Agenda Item
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Shetland Islands Council

MINUTE - PUBLIC

Meeting	Integration Joint Board
Date, Time and Place	20 November 2015 at 2.30 p.m. Bressay Room, NHS Headquarters, Montfield, 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 Bokor-Ingram, IJB Chief Officer K Williamson, IJB Chief Financial Officer S Gens, SIC Staff Representative C Hughson, Voluntary Sector Representative H Massie, Patient/Service User Representative M Nicolson, SIC Chief Social Work Officer J Unsworth, Senior Consultant: Local Acute Sector E Watson, NHS Chief Nurse Community and ACF
In attendance [Observers/Advisers]	R Roberts, NHS Chief Executive M Boden, SIC Chief Executive C Ferguson, Director of Corporate Services SIC S Taylor, Director of Public Health J Belford, Executive Manager Finance SIC J Riise, Executive Manager – Governance and Law SIC S Brunton, Team Leader – Legal SIC S Duncan, Financial Accountant SIC A Cogle, Team Leader – Administration SIC *[note taker]*
Apologies	Voting Members None Non-voting Members S Beer, Carers Representative S Bowie, Senior Clinician – GP I Sandilands, NHS Staff Representative Observers/Advisers None.

Chairperson	Mr C Smith, Chair of the Integration Joint Board, presided.
Declarations of Interest	None.
09/15	**Confirm minutes of meeting held on 25 August 2015**
	The Board approved the minutes of the meeting held on 25 August 2015 on the motion of Ms M Williamson seconded by Mr G Cleaver. With reference to minute reference 05/15, the Chair advised that the Clinical Care and Professional Governance Committee proposals had been agreed at the last meeting, and had subsequently been approved by the NHS and SIC, and that it was agreed that substitutes may be allowed in particular circumstances, and in discussion with the Chair of the Committee.
10/15	**Financial Recovery Plan**
Report No. CC-51-15-F	The Board considered a report which set out the current financial pressures across both the Community Health and Social Care Directorate and Acute and Specialist Services Directorate. The Chief Officer outlined the terms of the report, indicating that the cost pressures for the NHS in particular were considerable. He said that the NHS Board, in preparation of the Financial Recovery Plan for 2015/16, confirmed that overspends within the health directorate will be covered in full by the Health Board. He advised that in dealing with and managing the two directorates, consideration will be given as to recurrent and non-recurrent savings, with an emphasis on those non-recurrent service aspirations. The Chief Officer went on to say that the 2016/17 efficiency programme will be presented to the IJB at a future meeting, as part of the process for agreeing a strategic plan for 2016-2019. Mr G Cleaver said he was pleased to receive clarity around the responsibility for the current position on overspends, and that clarity was welcomed as the relationship with the Council and the Health board moving forward had perhaps been a little misunderstood, and that it would be important to see a recovery plan and receive an understanding of how the scrutiny of that will proceed, and if it would be maintained as a Health Board risk, reported frequently to the IJB. The Chief Officer said that the Strategic plan for 16-19 would include an indication of the potential changes and the financial recovery plan would have to consider the detail of that. He confirmed that this would come to a meeting of the IJB in February, on the understanding that the cost pressures were not just for 2016/17 but beyond.

	Mr K Massey asked what levels of confidence the NHS had that the redesign process will come to fruition in years 2, 3 and 4, given the difficulty in meeting those targets in the past. The NHS Chief Executive said that this was the most challenging position that the NHS has faced for some time, and it was not just in Shetland. He said the scale of the challenge for next year did make him question whether it could all be delivered in one year. In this regard the redesign process would have to be done in a managed way, with regard to recurring and non-recurring savings, but in a way that does not impact on services. Mr G Cleaver asked for a wider understanding about how the challenges could be met, and if there was anything outwith the Health Board budget that could be used to assist the position. The Chief Officer said that, in terms of funding, there was some non-recurrent funding available, such as for innovation, and there was the Integrated Care Fund, to do things differently. He said those were areas where there could be opportunities in terms of spend to save, but it would have to be considered carefully. Mr B Fox said he had hoped that a recovery plan would have been in place before now, but he took on board what was being said, and understood the different way in which the Health Board budgets work, compared to the Council. The Chief Officer said that the NHS received a core Government allocation ahead the new financial year, and so there was some indication of the level of funding to be received. He said that this was not all the money that would be available, as there was a significant amount of non-recurrent funding that NHS boards received every year, and there would be opportunities for the NHS to bid for particular initiatives. In this regard, the Chief Officer said there was less certainty at the start of the year with regard to income, including the level of charges for services, and in this regard it was very difficult to budget accurately at the start of the year. The Chief Officer went on to say that there had never been a deficit at the end of the year before, and it was hoped that will be the case again. He said there was a gap in terms of recurrent savings, but that could be covered with non-recurrent means, although it was proving increasingly difficult to sustain that approach in the long term. Mr Cleaver said he welcomed the opportunity that this report had provided, and that the reassurances given were also welcomed. Mr Smith said he was reassured with what he had heard today, but said it was important to be realistic and the plan should be presented to the IJB in February, and that the risks associated with that plan and the timescales involved should be included.

	The IJB noted and agreed the actions being taken.
Decision	The Integration Joint Board noted the financial information presented in the report and the actions being taken and planned for and noted that, assuming the IJB approves the Strategic Plan for 2015/16, a detailed Financial Recovery Plan will be presented to a future meeting of the IJB.
11/15	**Joint Strategic Commissioning Plan 2015-16**
Report No. CC-48-15-F	The Board considered a report which presented the Joint Strategic Commissioning Plan, setting 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. The Director of Public Health introduced the report, advising that the IJB was being asked to approve the Joint Strategic Commissioning Plan, which services were working to in the current year 2015/16. The Director of Public Health went on to say that the Plan itself had been developed and built upon earlier plans and so the content would be familiar to the Board members. She said that adoption of this Plan would allow the IJB to assume its responsibilities for the functions delegated to it by the Council and the Health Board. Mr K Massey said that although the Plan was quite weighty, it was well laid out and easily read. With regard to long term conditions, Mr Massey said that a lot of work had been done from 2008 to 2011 and an annual plan was put forward. He asked if this Plan and the integrated approach would give enough reassurance on the work being done in this area, and if it would satisfy Government requirements for funding particular areas of work in relation to long term conditions. The Director of Public Health agreed there would be a cross over from previous plans into the integrated plan, and there were a lot of interdependencies and so classic integration was being met in terms of long term conditions. The Chief Officer said that things that have been put in place have kept the ball rolling. He said that keeping people in their own homes required teams to work together and it would be important for the services to capture how that was working, and the joint plan provided the opportunity to focus on how the medical health care model was integrating with the social care model, and provide a refocus on long term care. In response to questions, the Director of Public Health advised that the IJB would be informed of changes in delivery through regular reporting on outcomes and performance indicators. She said the IJB was required to take a long term view, and the next plan would be a three year plan and the outcomes within that

	plan would be monitored and reported, in order to give assurance to the IJB that the operational management of the delivery of services was supporting the strategic plan moving forward, including changes which the IJB was directing. She went on to confirm tht the NHS Board would continue its role in performance monitoring, but the IJB would receive quarterly performance reporting that was previously reported to the Social Services and CHCP Committee. In this regard, the same level of scrutiny would be applied by the IJB to the operational issues around budgeting and service performance and that benchmarking with other IJBs would be considered as part of the reporting process. Mr B Fox asked if the issue regarding insurance for the IJB could be clarified. The Executive Manager – Governance and Law said that there was a general view taken by some authorities that the IJBs may have to find its own insurance cover. However, he said the IJB was a unique corporate body in that it's Scheme of establishment, which was subject to ministerial approval, stated that the Board's liabilities would be underwritten by the Health board and the Council. He said that both of those organisations are covered by their relevant insurance, and liability for and any processing of claims would be processed through those insurances. In this regard, the Executive Manager – Governance and Law advised that a Memorandum of Understanding would have to be created between the SIC and the NHS, which would clarify where responsibilities lay and how any matters of joint liability would be handled. He undertook to provide IJB members with a briefing note on this matter, and that the Memorandum of Understanding would be developed, subject to input from the existing insurers. On the motion of Mr C Smith, seconded by Mr K Massey, the Board approved the recommendations in the report.
Decision	The Integration Joint Board RESOLVED to approve the Joint Strategic Commissioning Plan for 2015-16.
12/15	**Proposed Establishment of Strategic Planning Group**
Report No. CC-50-15-F	The Board considered a report which proposed the establishment of a Strategic Planning Group to support the integration of Health and Social Care in Shetland and the work of the Integration Joint Board. In response to questions from members of the Board, the Director of Public Health advised that the number and type of representatives to be included in the Group would depend in some respects as to how the structure for locality support would be organised, and some flexibility around locality representatives would be important. There was concern regarding the numbers to be involved, but the Chief Officer said that the right mechanisms would be put in place that suited the localities, but it was important to ensure wide engagement across all

	communities, ensuring that everyone was given the opportunity to be heard as part of the strategic planning process. On the motion of Mr C Smith, seconded by Mr K Massey, the Board approved the recommendations in the report.
Decision	The Integration Joint Board RESOLVED to approve the arrangements for establishing the Strategic Planning Group; specifically to agree: • The Terms of Reference • Membership • The appointment of the Chairman and Vice-Chairman • The establishment of the Group
13/15	**Participation and Engagement Strategy – Action Plan**
Report No. CC-53-15-F	The Board considered a report which presented the Participation and Engagement Strategy Action Plan for discussion and approval. With regard to Social Care representation on the PFPI Steering Group the Board noted that earlier decisions had been made to invite members from various groups of people and that work would be starting on that soon. The NHS Chief Nurse confirmed that other ways of capturing feedback and patient opinion were being developed, with a view to ensuring that the Group were receiving information about patient and client experiences throughout Shetland. The Board approved the recommendations in the report on the motion of Mr B Fox, seconded by Dr C Waddington.
Decision	The Integration Joint Board RESOLVED to approve the IJB Participation and Engagement Strategy Action Plan.
14/15	**NHS Public Health Annual Report 2015**
Report No. CC-52-15-F	The Board considered a report which presented the Public Health Annual Report to bring public health to the forefront of IJB thinking. The Director of Public Health summarised the terms of the annual report, and explained the promotional activities the NHS would be undertaking over the next few years. She also commented on the important role that a range of health and care staff provide and how the work they do contributes to the overall public health outcomes. In response to questions, she advised on the promotional work being done in terms of healthy eating, and how the NHS and SIC would be leading by example through a range of activities being developed by the Health Improvement Team. The board approved the recommendations in the report, on the motion of Mr C Smith, seconded by Mr K Massey,

Decision	The Integration Joint Board: 1. Received the Public Health Annual Report; 2. Supported efforts to improve the public health in Shetland through the promotion of healthy eating; 3. Support public health work on 'investing to save' to reduce long term preventable morbidity and mortality.
15/15	**Joint Strategic Commissioning Plan 2016-2019**
Report No. CC-49-15-F	The Board considered a report which presented the draft Joint Strategic Commissioning Plan for 2016-19. The Director of Public Health introduced the report, and advised that this version was in draft at this stage. She said that the structure and layout had been agreed, but content would adapt and change as other matters emerge and develop over the next few months and will provide further detail for the IJB to approve the Plan. She went on to explain, in response to questions, that the Strategic Planning Group would ensure that stakeholder input was received, particularly from the third sector, and that services would be required to explain the impact of cuts or savings and that this would provide further detail for the next version on impacts and risks. In response to further questions regarding the HR section, the Director of Public Health explained that matters regarding recruitment were being looked at for this year, and those considerations would provide more detail for the 16/19 plan as those matters develop. She agreed that summarising information against the national health and wellbeing outcomes was a helpful suggestion and would be looked at. The Director of Public Health went on to explain that the IJB would want to know the number of services it was responsible for and further work would be done on developing outcome focused planning, The Chief Officer advised that the Older Peoples Strategy would have an impact on the content of the Plan in future years, as well as any matters that come through the Council or Health Board's corporate plans. He said the changing need and demographics will bring changes in Council budgets, and in this regard the 3 year Plan will be different from the current Plan.
Decision	The Integration Joint Board noted the draft Joint Strategic Commissioning Plan for 2016-19.

