2016, and RESOLVES to approve any changes or additions to the Business programme.

High Level Summary:

The purpose of this report is to inform the IJB of the planned business to be presented to the Board over the remaining quarters of the current financial year to 31 March 2016, and discuss with Officers any changes or additions required to that programme.

Corporate Priorities and Joint Working:

Work of the IJB is essential in ensuring the efficient and effective performance of Shetland's Health and Social Care Partnership in order to deliver the outcomes set out in the Integration Scheme.

In order to fulfil the statutory duties with regard to the functions delegated to the IJB by the Shetland Islands Council (the Council) and Shetland NHS Board (the Health Board), and in order to meet public governance principles, the IJB must make sure its Business Programme supports its role in the planning and direction of services to meet the needs of some of the most vulnerable people in our community, and to set its business in accordance with local and national reporting frameworks.

Key Issues:

The IJB's governance documents contain the legislative requirements and matters of best practice and standards, and the Business Programme enhances these by publicising the plans for decision making and other public reporting requirements, in keeping with the principles of good governance.

Implications :

Service Users, Patients and Communities:	The Business Programme provides the community and other stakeholders with important information, along with the Strategic Commission Plans, as to the planned business for the coming year.
Human Resources and Organisational Development:	There are no direct impacts on staffing or organisational development matters with regard to approval of the Business Programme. However approval of the Business Programme will give direction and assurances to staff with regard to the timing and requirements for decisions and public reporting that the IJB has agreed. It has been agreed that support for the Business Programme function for the IJB will be co-ordinated by the Council's Corporate Services Department as part of the corporate services support for the IJB. This will be achieved within existing resources.
Equality, Diversity and Human Rights:	There are no direct impacts on equality, diversity or human rights with regard to approval of the Business Programme, although individual items will have to have regard to those in terms of any outcomes and associated risks. The recommendation in this report does not require an Equalities Impact Assessment.
Legal:	The IJB is advised to establish a Business Programme, but there are no legal requirements to do so. There are no direct legal impacts with regard to approval of the Business Programme, although individual reports will have to have regard to current and impending legislation and the impact on the IJB, and the services which the NHS and SIC deliver, in terms of outcomes and legal risks.
Finance:	The there are no direct financial implications by approving the Business Programme, but indirect costs may be avoided by optimising time spent by officers and members of the IJB at scheduled meetings. Regular financial and performance reporting will ensure that the IJB fulfils the terms of the Integration Scheme. Any costs associated with the development and maintenance of the IJB Business Programme will be met from within existing budgets of the Council and the Health Board.
Assets and Property:	There are no implications for major assets and property. It is proposed that all meetings of the IJB will be held in either the premises of the Council or the Health Board and that the costs will be covered accordingly by the Council and the Health Board.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The risks associated with setting the Business Programme are

	around the challenges for officers meeting the timescales required, and any part of the Business Programme slipping and causing reputational damage to the IJB, the Council or the NHS. Equally, not applying the Business Programme would result in decision making being unplanned and haphazard and aligning the IJB's Business Programme with the objectives and actions contained in its Strategic Plans could mitigate against those risks.
Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB will assume responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approves and adopts a joint Strategic (Commissioning) Plan. Maintaining a Business Programme will ensure the effectiveness of the IJB's reporting framework, and its planning and performance management, by monitoring and reviewing the achievement of key outcomes and objectives as set out in its Strategic Plans, . The IJB has the authority to approve the IJB Business programme 2015/16 as set out in this report.
Previously considered by:	The Business Programme was considered by the IJB at its meeting on 25 August 2015. The Business Programme continues to be considered by the SIC Social Services Committee and the NHS CHCP Committee, until such time as the IJB adopts its Strategic Commissioning Plan for 2015/16.

END

Agenda Item

11

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	20 November 2015
Report Title:	IJB Business Programme 2015/16
Reference Number:	GL-49 Report
Author / Job Title:	Jan Riise, Executive Manager – Governance and Law

1. Introduction

1.1 This report presents an updated draft IJB Business Programme 2015/16 for the Integration Joint Board (IJB). The draft IJB Business Programme is attached at Appendix 1.

2. Background

2.1 The purpose of this report is to inform the IJB of the planned business to be presented to the IJB for the financial year to 31 March 2016 for the IJB to consider and advise regarding any changes or additions required to that programme.

2.2 The IJB have agreed that the Business Programme will be presented to every meeting of the IJB for the time being. It is anticipated that by April 2016, the Business Programme would be presented on a quarterly basis for discussion and approval.

2.3 The Strategic Plan for 2015/16 will be discussed at today's meeting of the IJB, and only after approval of a Strategic Plan for the IJB will the IJB assume responsibility for the functions delegated to it by the Council and the Health Board. In the meantime, the Business Programme for the Social Services and CHP Committee have continued to be presented to those meetings, together with that of the IJB for information.