16/15	Directorate Service Plan 2016-17
Report No. CC-56-15-F	The Board considered and noted a report which presented the final edit of the Community Health and Social Care Directorate Plan for 2016/17, aligned with the Council's Corporate Plan and NHS Shetland's Local Delivery Planning process.
Decision	The Integration Joint Board APPROVED the Directorate Plan 16/17.
17/15	**2016/17 SIC Budget and Charging Proposals**
Report No. CC-57-15-F	The Board considered a report which enabled understanding of the controllable budget proposals for the services within their remit. The Chief Financial Officer summarised the terms of the report, and explained the NHS set aside budgets. He agreed that it would be helpful for more clarity to be provided around those integrated services for which the IJB had delegated responsibility for and that the format of the information provided to members of the IJB during their induction programme would be useful. In particular, the IJB noted that a number of off island services were commissioned by the NHS which was included within the budgets illustrated, such as Mental Health Services. In response to questions regarding the NHS efficiency target of £1.057m for 2016/17, the Chief Officer confirmed that a recovery plan was being worked on and would be presented to the NHS to ascertain what was achievable and then reported to the IJB. The IJB noted and recommended the report to the Council and the Health Board, subject to future reports containing more clarity around the responsibility for delegated services and functions.
Decision	The Integration Joint Board recommended the budget allocations for the delegated functions to the Council and the Health Board.
18/15	**Appointment of Members to the Shetland Partnership Board**
Report No. GL-52-IJB	The Board considered a report which sought appointment of a member and a substitute to the Shetland Partnership Board (SPB). On the motion of Mrs M Williamson, seconded by Mr G Cleaver, the IJB appointed Mr C Smith as the IJB member of the Shetland Partnership Board. On the motion of Mr C Cleaver, seconded by Mr K Massey, the IJB appointed Dr Waddington as substitute. On the suggestion of Mrs M Williamson, the IJB agreed to ask the Shetland Partnership Board to considering appointing both Mr Smith and Dr Waddington as substantive members, given the

	large resources that the IJB now controlled.
Decision	The Integration Joint Board RESOLVED to: • appoint one substantive member to the Shetland Partnership Board, namely Mr C Smith; • appoint one substitute member to the Shetland Partnership Board, namely Dr C Waddington; and • ask the Shetland Partnership Board to consider giving the IJB two substantive positions on the Board.
19/15	**IJB Business Programme 2015/16**
Report No. GL-49-IJB	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. Mr G Cleaver referred to the meeting of the Social Services Committee planned for 24 November and asked if performance reporting should now be coming to the IJB. The Executive Manager – Governance and Law said the Social Services Committee had come to end and this would be formally notified to the Council at its next meeting. However, he said it was considered logical for the Committee to have a final meeting on 24 November to consider the Q2 performance information for matters on which the Social Services Committee and the CHCP Committee had overseen, and that Q3 performance and beyond would now come to the IJB. With regard to future reports the IJB agreed the following should be added to the Programme, with dates to be agreed: • Mental Health Action Plan Update • ANP/Lerwick Health Centre Update • Intensive Care Team – first year update • Financial Recovery Plan 16/17 • Insurance Update
Decision	The Integration Joint Board considered its planned business for the financial year to 31 March 2016 and RESOLVED to approve the Business Programme with the following additional reports: • Mental Health Action Plan Update • ANP/Lerwick Health Centre Update • Intensive Care Team – first year update • Financial Recovery Plan • Insurance Update

The meeting concluded at 5 p.m.

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CHAIR

Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	04 January 2016
Report Title:	2016-17 Budget
Reference Number:	CC-09-16 F
Author / Job Title:	Karl Williamson / Chief Financial Officer

Decisions / Action required:

The IJB is asked to:

1 SUPPORT and RECOMMEND the proposals with regard to the IJB budget allocations for 2016/17 as set out in this report; and

2 NOTE the information with regard to the due diligence work undertaken to date and that further reports will be presented to the IJB Audit Committee in this regard.

High Level Summary:

1 The purpose of this report is to enable the Integration Joint Board (IJB) to consider and understand the controllable budget proposals for the services within their remit.

2 In accordance with the Integration Scheme the IJB is invited to make recommendations to NHS Shetland (NHSS) and Shetland Islands Council (SIC) regarding the budget allocations for the functions delegated by them to the IJB so that this information can be considered prior to both organisations finalising their budgets. The SIC budget will be approved by members on 10th February 2016 and the draft NHSS budget will be discussed by NHSS Board on 16th February 2016 and agreed with Scottish Government on 30 June 2016.

3 This report also summarises the due diligence process that has been carried out in preparing the 2016/17 budget allocation proposals for the IJB. This is in line with national guidance and is intended to provide assurance to the IJB that the budget proposed is sufficient to meet all the objectives as identified in the draft Strategic Plan 2016-19, which is the subject of a separate report on today's agenda.

Corporate Priorities and Strategic Aims:

The IJB is required to advise the Council and NHS Shetland (NHSS) of their views on funding and the implications for the successful delivery of services to achieve the 9

national health and well being outcomes. This report provides information in that regard.

The proposals support the IJB's vision, aims and strategic objectives as set out in the Integration Scheme, the Strategic Plan 2015/16 and the Draft Strategic Plan 2016-19, which is the subject of a separate report on today's agenda, however the report recognises that there is currently a lot of work to do in order to close the budget gap in the proposals for the allocation of funds from NHSS and that further reports will be required to inform and seek decisions from the IJB with regard to any changes that may be proposed to services and the Strategic Plan in order to close the budget gap.

Key Issues:

The 2016/17 budget in this paper is in draft form and is subject to the decisions of the Council and the Health Board.

The Health Board cannot finalise its budget before the start of the new financial year 2016/17 as this process is subject to final approval by the Scottish Government on 30 June 2016.

The due diligence work completed so far comes with a caveat regarding the unidentified efficiency gap currently shown in the NHS IJB budget. The IJB cannot advise the statutory agencies of the implications for the delivery of the outcomes set out in the Strategic Plan until a Recovery Plan has been developed setting out the schemes that will deliver efficiencies and savings to close the gap.

The different processes and timescales that are available to the Council and the Health Board means that the integration of budgets and allocation of budgets to localities is severely constrained at this time and it is difficult to see how this situation can be improved when the NHS must follow a timetable that does not allow the budget to be set prior to the start of the financial year.

Implications : *Identify any issues or aspects of the report that have implications under the following headings*	
Service Users, Patients and Communities:	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. Changes to NHS 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 arising directly from this report. Any service development proposals or changes affecting staff will be subject to full staff engagement and consultation using the relevant agencies policies and procedures and reported via the Joint Staff Forum.

Equality, Diversity and Human Rights:	None arising directly from this report. Any equalities impacts will be assessed and considered as part of any proposals for change and schemes for efficiency savings. Budget proposals for SIC have been impact assessed at a high level.
Partnership Working	The Budget proposals in this report will support partnership working across the Health and Social Care Partnership and include budget proposals for integrated services.
Legal:	The proposals in this report are consistent with the Public Bodies Act and the Integration Scheme for Shetland's IJB.
Finance:	This report presents draft IJB budget allocations for 2016/17 which are subject to change as both parties finalise their 2016/17 budgets. The detail is contained in the report attached.
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. IJB Any service developments that have implications for accommodation will be considered by the IJB before being presented to the Council and NHS who retain control and responsibility for the management of the capital programmes and assets.
Environmental:	None arising directly from this report.
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. <u>NHS</u> 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. <u>IJB</u> The main risks for the IJB are that the funding allocations from the Council and NHSS for the functions delegated to the IJB are insufficient to deliver the outcomes set out in the Strategic Plan. The IJB is required to assess these risks and advise the partners accordingly.

Policy and Delegated Authority:	The IJB has delegated authority from the Council and NHSS for the functions covered by the budget allocations presented in this report. The budget allocations of each of the partners will be set by the Council and NHSS and thereafter, the IJB must direct service delivery within the budget allocation informing the partners of any issues with regard to the budget allocations. With regard to the deficit in the NHS budget allocation, the IJB will be required to approve a Recovery Plan.
Previously considered by:	The proposals in this report have not been presented to any other committee or organisation.

“Exempt / private” item	No

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	4 February 2016
Report Title:	2016/17 Budget
Reference Number:	CC-09-16-F
Author / Job Title:	Karl Williamson / Chief Financial Officer

1. Introduction

1.1 The purpose of this report is to enable the Integration Joint Board (IJB) to consider and understand the flow of funding to and from the IJB and the controllable budget proposals for the services within its remit.

1.2 In accordance with the Integration Scheme, the IJB is invited to make recommendations to NHS Shetland (NHSS) and Shetland Islands Council (SIC) regarding the budget allocations for the functions delegated by them to the IJB so that this information can be considered prior to both organisations finalising their budgets. The SIC budget will be approved by members on 10th February 2016 and the draft NHSS budget will be discussed by NHSS Board on 16th February 2016 and agreed with Scottish Government on 30 June 2016.

1.3 This report also summarises the due diligence process that has been carried out in preparing the 2016/17 budget allocation proposals for the IJB. This is in line with national guidance and is intended to provide assurance to the IJB that the budget proposed is sufficient to meet all the objectives as identified in the draft Strategic Plan 2016-19, which is the subject of a separate report on today's agenda.

2. Background

2.1 The IJB was presented with a draft budget on 20th November 2015. Since then a number of events have resulted in a need to change the proposed delegated budgets.

2.2 NHSS Strategy & Redesign Committee reviewed and approved cost pressures of £864k over their November 2015 and January 2016 committee meetings. To retain overall financial balance, NHSS efficiency target will also be required to be increase by the same amount. The cost pressure funding agreed specifically relevant to the IJB consists of £300k to support a

predicted increase in prescribing costs, and £34k for additional renal activity necessary to support an increase in demand.

2.3 On 16th December 2015, the Scottish Government's draft budget announcement regarding the funding allocations to NHSS and SIC indicated that the funding for both agencies for 2016/17 would be significantly lower than had been originally anticipated when drafting the previous IJB budget proposals.

2.4 The impact of the Scottish Government budget means that NHSS faces a 7.5% reduction on their non-core allocations which, subject to confirmation from the Scottish Government, will be a reduction of approximately £221k.

2.5 The Council's Policy and Resources Committee considered budget proposals for 2016/17 at a meeting on 25th November 2015. The proposals were for a balanced budget based on a 1.5% reduction in the Scottish Government settlement to the local authority for 2016/17 however, when the Scottish Government settlement was announced on 16 December, the SIC's grant allocation had been reduced by 5.1%. This means a further £2.6m of savings is required in order that the SIC can set a balanced budget for 2016/17.

3. 2016/17 Budget Proposals

3.1 The draft 2016/17 budget for the services the IJB has responsibility for is in excess of £43m. These services are paid for by contributions from SIC and NHSS. This forms the funding that is available to the IJB and enables it to then distribute funding to ensure the delivery of services in accordance with its Strategic Plan.

3.2 The funding that is anticipated from each organisation has been advised as follows:

	SIC	NHSS	NHSS Set Aside	Total
	£,000	**£'000**	**£'000**	**£,000**
Core Funding	19,920	17,990	4,400	**42,310**
Integration Funding	-	410	-	**410**
Social Care Funding	-	1,025	-	**1,025**
Total	**19,920**	**19,425**	**4,400**	**43,745**

3.3 This provides the IJB with a total funding allocation of £43.745m with which to direct service delivery through SIC and NHSS.

3.4 The historic Integration Funding of £0.410m to be received by NHSS is now included recurrently in the baseline core funding. The budget on 16 December announced a new £250m fund for Social Care Funding. The indicative allocation to NHSS is £1.025m for Adult Social Care outcomes. Scottish Government has issued guidelines on the use of these funds.

3.5 The proposed distribution of the funding allocation for the IJB has been prepared by taking account of the costs associated with delivering the current services, the service challenges and cost pressures that require to be

accommodated during the year and emerging guidance from Scottish Government with regard to the Integration Funding streams.

3.6 The anticipated cost of service delivery presented in the table below, includes the figures prepared for the 2016/17 draft IJB budget in November 2015, split by organisation and service area, updated to reflect additional NHS funding announced in Pharmacy & Prescribing and Renal Services (NHSS has agreed £0.3m to support a predicted increase in prescribing costs, and £0.034m for additional renal activity necessary to support an increase in demand).

3.7 The total anticipated cost of service delivery is £45.606m, which means there is a shortfall in funding of £1.861m in the IJB budget for 2016/17. This is due to the inclusion of the NHSS efficiency target for the IJB which is explained in paragraph 3.16 below.

	2016/17 Draft IJB Budget		
Service	**SIC £'000**	**NHSS £'000**	**NHSS Set Aside £'000**
Mental Health	1,060	1,513	-
Substance Misuse	257	568	-
Oral Health	-	3,382	-
Pharmacy & Prescribing	-	5,784	1,017
Primary Care	-	4,402	-
Community Nursing	-	2,313	-
Directorate	425	92	-
Pensioners	78	-	-
Sexual Health	-	-	38
Adult Services	5,201	70	-
Adult Social Work	1,665	-	-
Community Care Resources	10,346	-	-
Criminal Justice	29	-	-
Speech & Language Therapy	-	88	-
Dietetics	-	119	-
Podiatry	-	225	-
Orthotics	-	143	-
Physiotherapy	-	603	-
Occupational Therapy	1,371	192	-
Health Improvement	-	-	340
Unscheduled Care	-	-	3,183
Renal	-	-	179
Total	**20,432**	**19,494**	**4,757**
Scottish Government Additionality Funding for Adult Social Care (see paragraph 3.8)	513	-	-
Integrated Care Funding (see paragraph 3.10)	-	410	-
Total	**20,945**	**19,904**	**4,757**
Grand Total	**45,606**		

3.8 The £0.513m Scottish Government Additionality Funding for Adult Social Care in the table above represents 50% of the £1.025m received by NHSS as a result of the additional £250m funding announced nationally for Adult Social Care outcomes, which is being paid to NHS boards. This funding is to be made available for the delivery of additional adult social care services and outcomes in order to address the rising demand for services from an ageing population.

3.9 The remainder of the £1.025m additional integration funding has been recognised by SIC as funding to support the cost of current service delivery, i.e. to pay for cost increases and the living wage applying to all adult social care service providers. This use of the additional funding allocation is in line with emerging guidance from Scottish Government.

3.10 The Integrated Care funding of £0.410m has supported a number of initiatives, some of which it has been agreed would be supported recurrently, such as the Intermediate Care Team. This funding will be committed in part on a recurrent basis and will be identified in future iterations of the Strategic Plan.

3.11 Further information regarding the approach taken by SIC and NHSS to preparing the budget allocation proposals for the IJB is provided in the remainder of this section of the report.

SIC Budget Allocation for the IJB

3.12 The Council's Corporate Management Team (CMT) has reviewed the budget proposed to the Policy and Resources Committee in November 2015 and in addition to the savings plans proposed at that time has looked at how to meet the additional savings target of £2.6m caused by the reduction in the allocation of funding from the Scottish Government.

3.13 The Director of Community Health and Social Care (CH&SC) is a member of CMT and has been fully involved in this process. During the review, £2m of costs have been identified within the proposed SIC budget for 2016/17 that meet the criteria for the additional Scottish Government funding. Therefore the budget recommendations for 2016/17 which will be presented to the Council on 10 February 2016 will take the full value of this funding into account in determining the Council's budget and its allocation for the IJB.

3.14 Other proposals to meet the £2.6m funding gap do not affect the IJB directly apart from a reduction in salaries budgets to recognise a vacancy factor (£0.166m), which has been calculated by the CH&SC directorate.
There is a proposal to reduce the budget for adaptations through the scheme administered by Infrastructure Services, however, this is based on historical spending patterns and will not mean that any applications that meet the criteria will be refused or delayed as there will be provision made in the Council's contingencies.

3.15 The SIC budget allocation for the IJB is summarised in the table at paragraph 3.7 above. This is a balanced budget and the budget allocation is reflected in the draft Strategic Plan 2016-19, which is the subject of a separate report on today's agenda.

NHS Shetland Budget Allocation for the IJB

3.16 The difference between funding and service expenditure for the IJB as set out in this report is explained by the shortfall between how much the NHSS services are costing and the core funding that is available from NHSS. Finding savings to resolve this imbalance is therefore essential to the balancing of the budget in the coming year. The NHSS efficiency target proposed for the IJB is made up of:

	NHSS £'000	NHSS Set Aside £'000
CH&SC 2015/16 unachieved recurring target b/f	745	172
CH&SC 2016/17 target	368	97
CH&SC Additional 2016/17 target	390	88
Total	**1,504**	**357**

The £357k target for the 'set aside' budget is a notional 26% of the overall target for the Directorate of Acute & Specialist Services.

3.17 Members of the IJB are asked to note that the resultant gap between expenditure and income for NHSS means that options to balance the budget will need to include the consideration of reductions in service budgets across all service areas and that the very low growth for NHSS now and anticipated in future years means that this is likely to have an impact on the final value of funding distributed to the IJB during the three years covered by the Strategic Plan 2016-19. The IJB Chief Officer will continue to be fully involved in the discussions with senior colleagues in NHSS through NHS Executive Management Team (EMT) and will present any detailed proposals with regard to savings in the IJB budget allocation for consideration by the IJB in due course together with any changes required to the information and proposals in the Strategic Plan 2016-19.

3.18 Appendix 1 sets out the options that will be considered by NHSS when they set their draft budget on 16 February 2016 including the budget allocation for the IJB. The option in the first table in Appendix 1 apportions the additional efficiency target across the various directorates based on the directorate directly associated with the reduced allocation or cost pressure funding. The second option apportions the additional efficiency target across the various directorates using the original methodology agreed in 2012. In 2012 Senior Management decided to set support services a 25% efficiency target over 5 years (2012/13 to 2016/17) with Acute Services and CH&SC picking up the remainder on a 50/50 basis. The methodology for 2017/18 onwards is under review.

3.19 The IJB is asked to comment on the options set out in Appendix 1 and on the likely implications for the Strategic Plan 2016-19 that are apparent at this stage. A final decision on the IJB budget allocation from NHSS will be made by NHSS Board having considered the IJB's recommendation and views.

Overall IJB Budget Summary

3.20 Reconciling the differences between the funding and service delivery can be shown as follows.

	SIC £'000	NHSS £'000	NHSS Set Aside £'000	Total £'000
Funding Received from	(19,920)	(19,425)	(4,400)	**(43,745)**
Funding Distributed to	20,945	18,400	4,400	**43,745**
Inter body Movement of Resources	**1,025**	**(1,025)**	**0**	**0**
Indicative cost of Core Services	20,432	19,904	4,757	**45,093**
Funding held for Additionality	513		-	**513**
Efficiency Targets to meet funding	-	(1,504)	(357)	**(1,861)**
	20,945	**18,400**	**4,400**	**43,745**

3.21 The table above shows the shift in resources to ensure that the full value of £1.025m that has been made available through NHSS is used / allocated for the purposes of adult social care services. In-line with the Scottish Government letter to COSLA SIC is offsetting 50% of these costs £513k against prior investments.

Next steps

3.22 The recommendation and views of the IJB on the proposed budget allocation from the Council will be considered at a meeting of the Council on 10 February 2016 the as part of the proposals for all Council budgets for 2016/17.

3.23 Similarly, the recommendation and views of the IJB on the proposed budget allocation from NHSS will be considered at a meeting of NHSS on 16 February 2016 the as part of the proposals for all NHSS budgets for 2016/17.

3.24 Once the budget proposals have been considered by the Council and NHSS at meetings on 10 February and 16 February respectively, a further report will be prepared for the meeting of the IJB on the 29 February when the final budget allocations from the Council and NHSS can be considered along with the 2016-19 Strategic Commissioning Plan however. It should be noted that the NHSS proportion of the budget may not be finalised until after the 31 March because NHSS will not have its budget finalised with the Scottish Government until 30 June 2016.

4. Financial Due Diligence

4.1 The Integrated Resources Advisory Group (IRAG) guidance sets out the process that should be followed by councils and NHS boards in calculating the budget allocation for their IJB for the functions that have been delegated to the IJB under the terms of the Public Bodies Act. This includes taking into account historical patterns of spend, likely cost pressures, demographic changes and service development proposals. Full details can be found in

the IRAG Guidance which is available on line[1]. The due diligence requirements, as recommended in the IRAG guidance have been followed during the preparation of the revenue budget proposals for Shetland Islands Health & Social Care Partnership.

4.2 The budget setting process for the IJB is set out in the Integration Scheme. The financial processes of each partner organisation i.e. SIC and NHSS are governed by their own financial instructions and are subject to auditor scrutiny on an annual basis.

4.3 In preparing the budget proposals for 2016/17, NHSS pay budgets were zero based and all non pay budgets were set in collaboration with service managers. Cost pressures were identified by service managers, reviewed and refined by NHS finance staff and agreed by the NHS Board's Strategy & Redesign Committee.

4.4 Initially, SIC budgets were set in line with the Council's Medium Term Financial Plan 2015 with each Directorate developing their budget proposals within set operating budgets for 2016/17. Further work has been done in light of the Scottish Government settlement announced on 16 December 2015 as indicated earlier in this report. The Community Health and Social Care budget was set by undertaking an incremental budget approach, using previous year's outturns, and in year financial information, adjusted for anticipated changes in the coming year and the service developments proposed in the Strategic Plan 2016-19.

4.5 It should be noted that whereas the Council having taken these matters into account is able to present a balanced budget proposal for approval by the Council on 10 February 2016, the NHS proposals include efficiency targets and further proposals will be developed during 2016/17 to show how these targets will be met. This means that the overall budget allocation to the IJB is not sufficient to fund the IJB services as a whole due to the unidentified efficiency gap in the NHS budget allocation. This gap must be closed before financial balance can be achieved. The Integration Scheme states that if there is budget overspend, a Recovery Plan must be prepared and approved by the IJB. As it stands, without agreed plans to meet the efficiency targets set, the IJB will over spend in 2016/17 and therefore a Recovery Plan will be required.

4.6 The internal and external auditors of the Council, the NHSS and the IJB will review the 2016/17 budget setting process regarding the IJB allocations as part of their annual work programme. These reports will be presented to the relevant agency's audit committee and made available to those of the other agencies for information.

5. Recommendations

The IJB is asked to:

5.1 SUPPORT and RECOMMEND the proposals with regard to the IJB budget allocations for 2016/17 as set out in this report; and

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[1] http://www.gov.scot/Resource/0048/00480477.pdf

5.2 NOTE the information with regard to the due diligence work undertaken to date and NOTE that further reports will be presented to the IJB Audit Committee in this regard in due course.