3. Establishing the IJB Business Programme for 2015/16

3.1 The IJB should have an effective business programme in place to support its activities. The IJB is responsible for:

3.1.1 Strategic planning for health and social care services as specified in the Integration Scheme, developing and maintaining a three year Strategic Plan;

3.1.2 Directing service delivery by the Council and the Health Board in line with the Strategic Plan; and

3.1.3 Operational oversight, performance monitoring and reporting on integrated health and social care services through the Chief Officer.

3.2 The manner in which meetings have been scheduled is described below.

- Ordinary meetings – where there is no scheduled business within 2 weeks of the meeting, the meeting will be cancelled.
- Special meetings may be called on specific dates for some items – other agenda items can be added, if time permits.
- It is planned to build in quarterly PPMF (Planning and Performance Management Framework) meetings for the IJB. These meetings are time restricted, with a specific focus on PPMF only and therefore no other business will be permitted on those agenda.
- "Budget" meetings are budget setting meetings, where other agenda items can be added, if time permits, or if required as part of the budget setting process.
- In consultation with the Chair, Vice Chair and relevant Officers, and if required according to the circumstances, the time, date, venue and location of any meeting may be changed, or special meetings added.

Recommendations

3.3 It is recommended that the IJB considers its business planned for the remaining quarters of the current financial year to 31 March 2016, and RESOLVES to approve any changes or additions to the Business programme.

4. Conclusions

4.1 The presentation of the IJB Business Programme for 2015/16 at each meeting provides a focussed approach to the business of the IJB and allows senior officers an opportunity to update the IJB with regard to any changes and / or additions required to the Business Programme in a planned and measured way.

Contact Details:
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9 November 2015

Appendices

Appendix 1: IJB Business Programme for 2015/16

Background Documents

H&SCI Integration Scheme Integration Scheme

Integration Joint Board - Shetland Health and Social Care Partnership
Meeting Dates and Business Programme 2015/16

Chair: Mr Cecil Smith, SIC / Vice-Chair: Dr Catriona Waddington, NHS
as at Monday, 16 November 2015

Integration Joint Board - Shetland Health and Social Care Partnership			*D= Delegated R=Referred*
Quarter 2 1 July 2015 to 30 September 2015	**Date of Meeting**	**Business**	
	Monday 20 July 2015 11 a.m.	Appointment of Joint Accountable Officer - Chief Officer, Chief Financial Officer and Non-voting Members	D
	Wednesday 29 July 2015 2.30 p.m.	Approval of Constitutional Documents: Scheme of Administration Standing Orders for Meetings Financial Regulations	D
	Tuesday 25 August at 11am	Participation and Engagement Strategy	D
		Risk Management Strategy	D
		Establishment of Care and Clinical Governance Committee	D
		Establishment of Audit Committee	D
Quarter 3 - 1 October to 31 December 2015	Friday 20 November At 2.30 p.m.	Financial Recovery Plan	D
		Joint Strategic Commissioning Plan 2015/16	D
		Establishment of Strategic Planning Group	D
		Participation and Engagement Strategy – Action Plan	D
		NHS Public Health Annual Report 2015	D
		2016/17 Budget and Charging Proposals	R P&R 25 Nov SIC 2 Dec
		Joint Strategic Commissioning Plan 2016-19	D
		IJB Business Programme 2015/16	D

Integration Joint Board - Shetland Health and Social Care Partnership
Meeting Dates and Business Programme 2015/16

Chair: Mr Cecil Smith, SIC / Vice-Chair: Dr Catriona Waddington, NHS
as at Monday, 16 November 2015

Social Services Committee / CHP Committee			*D= Delegated R=Referred*
Quarter 3 1 October 2015 to 31 December 2015	**Date of Meeting**	**Business**	
	PPMF 24 November 2015 10 a.m.	Community Health and Social Care Services Directorate – Performance Overview – Quarter 2	D
		Directorate/Integrated Joint Board Risk Register	D
		Chief Social Work Officer Report	D
		Financial Monitoring Report [NHS]	D
		Management Accounts – Quarter 2	D
		IJB Business Programme 2015/16	D

Integration Joint Board - Shetland Health and Social Care Partnership			*D= Delegated R=Referred*
Quarter 4 1 January 2016 to 31 March 2016	*Ordinary* 4 February 2016 10 a.m.	New Eric Gray Resource Centre Update	D
		Delays in Discharge from Hospital to Community Setting	D
Quarter 4 1 January 2016 to 31 March 2016	**Date of Meeting**	**Business**	
	Performance Monitoring 29 February 2016 11.30 a.m.	Management Accounts – Quarter 3	D
		Financial Monitoring Report [NHS]	D
		Community Health and Social Care Services Directorate - Performance Overview Q3	D
		CHCP Action Plan Main Priorities	D
		Integrated Joint Board Risk Register	D
		Quarterly Report on Health Improvement and Health Inequalities	D
		IJB Business Programme 2016/17	D

Planned Committee business still to be scheduled - as at Monday, 16 November 2015

- Primary Care Strategy

Performance Management – no other business to be added
Ordinary = Ordinary meetings – other items can be added
Special = Special meetings arranged for particular item(s) – other items can be added if time permits

END OF BUSINESS PROGRAMME as at Monday, 16 November 2015