Contact Details:
For further information please contact:
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18th January 2016

Appendices
Appendix 1 – NHSS Savings options January 2016

APPENDIX 1

2016/17 Savings Requirement Jan 2016

Additional savings allocated to relevant directorate

	Acute Services	Community Health and Social Care	Healthcare SLA's	Public Health	Human Resources	Chief Executive	Estates	Finance	Board Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Unachieved recurring savings brought forward	647.66	745.40	0.00	0.00	55.15	24.38	37.53	-103.80	1,406.31
2016-17 Savings Target	368.10	368.10	208.10	18.20	72.00	12.30	122.00	25.20	1,194.00
Additional savings required as a result of agreed cost pressures	43.40	300.00	476.00	0.00	44.43	0.00	0.00	0.00	863.83
Additional savings required as a result of 7.5% reduction in 'bundled' allocations	46.09	90.95	0.00	9.56	50.58	19.35	3.60	0.60	220.72
Sub Total	1,105.25	1,504.44	684.10	27.76	222.15	56.03	163.13	-78.00	3,684.85

2016/17 Savings Requirement Jan 2016

Additional savings split proportionately as per original 16/17 target

	Acute Services	Community Health and Social Care	Healthcare SLA's	Public Health	Human Resources	Chief Executive	Estates	Finance	Board Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Unachieved recurring savings brought forward	647.66	745.40	0.00	0.00	55.15	24.38	37.53	-103.80	1,406.31
2016-17 Savings Target	368.10	368.10	208.10	18.20	72.00	12.30	122.00	25.20	1,194.00
Additional savings required as a result of agreed cost pressures	266.31	266.31	150.56	13.17	52.09	8.90	88.26	18.23	863.83
Additional savings required as a result of 7.5% reduction in 'bundled' allocations	68.04	68.04	38.47	3.36	13.31	2.27	22.55	4.66	220.72
Sub Total	1,350.12	1,447.85	397.12	34.73	192.55	47.85	270.34	-55.71	3,684.86
	30.8%	30.8%	17.4%	1.5%	6.0%	1.0%	10.2%	2.1%	
	30.8%	30.8%	17.4%	1.5%	6.0%	1.0%	10.2%	2.1%	
	30.8%	30.8%	17.4%	1.5%	6.0%	1.0%	10.2%	2.1%	

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	4th February 2016
Report Title:	Joint Strategic Commissioning Plan 2016-2019 Cover Paper
Reference Number:	CC-06-16 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 draft Joint Strategic Commissioning Plan for 2016 – 2019, recognising that in light of the evolving financial position a revised plan will be developed and be brought back to the IJB for further consideration.

High Level Summary:

The Joint Strategic Commissioning Plan (referred to as the Strategic Plan) for 2016-19 has been developed in consultation with stakeholders and is now presented for approval. 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.

A summary of the plan has been produced to provide an easy-read, overarching summary highlighting the key areas of change and improvement within the Plan.

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:

Consultation on the draft plan has been undertaken in line with the IJB's Participation and Engagement Strategy, and publicly through publication on the Integration web-site, and

feedback has been incorporated into the final plan as presented. It will also be considered by the newly established Strategic Planning Group before being presented to the IJB.

The Strategic Plan has been developed to focus more on plans for change and on achieving specific outcomes, and to standardise the format in response to comments received during the consultation.

Further development work will continue through the lifetime of the plan in areas such as Locality Planning, including budget setting at locality level; and in developing the process of joint commissioning.

The plan is based on financial assumptions and service planning as at end December 2015, but these assumptions have already been overtaken by subsequent changes to government allocations to both NHS Shetland and Shetland Islands Council, and final budget allocations to the IJB to take account of these changes are still to be determined. The Plan will need to be adjusted to take account of new savings targets and service change to deliver within any reduced budget allocations. Therefore an adjusted Plan will be presented to a future meeting of 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 is likely to have an impact on staff, and will be planned and delivered in partnership with staff and their representatives through due process. Headline workforce change is signalled in individual service sections. Staff recruitment and retention poses a more immediate risk to the delivery of services and strategies to address recruitment and retention are being developed and will continue to develop as part of emerging services.
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 is attached as an Appendix to the Plan.
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. Having approved the Strategic Plan for 2015/16 it has now assumed 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:	Integration Joint Board (as draft for consultation) Shetland NHS Board Strategy & Redesign Committee (as draft for consultation) Strategic Planning Group	20.11.2015 15.01.2016 03.02.2016

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	4th February 2016
Report Title:	Joint Strategic Commissioning Plan 2016-2019
Reference Number:	CC-06-16 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) for approval. The draft Joint Strategic Commissioning Plan (known as the Strategic Plan) is attached at Appendix 1, and the Summary Plan attached as Appendix 2.

2. Background

2.1 The Health and Social Care Integration 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.

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 during consultation, 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, with a section on Locality Planning. 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, drivers for change including savings targets, needs and unmet needs, plans for change linked to expected outcomes and key risks to delivery. It specifies key actions and priorities for the coming year.

3.3 A summary of the Plan has been prepared to provide an easy-read, overarching summary of the Plan with highlights of the key areas of change and improvement.

3.4 The Plan includes headline figures on service budgets, based on budget assumptions as at end December 2015. However, these assumptions have already been overtaken by subsequent changes to government allocations to both NHS Shetland and Shetland Islands Council, and final budget allocations to the IJB to take account of these changes are still to be determined. The Plan will need to be adjusted in future to take account of any new savings targets and service change to deliver within any future reduced budget allocations, and this will need to be re-presented to the IJB for approval at a future date.

3.5 The Plan is informed by local strategies and strategic needs assessment work.

3.6 The Plan also sets out the arrangements for carrying out the integration functions in Shetland over the period of the plan, and refers to development work being undertaken and planned to support the process of joint strategic commissioning.

3.7 The arrangements for each locality established for locality planning purposes: the IJB has 7 localities for strategic planning purposes as detailed in the Plan. During 2015/16 a round of meetings was held across localities to inform the development of joint commissioning at locality level, feedback from this engagement has been given to service managers to take account of in writing their plans, and also considered by the Strategic Planning Group.

3.8 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 Plan, and a substantive Strategic Planning Group has now been established which will consider the draft Plan before its presentation to the IJB.

3.9 An Equality Impact Assessment of the Plan has been developed and is published as an Appendix to the Plan.

3.10 Further development work to be included in future updates to the 2016-19 Joint Strategic Commissioning Plan:

- 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.

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 draft Joint Strategic Commissioning Plan for 2016 -2019.

6. Conclusions

6.1 This is the presentation of the draft Joint Strategic Commissioning Plan for 2016/19 for approval following consultation.

Contact Details:

Dr Sarah Taylor, Director of Public Health and Planning sarahtaylor1@nhs.net

17th January 2015

Appendices: Appendix 1: The Draft Joint Strategic Commissioning Plan 2016-19
Appendix 2: Summary of the Joint Strategic Commissioning Plan 2016-19

Background Documents:

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

Appendix 1

NHS SHETLAND

SHETLAND ISLANDS COUNCIL

Draft Joint Strategic (Commissioning) Plan 2016-19

Version 5.1 – January 2015

Contents

1. Introduction

The Joint Strategic (Commissioning) Plan for 2016/19 (known as the Joint Strategic Plan or the Plan) 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 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 Joint Strategic 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 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, 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 Joint 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.

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

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 disability, including physical disability and learning disability, and on specific delegated services such as primary care, mental health services and criminal justice.

The Plan also sets out the arrangements for carrying out the integration functions in Shetland over the period of the plan:

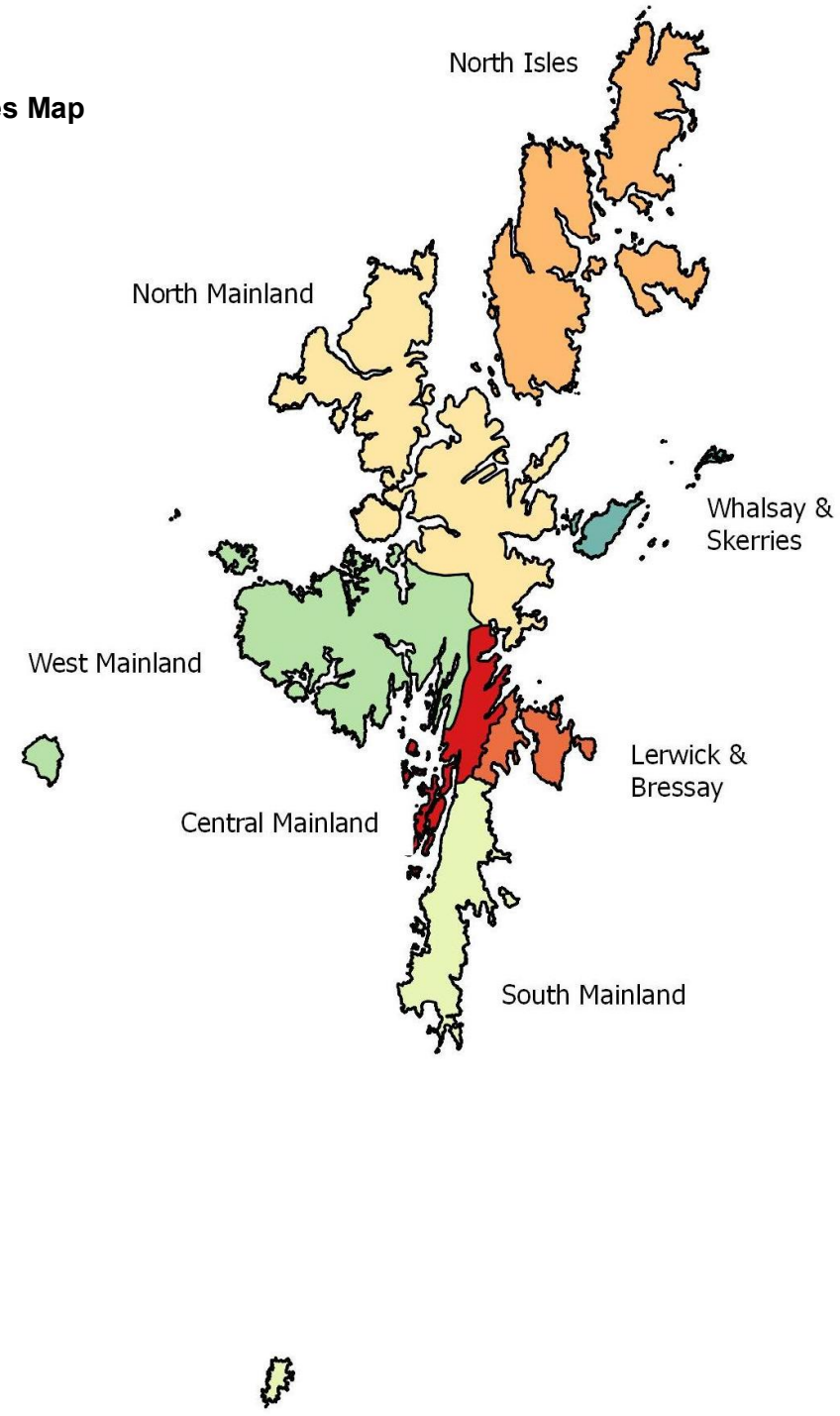
- The arrangements for each locality established for locality planning purposes – Section 2: Shetland Localities and the Locality Planning process;
- The operation of the Strategic Planning Group for the purposes of preparing the strategic commissioning plan (detail included in the briefing on Strategic Planning for Health & Social Care Integration – http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/BriefingonStrategicandLocalityPlanningupdatedNov2015.pdf).
- 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.

2. Planning In Localities

We have 7 localities based on geography and ward boundaries, used for locality planning purposes and for community planning. 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 they 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.

Localities Map



Each locality has a set of services delivered within the locality:

- Primary care
- Community nursing
- Care at home and care home resources.

In addition, Occupational Therapy (OT) and health improvement have practitioners allocated to individual localities to deliver services locally and work with partner services within the locality, and social work have identified link professionals for each locality.

The details of these are currently described in the individual services sections of the plan, but the intention over time is to describe these at locality level, along with defining locality level budgets and activity. Work is currently in progress on this, and also on apportioning the activity of other services to locality level (ie showing the proportion of a service used by the people living in each locality) so that we can start to see budgets and use of services by localities to support future locality planning.

During 2015/16 a series of locality planning meetings were held across localities to engage local staff and key other stakeholders (third sector, user and carer representatives, and community leaders - Community Council and SIC councillors), and feedback of the issues identified has been passed to services to inform the development of the Joint Strategic Commissioning Plan.

This section of the Plan will be developed as this work develops.

3. Health & Social Care Integration Plans

3.1 Adult Protection Committee

Policy Context

Shetland's Adult Protection Committee was established under the Adult Support and Protection (Scotland) Act 2007, and includes membership from NHS Shetland, Police Scotland, Shetland Islands Council, Voluntary Action Shetland, Procurator Fiscals Office and the Fire Service.

Current Services

The Committee oversee the multi agency work which takes place to protect adults who may be subject to risk. They do this by producing Multi-agency Adult Support and Protection Procedures which guide what needs to be done should anyone have a concern for an adult who may be at risk; by organising, coordinating and delivering training and public awareness; by monitoring activity of the three public bodies with specific duties in the Adult Support and Protection (Scotland) Act 2007, who are Shetland Islands Council, NHS Scotland and Police Scotland.

Priorities for Adult Protection Committee in 2016-17

- Engagement with groups of service users and carers to raise awareness of adult protection
- Financial abuse - workshops for practitioners and improving joint working and information sharing with Trading Standards, Police Scotland, local banks and CAB
- Updating adult protection procedures
- Working to improve quality assurance systems- following a recommendation made by the Care Inspectorate in their Joint Inspection of Services to Older People improving scrutiny of adult protection processes and risk assessments and risk management will be priority in 2016/17
- To update and improve Adult Protection Training

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. It is likely that in 16/17 there will be a need to make savings from the Adult and Child Protection Budget and this will pose some challenges in prioritising work.

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.

3.2 Adult Services

Adult Services: 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 and autism. The main statutory duties are contained in the Social Work (Scotland) Act 1968, which establishes an overall duty to 'promote social welfare' by providing advice, guidance and assistance; the National Health Service and Community Care Act 1990 which requires the local authority to assess the individual care needs of people, including people who have care needs as a consequence of disability, mental health problems or increasing age; and in Sections 25 and 26 of the Mental Health Care and Treatment (Scotland) Act 2003. Section 25 requires the local authority 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 and give people 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 requires the local authority to provide or arrange provision of service which promote the social development and well being of persons with a mental disorder. This includes social and recreational activities; training for people over school age; and assistance in obtaining and undertaking employment.
In addition, all social care organisations and staff are under a general duty to carry out their work in a way that promotes equality of opportunity and seeks to counter or eliminate discrimination.

Other legislation which shapes service delivery for people with learning disabilities and autistic spectrum disorders includes; Adults with Incapacity (Scotland) Act 2000; Regulation of Care (Scotland) Act 2001; 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, autistic spectrum disorder and complex needs. Outreach support for people living in their own or family home may also be available. Each person 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, autistic 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, autistic spectrum disorder and complex needs and that of any unpaid carer in line with eligibility criteria. Newcraigielea also offers a day care service 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Adult Services	137.39	5,718,438	447,135	5,271,303	TBC

With less public funding available in 2016/17 than in 2015/16 due to a reduced settlement for local authorities, Adult Services will undertake a whole model appraisal in 2016. Delivery on findings from this work will ensure that any change delivers a sustainable and affordable service that meets the needs of clients.

Needs/Unmet needs/Drivers for change

Any individual (18+) with an assessment of need linked to their learning disability, autistic spectrum condition or complex need will be supported to develop a plan to meet those needs.

Young people age 16 – 18 can be at risk of falling between services for children and adults. The Children and Young People Act (Scotland) 2014 is clear that all young people up to the age of 18 should have a Named Person in place that can be a first point of contact if the young person requires advice and assistance. For some young people between the ages of 16 and 18, Shetland Inter- Agency Adult Support and Protection Procedures may apply wherever concerns are raised. Where the young person is 'Looked After' at the age of 18 the local authority has a responsibility for their care and welfare up to the age of 26.

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. With rising demand, the main challenge for the foreseeable future will be the provision of flexible, creative and responsive services to appropriately meet the statutory duties of the local authority and the personal outcomes of individuals we support within the available resources.

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 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	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.

[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

Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.	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 reducing 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 and that the services provided are able to operate within the available resources.

Key Risks to Delivery

Risk	Mitigation
Staff Numbers/Skill Shortage/Retention	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

Contact Details

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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

Safeguarding Children, Young People and Adults in Shetland
http://www.safershetland.com/

3.3 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Adult Social Work	19.29	1,753,689	89,103	1,664,586	TBC

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 200 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)
Quality assurance framework to be further developed for the service to ensure that rapid changes across the sector can be responded to in a way that minimises risks	Executive Manager Adult Social Work	Target September 2016	People using health and social care services are safe from harm
Extend the input and presence of social work in localities	Executive Manager Adult Social Work	Target September 2016	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.

Key Risks to Delivery

Risk	Mitigation
Reductions in services elsewhere due to less funding being available	Timely assessments, that are goal orientated, are client led, and where more signposting to alternatives takes place.

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**

Contact Details

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3.4 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Community Care Resources	396.31	16,173,533	5,661,744	10,511,789	TBC

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;
- Difficulties in recruiting and retaining 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	Sept 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	Nov 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	Dec 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

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

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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

3.5 Community Nursing

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; and
- People back to their home/community as soon as possible with minimal risk of readmission.

The national population demographic of an ageing population with individuals living longer, with more complex healthcare needs, and with more long term conditions is also reflected locally. Within this context, the Community Nursing service has an integral role to play in achieving the delivery of the Scottish Government's 2020 vision.

A national review of District Nursing services is scheduled to report in April 2016 and this, as well as the new GP contract being developed for implementation in April 2017, will influence the 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, which 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.

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 NHS 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Community Nursing services	47.45	2,312,966	0	2,312,966	TBC

Needs/Unmet needs/Drivers for change

The service priorities have been informed by both national and local drivers for change and are aimed at enhancing service delivery at locality level. The actions outlined should respond to the issues of importance to local communities, which have been identified through the round of Locality Planning meetings. Consideration has also been given to additional service specific information which has been gained by engagement with various groups eg patient satisfaction survey for ANP service at Lerwick Health Centre, General Satisfaction survey across all of District Nursing and Continence Service, discussions with Community Councils regarding sustainability of provision of health 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 manage their own condition as well as 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, where appropriate.

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 within Community Nursing services	Chief Nurse / Clinical Team Leaders	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.
Conduct review	Chief Nurse	April 2016	September	Ensure that District	District Nursing

New Planned Actions Due to Start in 2016/17					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
of local District Nursing services in line with national "Transforming Nursing Roles" project			2016	Nursing workforce locally continues to develop in line with national direction	workforce is fit for purpose for 21st century Role of District Nurse in Locality based teams is confirmed
Review of skill set across Nursing and Care staff	Chief Nurse / Exec Manager Community Care Resources	Ongoing	September 2016	Agreed roles / skill sets across nursing and care staff	Better utilisation of staff within integrated team
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
Review model of service provision in remote areas	Chief Nurse With key partners	April 2016	March 2017	Service model which meets health needs of island communities	Sustainable, safe, effective, person-centred service in place

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 long term 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 caseloads.
Any further recruitment/retention issues leading to ongoing reduced staffing levels will have a significant impact both on service delivery and on the ability of the service to take forward the initiatives above within the timescales outlined.
The Community Nursing service has previously made approx. £500,000 of savings in years gone by, and is currently facing a further savings challenge of £250,000. Some of the projects outlined above have the potential to identify savings but have various risks associated both with delivering these and with delivering them within the outlined timescales.

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

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		

Performance Measure	Performance 2015/16	Target 2016/17
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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3.6 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Criminal Justice	7.37	358,483	329,334	29,149	TBC

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	Sept 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	Jan 17	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.

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3.7 Domestic Abuse (Gender Based Violence)

Domestic Abuse and other Gender based violence 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 come together at a strategic level through the Shetland Domestic Abuse Partnership.

Policy context

Equally Safe, the Scottish Government and COSLA's joint strategy for preventing and eradicating violence against women and girls (VaWG) was launched in 2014. Equally Safe is Scotland's strategy to tackle all forms of violence against women and girls: domestic abuse, rape and sexual assault; sexual harassment and intimidation at work and in public; stalking; commercial sexual exploitation such as prostitution, pornography and human trafficking; dowry-related violence; female genital mutilation (FGM); forced marriage; and so-called 'honour' based violence. The strategy recognises that women and girls are at risk of such abuse precisely because they are female and it aligns with the UN definition of violence against women. Clearly, boys and men can also experience violence and the strategy does not diminish the seriousness of that experience or proposing to alter the support on offer to them. However the strategy aims to highlight that being female in itself can lead to a range of discrimination and disadvantage, including experiencing male violence. Furthermore violence against women can have significant consequences beyond those experienced by the individual. Children and young people growing up in the same family setting can be badly affected, whether as victims of violence directly or as witnesses to violence. VaWG is underpinned by gender inequality, and in order to prevent and eradicate it from society efforts must be focused on delivering greater gender equality, tackling perpetrators, and intervening early and effectively to prevent violence.

The Shetland Domestic Abuse Strategy 2013-16 www.shetland.gov.uk/news-advice/documents/SDAPStrategy2013-16.pdf and associated action plan sets out how the Partnership currently addresses and prevents domestic abuse and gender-based violence in Shetland. The strategy is being revised in response to Equally Safe and building on a needs assessment to develop a new strategy for 2016-19.

Current Services

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, and most are represented on the Partnership:

- Shetland Women's Aid
- Shetland Islands Council (including Adult & Child Protection; Criminal Justice Social Work, Housing Service, Schools Service, Adult Services Social Work, Children & Families Social Work , Community Development)
- Police Scotland
- NHS Shetland (including Reproductive Health Services, 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
- Local solicitors

The only service from this list above 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 house one family at a time.

For all the other services, responding to domestic abuse and other forms of gender based violence is one element of their overall service.

MARAC

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 currently reporting to the Domestic Abuse Partnership and the Senior Officer Group. 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)
www.safershetland.com/assets/files/Signposting%20Leaflet%20(V2%20June%202013).pdf

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

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Shetland Women's Aid (funded by SIC Housing Dept; Big Lottery; Scottish Government VAW fund)	N/A	N/A	N/A	N/A	N/A
MARAC (funded by VAW fund)	N/A	N/A	N/A	N/A	N/A

Needs/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.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Strategy for 2016-19 currently in development	Susan Laidlaw	In progress - to complete by July 2016	**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 **Outcome 7.** People using health and social care services are safe from harm **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services
Action plan for 2016-17 to be developed in response to Strategy	Susan Laidlaw	In progress - to complete by July 2016	Outcomes 4,5,7,9

Key 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 have been picked up through Community Planning, but we do not have the dedicated input that was previously provided by the Community Safety Officer.
- Womens Aid, like most voluntary sector organisations, is dependent on short term funding awards.
- The current one year funding for the MARAC runs up to the end of March 2016; 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 Targets with links to National Outcomes

To be developed.

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3.8 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Intermediate Care Service	TBC			TBC	TBC

Needs/Unmet needs/Drivers for change

Service redesign is based on the availability of funding for the next financial year. The service is currently expanding to meet the needs of a growing elderly population.

Plans for change

Currently the service has been developing for the past 12 months. Service evaluation is currently being taken place.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Extend intermediate care model to all localities using investment opportunities and through redesign of teams.	Chief Nurse Community Executive Manager AHPs	Target Oct 16	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.

Key Risks to Delivery

Funding cuts are a viable risk. Audit is being conducted on a regular bases to show the cost saving of patients in the community setting versus 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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3.9 Mental Health

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

The Adult Mental Health Service2 comprises a number of regulatory and front-line services and it has specific responsibilities in respect of *The Mental Health (Care and Treatment) (Scotland) Act 2003* and associated legislation and policy. The services can be accessed via a GP by means of an Electronic Single Point of Referral. The aim of the service is to deliver safe and effective care, with people being seen by the right practitioner at the right time.

[2] Child and Adolescent Mental Health Services (CAMHS) are managed by Child Health

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 Service Leads and a Social Care Manager. The seven operational services that make up Shetland's Adult 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Mental Health	50.44	2,621,759	47,802	2,573,957	TBC

Needs/Unmet needs/Drivers for change

Needs[3]

There is limited data on the actual prevalence and incidence of mental health problems and mental illness in Shetland, though GP practices hold registers of patients with serious mental illness (defined as being schizophrenia, bipolar affective disorder or other psychoses).

The Scottish Mental Health Strategy uses European figures to demonstrate the prevalence of mental health problems in the population. Mental illness is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. Applying that to the Shetland population, it means that out of 15,000 adults aged 15-65, at least 5,000 will experience some form of mental ill health or distress each year. About 1-2% of the population have psychotic disorders (approximately 150-300 adults in Shetland, which fits with the prevalence from GP data). The ageing population is leading to an increase in the number of people with dementia, 5% of people over 65 (approximately 200 in Shetland) and 20% of those over 80 years of age.

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

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

[3] Shetland Mental Health Strategy 2014-2024

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

There are a number of urgent changes required to address gaps in provision, ensure the safe and effective delivery of local mental health services and the achievement of agreed strategic objectives. The change programmes are monitored and reviewed via their respective strategy specific Action Plans (e.g. Mental Health, Dementia, Substance Misuse). The headline objectives, some of which are already in progress and others which are under review at the time of writing, are presented in the following table:

Description	Lead Officer	Start Date	Target Date	Expected Outcome(s) (link to National Outcomes)
Extend the availability and responsiveness of Out of Hours support for psychiatric emergencies	TBC	October 2015	March 2017	Improve the safety and quality of patient care; reduce the demand on GBH; fewer beds used in RCH. National Outcomes 3 & 7
Establish a purpose built room in GBH for the management of psychiatric emergencies	Lawson Bissett	April 2016	June 2016	Improve the safety and quality of the patient environment; reduce demand on A&E and Ward 3; improve transfer time to mainland inpatient services. National Outcomes 3 & 7
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)	TBC	April 2016	March 2017	Improve the safety and quality of patient care; make the most effective use of existing resources (e.g. Annsbrae & GP care). National Outcomes 2, 3,4, 5, 8 & 9
Establish and develop access to Clinical/Counselling Psychology Services	TBC	Ongoing	March 2017	Fill a clinically significant gap in local service provision; improve the quality and effectiveness of patient care; reduce the number of ECRs to

Description	Lead Officer	Start Date	Target Date	Expected Outcome(s) (link to National Outcomes)
				mainland providers. National Outcomes 3, 4 & 7
Redesign psychological therapy services and increase local capacity by training a wider range of existing staff	TBC	Ongoing	March 2018	Reduce waiting times; increase the number of locally available evidence based psychological therapies; improve the resilience and sustainability of psychological therapy services. National Outcomes 3, 4 & 5
Implement the 2015-18 Dementia Strategy Action Plan	Alan Murdoch	October 2015	March 2018	People living with dementia and their carers will be able to live well with their diagnosis, remaining integrated, within their community, and where possible, within their own home for the rest of their lives. National Outcomes 2, 3 & 4
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan	Lawson Bissett	April 2016	March 2017	Safe and appropriate premises for the delivery of drug and alcohol services; patients have a positive experience of the service and their dignity is respected; staff are supported to continuously improve the care and treatment they provide. National Outcomes 3, 4, 5, 7, 8 & 9
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD	TBC	April 2016	March 2017	Fill a clinically significant gap in local service provision; improve the quality and effectiveness of patient care; reduce the number of ECRs to mainland providers; enhance the resilience and sustainability of local ASD services. National Outcomes 1, 3, 4 & 5
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress	TBC	April 2016	March 2018	Improve the safety and quality of patient care; reduce the number of mental health related presentations and admissions to GBH. National Outcomes 2, 3, 4 & 7

Description	Lead Officer	Start Date	Target Date	Expected Outcome(s) (link to National Outcomes)
Introduce role appropriate "Equal Partners in Care" (EPiC) training for all staff	TBC	April 2016	March 2018	Carers are free from disadvantage or discrimination related to their caring role; Carers are recognised and valued as equal partners in care. National Outcomes 3, 5 & 6
Establish a person centred Consultation & Engagement Framework (inc a Mental Health Website) to facilitate Co-Production	TBC	Ongoing	March 2017	People will have easy access to the information they need to become equal partners in the design, delivery and evaluation of local mental health services; departmental governance structures will be remodelled to support Patient and Carer participation. National Outcomes 1, 3, 4, 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 challenges by enhancing community provision and resourcing this change in focus by disinvesting from inpatient facilities. In the absence of such facilities in Shetland, local services will need to develop capacity in different ways if they are to meet those expectations and deliver safe and sustainable services. The risks to delivery will be managed by the strategic allocation of available resources and the redesign of services to achieve maximum efficiency and effectiveness. This will be achieved by working in partnership with patients, carers, staff and the Third Sector.

Performance Targets with links to National Outcomes

Measure	Outcome
Psychological Therapy HEAT Target	90% of people requiring a psychological therapy intervention will commence treatment within 18 weeks of referral. National Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of service users.
Dementia Diagnosis Standard	The number of dementia diagnoses exceeds 50% of prevalence. National 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.

Dementia Post Diagnostic Support	All people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support. National Outcome 6: People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing.
Off Island Mental Health Activity	The level of "off island" mental health activity will be reduced; fewer people will travel "South" to receive the services they need. National Outcome 9: Resources are used effectively in the provision of health and social care services, without waste.

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Further Reading

The Mental Health (Care and Treatment) (Scotland) Act 2003: http://www.legislation.gov.uk/asp/2003/13/contents

Mental Health Strategy for Scotland: 2012-2015: http://www.gov.scot/Publications/2012/08/9714

Shetland Mental Health Strategy: http://www.shb.scot.nhs.uk/board/planning/MentalHealthStrategy20142024.pdf

Scottish Patient Safety Programme for Mental Health: http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health

"The Matrix" (NES): http://www.nes.scot.nhs.uk/media/3325612/matrix_part_1.pdf

Shetland Dementia Strategy: Insert Link

Shetland Drug and Alcohol Strategy: Insert Link

Responding to Distress – DBI: http://www.chrysm-associates.co.uk/images/DBIpaper8may15.pdf

Equal Partners in Care: http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/about-equal-partners-in-care.aspx

3.10 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 has opened in Lerwick in January 2016, with the capacity to register in excess of 6000 people for NHS primary dental care.
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 open, 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

The PDS will need to respond over time to the opening of the new independent practice as the new practice expands its patient registration list. The PDS emphasis on providing general dental work will diminish, enabling a greater emphasis on more specialist services.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Oral Health	67.73	3,382,294	0	3,382,294	TBC

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	Dental Director	First d raft published 10/2015	Outcomes 1 - 9
Encourage independent NHS dental practices to open in Shetland	Dental Director	Ongoing	Outcomes 1, 3, 4, 5, 6, 7, 8, & 9
Develop referral protocols for use by local dental practices	Dental Director	11/2015	Outcomes 1, 3, 4, 5, 8 & 9
Review local oral health care for people with Special/ additional needs	Dental Director	4/2016	Outcomes 1-9
Review local availability of specialist oral health care	Dental Director	4/2016	Outcomes 1-9
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs	Dental Director	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.	Collaboration with regional partners

Risks	Mitigation
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 and retain 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	The Oral Health Strategy under development will identify what local specialities need to be prioritised.

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 FTE 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

3.11 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Pharmacy & Prescribing	9.08	6,800,724	0	6,800,724	TBC

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, and that the GP workforce will be supported to ensure a more efficient use of GP time and resources, 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

- Work towards meeting the efficiency challenge of £200,000 savings by maximising the effectiveness of skill mix and planned additional roles within the Pharmacy Team

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.

3.12 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Primary Care	30.08	4,402,320	0	4,402,320	TBC

Needs/Unmet needs/Drivers for change

Primary Care has been set a savings target for 2016/17 which includes efficiencies to be generated through improved processes; redesign of workforce and savings which will be identified from 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)
Identify permanent arrangements for Practice Management at the Lerwick Health Centre, utilising the capacity across all salaried practices to support primary	Lisa Watt	April 2016	Resources are used effectively and efficiently in the provision of health and social care services.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
care management of services			
Review the skill mix required in the Lerwick Health Centre following the extension of the ANP model, to ensure efficiency and to identify opportunity for savings	Lisa Watt	April 2016	Resources are used effectively and efficiently in the provision of health and social care services.

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

Contact Details

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Further Reading

[1] http://www.shb.scot.nhs.uk/board/planning/2020VisionReport.pdf

3.13 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 – 2018 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 a mixture of both voluntary sector and statutory sector services. The new Substance Misuse and Recovery Service (SMRS) is part of the Community Health and Social Care directorate and started operating in April 2015.

Tiers

The Scottish Governments, through its resource allocation, expects all ADPs to provide services under the following Tiers: -

Tier 1: Tier 1 interventions include provision of drug-related information and advice, screening and referral to specialised drug treatment.

- Drug & alcohol treatment screening and assessment;
- Referral to specialised drug & alcohol treatment;
- Drug & alcohol advice and information;
- Generic services should also provide their own services to drug misusers and some may be specifically designed for drug misusers (e.g. housing projects for those leaving rehabilitation).

Tier 2: Tier 2 interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare;

- Triage assessment and referral for structured drug treatment,
- Drug intervention which **attracts** and **motivates** drug misusers into local treatment systems, including engagement with priority groups, such as pregnant women, offenders and stimulant users,
- Interventions to reduce harm and risk due to BBVs and other infections for active drug users, including dedicated needle exchanges and the support and co-ordination of pharmacy-based needle exchanges,
- Interventions to minimise the risk of overdose and diversion of prescribed drugs, Brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if it does not require structured treatment),
- Brief interventions for specific target groups including high-risk and other priority groups,
- Drug-related support for clients seeking abstinence,
- Drug-related aftercare support for those who have left care-planned structured treatment,
- Liaison and support for generic providers of Tier 1 interventions,
- Outreach services to engage clients into treatment and re-engage people who have dropped out of treatment,
- A range of the above interventions for drug-misusing offenders

Tier 3: Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison;

- Comprehensive Substance misuse assessment,
- Care planning, co-ordination and review for all in structured treatment, often with regular keyworking sessions as standard practice,
- Harm reduction activities as integral to care-planned treatment,
- A range of prescribing interventions in the context of a package of care, a range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviours,
- Structured day programme and care-planned day care,
- Liaison services for acute medical and psychiatric health services (i.e. pregnancy, mental health and hepatitis service),
- Liaison service for social care services (i.e. child protection and community care teams, housing, homelessness),

- A range of the above interventions for drug-misusing offenders

Tier 4: Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.

- Inpatient specialist alcohol and drug assessment, stabilisation and detoxification/assisted withdrawal services;
- A range of alcohol and drug residential rehabilitation units to suit the needs of different service users;
- A range of halfway houses or supportive accommodation for substance misusers; residential alcohol and drug crisis intervention units (in larger urban areas);
- Inpatient detoxification/assisted withdrawal provision, directly attached to residential rehabilitation units for suitable individuals, provision for special groups for which a need is identified (i.e. pregnant women, substance users with liver problems, substance users with severe and enduring mental illness). These interventions may require joint initiatives between specialised substance use services and other specialist inpatient units;
- A range of the above interventions for substance misusing offenders.

- **Funding and Resources**
  Table of budget and savings targets, including workforce details

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Substance Misuse	9.55	941,485	116,486	824,999	TBC

- **Needs/Unmet needs/Drivers for change**
  The review of Tier 3 Substance Misuse services has been undertaken over the last two years and the development of the multi-disciplinary team SMRS ensures Tier 3 commitments are being fulfilled.
  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**
  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)
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

3.14 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[4], enablement, and asset based[5] 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.

[4] **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.**

[5] 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

- **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**
- **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 (FTE)	Expenditure	Income	Net Budget	Savings target
Health Improvement	6.13	340,494	0	340,494	TBC

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 end date	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

Health Improvement are based at Grantfield, Lerwick, Shetland ZE1 0NT
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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
- CEL 01 (2012) Health Promoting Health Service

3.15 Nutrition and Dietetics

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 (FTE)	Expenditure	Income	Net Budget	Savings target
Nutrition and dietetics service	2.84	118,839	0	118,839	TBC

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

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
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

3.16 Occupational Therapy

Policy context

The development of Occupational Therapy services is informed by key government Strategies. These include but are not limited to the Principles for Planning and Delivering Integrated Health and Social Care, the National Health and Wellbeing Outcomes, Scotland's National Dementia Strategy, the Delivery Framework for Adult Rehabilitation in Scotland, and Realising Potential, An Action Plan for Allied Health Professionals working in Mental Health Services.
The See Hear Strategy guides the development of our sensory impairment services.
The AHP National Delivery Plan is currently under review which will identify key actions for our service.
The legislative framework behind our role along with NHS and SIC current strategies and priorities also influence the occupational therapy service priorities and development.

Current Services

Occupational therapy is the use of functional assessment and treatment to develop, recover, or maintain the daily living and role skills of people with a physical, sensory, mental, or cognitive disorder. Occupational therapy is a client-centered practice that places emphasis on the progress towards the client's goals. We identify and eliminate environmental barriers to independence and participation in daily activities. We work closely with members of any multi disciplinary team and with community services.

GBH: Occupational therapy assessment, rehabilitation, treatment, advice and information enabling both in and out patients to adapt to impairment and return to their valued activities and occupations, their home and their community.
SIC: Community based occupational therapy enabling disabled, and older people to remain at home for as long as possible. Assessment, functional rehabilitation, advice and information are provided. Home adaptations and specialised equipment support these processes. People with sensory loss also access these services.
SIC Telecare: Technology is utilised to enable vulnerable people to live independently and securely in their home through a range of electronic monitoring equipment. These options provide real choices other than residential care.
SIC Independent Living Centre: A community resource with information and a selection of equipment for the public to view and trial. The Blue Badge Clinic is run from this facility.
SIC Equipment Store: Manages, maintains, delivers, installs, collects, and repairs all occupational therapy equipment used in the community. The Community Nursing store is also located here.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Occupational Therapy	20.71	1,597,399	34,582	1,562,817	TBC

Needs/Unmet needs/Drivers for change

Needs/Unmet needs include:

- Mental health occupational therapy services. The Mental Health Strategy for Scotland identifies that mental illness is one of the top public health challenges 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. With team members, occupational therapists emphasise and support a person's potential using the Recovery model to guide practice.
- Scotland's National Dementia Strategy identifies the need for improved services following diagnosis by providing excellent support and information to people with dementia and carers. There is a need for specialist occupational therapy knowledge and championing of occupational therapy as an integral part of dementia services
- Neurological outpatient occupational therapy assessment and treatment to maximise people's potential once discharged from hospital to maximise outcomes.
- A&E would be advantaged by a rapid response service to facilitate discharge directly home wherever possible, rather than a ward admission.

Drivers for change include:

- New and updated Government strategies
- The growing and aging population
- The expectation that aging, and disabled people will remain at home whenever possible
- The expanding possibilities of Telecare
- The need to develop a consistent best practice model of practice across all Localities with a focus on early integrated interventions
- The possibilities of electronic working (eHealth)

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

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
			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

Risk	Mitigation
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 http://www.gov.scot/Resource/0046/00466005.pdf
- National Health and Wellbeing Outcomes Framework
- Scotland's National Dementia Strategy 2013-2016
- Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult Rehabilitation in Scotland
- Realising Potential, An Action Plan for Allied Health Professionals - Bing
- Social Work (Scotland) Act 1968
- Chronically Sick & Disabled Persons Act 1972 - Bing
- Health and Safety at Work etc. Act 1974;
- Disability Discrimination Act 2005
- Housing (Scotland) Act 2006
- Occupational therapy information Live life your way | BAOT/COT

3.17 Orthotics

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 (FTE)	Expenditure	Income	Net Budget	Savings target
Orthotics	2.00	143,363	0	143,363	TBC

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
Tel: 01595743023.
Email: laurencehughes@nhs.net

Further Reading

- Ambulatory Care Services redesign plan
- Orthotic dept Business case

3.18 Physiotherapy

Policy context

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

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 (FTE)	Expenditure	Income	Net Budget	Savings target
Physiotherapy	12.89	602,664	0	602,664	TBC

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 end date	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

3.19 Podiatry

Policy context

Public Bodies (joint working) (Scotland) Act 2014; National Health and Wellbeing Outcomes; National Delivery Plan for Allied Health Professionals (AHP) in Scotland (2012); NHS Shetland Workforce Plan 2014-17; Localities Planning; 18 weeks Referral To Treatment (RTT); 4 weeks Musculoskeletal (MSK) RTT; AHP MSK Minimum pathway standards; Scottish Intercollegiate Guidelines Network (SIGN); Health + Care Professions Council; Older People Health and Wellbeing Strategy; Scotland's Dementia Strategy 2013-16; Shetland NHS Intermediate Care Operational Plan; Prevention and Management of Falls; Getting It Right For Every Child (GIRFEC); Community Care + Health Scotland Act 2002; Regulation of Care (Scotland) Act 2001.

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 (FTE)	Expenditure	Income	Net Budget	Savings target
Podiatry	4.40	224,917	0	224,917	TBC

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.

Although a stand alone, voluntary charitable organisation, the Shetland Voluntary Nail Cutting Service (SVNCS) will continue to be supported financially by NHS Shetland. Podiatry Services will continue to provide training, advice and logistical support. The SVNCS has challenges with recruiting volunteers leading to unmet needs of present and prospective service users. Foot care, including simple nail cutting is now classed as a personal care need and is a task for which Social Care now has responsibility. Podiatry Services will maintain its commitment to provide training and advice to social care teams when requested.

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,

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3.20 Renal

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 (FTE)	Expenditure	Income	Net Budget	Savings target
Renal	3.50	179,099	0	179,099	TBC

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

Contact Details

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Janice McMahon
Chief Nurse Acute and Specialist Services
Janice.mcmahon@nhs.net

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

3.21 Sexual Health

Policy context

The *National Framework for Sexual Health and Blood Borne Viruses* (2011), reviewed in 2015, 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. A local Sexual Health and Blood Borne Virus Strategy was published in 2015.

Current Services

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.

There are two main elements to sexual health services: the Sexual health and wellbeing clinic and primary care services. However sexual health work is also incorporated into a number of other services including school nursing and health visiting; secondary care (particularly gynaecology); public health and health improvement; sexual health and relationships education in schools and the voluntary sector (OPEN Peer Education project)

The Sexual Health and Wellbeing (SHWB) Clinic runs once a week 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 primarily nurse led with some GP clinics. The service has recently undertaken a project with NHS Grampian to develop telemedicine facilities for patients diagnosed with HIV, including consultant and psychologist appointments supported by the sexual health clinic staff in the hospital outpatient department, reducing the need for patients to travel off island for care and support. During 2015 the service was amalgamated with maternity, early pregnancy, and some gynaecology services to establish a more robust Reproductive Health Service. This new service is managed by the Senior Charge Midwife for Reproductive Health.

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. 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.

Funding and Resources

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 £38,137. Staff are rotated to the clinic from the maternity service and supported by other sessional nurses. In addition, there is a GP and a healthcare support worker at the clinic every other week.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Sexual Health Clinic	0.56 Sexual Health Clinic (staffing includes one GP, nurses, HCSWs and admin staff on a sessional basis; managerial support	38,137	0	38,137	TBC

Needs/Unmet needs/Drivers for change

- As 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, which will not be met within current resources.
- It is recognised that access to the Sexual Health and Wellbeing Clinic is limited, especially for people who live out with Lerwick and those that cannot get there in the evening. The development of the reproductive health team should allow greater flexibility in the provision of services out with the clinic.
- 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
- There is scope to improve the pathways for women who require a termination of pregnancy (who currently have to go to Aberdeen) and other services currently provided in Aberdeen utilising telemedicine to provide a satellite service linked to NHS Grampian.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Training for nurses / midwives to fit LARC implants	Elaine McCover	December 2015	Reduction in unplanned pregnancy
Training for nurses / midwives to fit contraceptive coils	Elaine McCover	December 2016	Reduction in unplanned pregnancy
Implementation of electronic patient record system (NaSH)	Elaine McCover/Andrew Carlisle	December 2016	ENMAHP health agenda
Look at improving termination pathway to reach 9 weeks target including looking at what elements of the service could be carried out on Shetland	Elaine McCover	December 2016	Reduction in unplanned pregnancy
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	Elaine McCover	Complete	Reduction in unplanned pregnancy
24/7 provision of emergency contraception through reproductive health service rather than A&E	Elaine McCover	April 2016	Reduction in unplanned pregnancy

Key Risks to Delivery

Training for staff and maintaining competencies

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. This is also particularly difficult for nurses in the sexual health clinic who might only work two sessions a month, again this should be improved by the newly established reproductive health team and greater ability to provide some training locally. 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.

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 integrated into the Reproductive Health Team, and also aim to have sustained clinical leadership through the new consultant post. We also have a team of sessional staff who have undergone training. However, a proportion of funding for the clinic is provided through the prevention Bundle allocation for the Scottish Government , and if this were to stop the service would be under threat.

Performance Targets with links to National Outcomes

National Sexual Health and BBV 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.

National Key Performance Indicators

Indicator	2013/14	2014/15	2015/16	TARGET 16/17
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%

There are currently no national HEAT targets or local SOA indicators relating specifically to sexual health

Contact Details

Reproductive Health Service: Elaine McCover

Further Reading

Healthy Shetland Website: Sexual Health Information, including information and a video and the clinic.
www.healthyshetland.com/health-topics/sexual-health

3.22 Speech and Language Therapy

- **Adults**

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 (FTE)	Expenditure	Income	Net Budget	Savings target
Speech & Language Therapy	3.29	180,135	92,000	88,135	TBC

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

Risk	Mitigation
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

- **Children**

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 FTE 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

Further Reading

www.nowhearme.co.uk

www.rcslt.org (**for** policy position papers on e.g. dementia, learning disabilities.)

3.23 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[6] 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)**

[6] 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.

- 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. 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 (FTE)[7]	Expenditure	Income	Net Budget	Savings target[8]
Unscheduled Care	58.19	3,138,445	0	3,183,445	TBC

Other Planned Care Services & Support Functions in the Acute & Specialist Services Directorate

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Planned Care	75.50	5,219,060	530,583	4,688,477	TBC

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:

[7] Establishment is taken from 2015/16 workforce plans

[8] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

- 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 FTE 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

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
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).

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
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
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

Contact Details

Kathleen Carolan, Director of Nursing & Acute Services, kcarolan@nhs.net

Further Reading

Older Peoples Strategy, Corporate Action Plan, Unscheduled Care Strategic Plan:
http://www.isdscotland.org/Health-Topics/Emergency-Care/

4. Support Services Plans

4.1 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 FTE
Facilities: Revenue - £1.66M Staffing – 71.12 FTE

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 (FTE)	Expenditure	Income	Net Budget	Savings target
Estates & Facilities	82.08	3,726,073	0	3,726,073	TBC

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

Lawson Bisset
Head of Estates and Facilities
lawson.bisset@nhs.net
01595 743029

4.2 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Finance	13.30	1,899,352	0	1,899,352	TBC

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

4.3 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. Successful implementation will support the progression of the national HR Shared Service (HRSS) agenda that will centralise some HR services.

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, FTE/ turnover/FOI's/ Junior Doctor)
- Workforce planning – projections and reports
- Redeployment
- Policy and procedure development
- Training delivery
- Equality and Diversity – policy, monitoring, action plans

Policy and procedures can be found on the department intranet page http://intranet/departments/hr/index.html and website http://www.shb.scot.nhs.uk/board/policies.asp

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Human Resources	10.70	522,353	0	522,353	TBC

A change in skill mix will provide a 3K recurring saving. Non pay savings continue to be found by modifying how services are delivered and the flexibility of the team.

Needs/Unmet needs/Drivers for change

Following the implementation of EESS in 2013, we released 1 FTE Band 3 vacancy to savings. The reduction was planned following successful implementation; however full implementation of the system is not yet complete. National delays in advancing the implementation of EESS and the lack of clarity regarding the impact of HRSS locally has resulted in a holding position, lengthening implementation plans and depending on flexibility form within the team to meet workload demands. HRSS will continue to shape skills requirements within the team.

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	Outcomes still to identified, redeployment of HR staff as applicable

Key Risks to Delivery

HRSS is nationally driven programme that will aim to centralise administration of recruitment and medical staffing within the next 2-5 years. There will be some discretion to determine what staff are required locally to support local service delivery. Staff and Manager's will require training for the EESS system to enable them to self administer recruitment administration activities within the system, including vacancy and candidate administration / coordination of short listing, interview and on boarding which is currently carried out by HR. Costs may shift from HR if the demand for administration support across other services increases and local pay costs may increase overall rather than decrease and local expertise will reduce.

Performance Targets with Links to National Outcomes

Reduction in administration demands will enable 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

4.4 Information Management & Technology and eHealth

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:

- Installation, management and support of IT infrastructure including servers, storage and network services.
- Management of Clinical, and Business application systems
- Installation, management and support of telephony including landlines, mobile phones, and pagers
- Multifunction devices (scanner/copier/printers)
- System integration services
- Freedom of Information administration
- Information Security
- Information Governance
- Information services and healthcare intelligence
- National eHealth leadership
- North of Scotland regional eHealth leadership and programme delivery
- Policy and procedure development
- Training delivery

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Information Technology	15.00	1,100,100	0	1,100,100	TBC

We do not anticipate savings in pay budgets in 16/17 due to pressure on existing resources to deliver service however dependent upon the level of savings and percentages required this may change post Feb 2016 and if so is likely to be in the region of 5%. Recurrent savings of £30,000 anticipated in non-pay IM&T budgets by reducing hardware refresh rate, and reduction in telephony maintenance charges.

Needs/Unmet needs/Drivers for change

The use of technology in NHS Shetland is increasing, and the number of systems supported continues to increase. The department has recently taken responsibility for training staff on a number of clinical systems and provides administration of those systems. On this basis, it has been identified that an increase of 2FTE Band 5 is required to deliver service.

All public sector organisations will be required to comply with the Public Records Act in 2016/17. This will involve significant change in the management of information assets across all areas. On this basis 1 FTE Band 6/7 will be required to meet the requirements of the Public Records Act,

and provide ongoing stewardship of information assets thereafter. It is anticipated that such a resource would organisationally fit within this department.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Increased use of technology to reduce patient and staff travel	Head of IM&T/eHealth	Commenced December 2015. Ongoing programme expected to run for 12 months.	Reduction in travel expenditure across the organisation. Improved patient care due to reduction in travel
Implementation of Records Management Plan to support compliance with Public Records Act	Director of Finance	Commencing April 2016.	Compliance with Public Records Act (mandatory).
Implementation of on-line services for patients	Head of IM&T/eHealth	Programme commencing April 2016, subject to national funding	Reduced DNA rates, reduced patient appointments Improved patient care through increased self-management of care

Key Risks to Delivery

Cost pressures – savings targets for core budgets, and reduction in Scottish Government eHealth allocations.

Insufficient staff – change programmes that will deliver recurrent savings are challenging to implement as staff are fully utilised supporting and maintaining existing systems.

Skills gaps – records management (Public Records Act) is a fundamental change to management of information assets, and suitable skills are challenging to recruit in remote areas.

Performance Targets with links to National Outcomes

The national eHealth Strategy, which supports the national Quality Strategy, includes outcome measures that we report to Scottish Government quarterly.

Contact Details

Craig Chapman, Head of IM&T/eHealth 01595 743210, craigchapman@nhs.net

Further Reading

Scottish Government / NHS Scotland eHealth Strategy 2014-18
http://www.gov.scot/Resource/0047/00472754.pdf

4.5 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Medical Records	27.99	896,660	0	896,660	TBC

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

4.6 Occupational Health

Policy context

Service changes are currently being driven by external and NHS local demand for services and nationally with national performance target for sickness absence of 4% and the introduction of the Fit for Work Service Scotland and also 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

Details can be found on the staff intranet http://intranet/departments/oh/index.html

In addition to a 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Occupational Health	3.00	167,332	55,630	111,702	TBC

Pay budget includes visiting consultant from NHS Highland. 4K recurring saving has been agreed from pay budget for 2016/17, which is only in current state of service demand. Line management and business management of SLA with NHS Highland is via the HRSM for which costs are included in Personnel plan & not included in above. There is a cost pressure for system development and achievement of the SEQOHS accreditation to maintain current service for which additional income has continued to cover in the last 2 years.

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. This has enabled our consultant to become an approved Doctor for the MCA, so we can offer ENG1 medicals to our customers
- Requirement for SEQOHS professional 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's sickness absence from work. NHS Shetland will participate in service delivery with allocation of referrals via a central call centre (NHS 24). The service level will be managed separately via a defined SLA. Telephone equipment and system are in place. Additional resource will be required to be trained to deliver this contract, for which funding allocation is to be agreed.

Current SLA with SIC will cease 31 March 2016. NHS Shetland has submitted a tender for a revised contract for services commencing 1 April 2016.

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
Introduction of Fit for Work Service	SOHN	2015/16	National reduction in sickness absence from work
OH Tender for SIC	HRSM/ SOHN	2016/17	To be confirmed in January

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 FTE Band 6. Current staff have supported 'set up' in readiness for commencement of the service. Local start delayed, awaiting training from NHS Lanarkshire, the FFWS lead for Scotland.

- There is a risk that we may lose income if Shetland Island Council do not accept the occupational health tender submission. Failure to generate sufficient income to replace this would require a reduction in staff 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. No funding has been received yet and unlikely until January 2016. Resource to deliver will be dependent on availability and level of funding provided.

- Retention of skilled staff will be essential to maintain service delivery levels – local availability of appropriate skills is very limited therefore national recruitment or use of a 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 demand, service would continue to provide support for NHS staff in maintaining health, wellbeing and fitness for work. The service supports the achievement of the 4% performance HEAT target for absence and reduces risk in relation to the Equality Act 2010, providing guidance on adjustments. Without a local service we would unlikely maintain current performance which is consistently below the Scottish average or achieve the 4% absence target.

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

4.7 Spiritual Care

Policy context

The current NHS Shetland Spiritual Care Policy dated Sept 2006 was to be reviewed Sept 2008. The policy will be updated in 2016 reflecting the NHS HDL (2015) National Delivery Plan for Spiritual Care 2015 – 2020, due to be published in 2016. Boards and Spiritual Care departments have worked hard to implement the recommendations made in CEL (2008) 49. The revised guidance (Annex A) and the new national delivery plan (Part Two) aim to further develop the Spiritual Care Service in the light of the integration of Health and Social Care. The 2020 vision, the integration agenda for health and social care, person centred care.

Current Services

There is a full time Spiritual Care Lead chaplain in a joint/shared post with NHS Orkney who oversees a multifaith spiritual care service. The spiritual care lead's main remit is staff support and to develop and ensure the delivery of spiritual and religious care across NHS Shetland. The Spiritual & Religious Care Service provides spiritual and religious care to NHS Shetland across primary and acute healthcare and social care in the local community. The intention would be to further expand the service over the next 5 years to create a well-integrated that will meet the spiritual and religious care service for staff and the community.

Due to the geographical factors of NHS Shetland, and to ensure equity of spiritual care provision across Shetland, 6 volunteers were recruited and trained by the spiritual care lead who will provide spiritual care on the wards in the Gilbert Bain hospital, supervised by the spiritual care lead. There will be volunteers recruited and specialist trained to provide a listening service, attached to GP surgeries, under the umbrella of CCL – Community Chaplaincy Listening. Staff support is provided on an ad hoc basis by referral, for e.g. from HR and Occupational Health, self referral and via managers, team leaders and working relationships with departments and professional teams. This includes following the asset-based approach of networking within the community. A tool that enables staff wellbeing is VBRP – values based reflective practice, facilitated by the spiritual care lead in regular sessions across health and social care and are also introduced through staff education and development. VBRP is also included within and as a useful tool within the nursing revalidation.

Funding and Resources

The options appraisal and service review will make recommendations which will potentially have an impact on recommended future staffing levels.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Spiritual Care	0.50	64,924	24,246	40,678	5%

Needs/Unmet needs/Drivers for change

Spiritual & Religious Care assessment to be undertaken in 2016 with the update of the Spiritual Care Policy. A service priority will undertake a needs analysis in terms of service delivery and it

is anticipated that the review will examine access to the service and ongoing provision of support to staff. A needs analysis will recommend future staffing levels for a service which is appropriately responsive to the needs of staff, patients, families, carers and users and in accordance with key government drivers and the CEL.

Plans for change

Service redesign has been the main purpose of the spiritual care lead's remit throughout 2015. Guided by the CEL update, VBRP for staff support, ensuring evidence and outcomes meet national guidelines. Quarterly attendance at SLG meetings, NHS Education for Scotland and annual professional SLG conference. More volunteers will need to be recruited to fulfil equity of spiritual and religious care across primary care.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Spiritual Care Policy	D Allan	02/2016 & 07/2016	To meet NHS Scotland, National Guidelines for delivery of Spiritual & Religious Care.

Key Risks to Delivery

The service professionally single-handed, there is a risk from the lack of financial input in terms of linking the spiritual care lead to the wider spiritual care network throughout NHS Scotland. There must be adequate opportunity for supervision and support on an ongoing basis provided through work time. Service provision in terms of meeting the needs of patients who are acutely unwell is a risk, because the spiritual care lead cannot be as responsive as is necessary. The national standard currently suggest 24/7 provision of support which NHS Shetland does not provide. Limitations of weather is a risk.

Performance Targets with links to National Outcomes

Based on the national and local delivery plans will be constructed both for NHS Orkney and NHS Shetland which will be required for service delivery.

Contact Details

NHS Orkney	**NHS Shetland**
Balfour Hospital	Upper Floor Montfield
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Orkney	Shetland
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Tel Orkney **01856 888184**
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Email dawnallan1@nhs.net
Video Conf dawnallan1@vc.scot.nhs.uk

Further Reading

CEL (2015) XXXX and The National Delivery Plan for Spiritual Care in Scotland 2015 – 2020 – (Version 10) when it is published in 2016. The following documents can be found via:
NHS Education for Scotland at www.nes.scot.nhs.uk
Spiritual Care Matters – Tel: 0131 313 8000
A Multifaith Resource for Healthcare Staff -
Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains -

4.8 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 collation and production of a joint training plan, ensuring 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

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 (FTE)	Expenditure	Income	Net Budget	Savings target across directorate / contribution 2016/17
Staff Development	5.91	344,918	0	344,918	TBC

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.

Drivers for change include:

Internal

- Local delivery plan
- HR/OD strategy
- Integration
- Leadership
- Culture

External

- Quality Strategy
- 20/20 vision
- SGAP
- Staff Survey
- iMatter
- Leadership
- Revalidation

Service Aims/Priorities	Objectives/Actions
Staff and organisational Development	**Compulsory** • Corporate Induction • Induction Refresher • Induction of Temporary Staff • Training Plan • EESS • KSF • Appraisal • iMatter **General** • LearnPro • BCP • Recruitment • Interview skills • E-Learning • Project Management • Volunteers
Service Improvement	• Improvement Methods

Service Aims/Priorities	Objectives/Actions
	• Leadership • Change Management • Psychometrics/CER • Integration • Project Management • Project Support • AHP Education • Supervision • Staff Survey
Clinical Education	• Resuscitation • Moving and Handling • Developing the Clinical HCSW • CPD for Nurses, Midwives • Supporting Undergraduate Nurses and Midwives in practice • Mentor support and development

Plans for change

Description	Start date/Comments	Expected Outcome
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.	Improvement of uptake by 10%
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 e.g. 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, 2	Implementation of all cohorts in 2016 and continuation of

Description	Start date/Comments	Expected Outcome
	and 3 staff in line with SGHD plan. This includes: Finance, Human Resources and Support Services, Public Health and Performance.	rolling programme and improvement cycle.
Board Quality Group	Actions carried out by Quality Working Group - Currently under review	
Transition from registration to revalidation for nurses and midwives	Design and deliver workshops for registrants, confirmers and non registrant managers, support practitioners through process as needs are identified.	All nursing and midwifery staff will successfully complete revalidation process between April 2016 and April 2019 (first round of new process)

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

5. NHS Plans

5.1 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 FTE0.6 to FTE 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Audiology	1.60	132,659	0	132,659	TBC

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 FTE 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

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 FTE0.6 rather than FTE1.0 **HCS Deliverable 4** Developing sustainable services

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
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 FTE 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

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
			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 FTE 0.6 after a temporary period of FTE 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 **1.0FTE 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

5.2 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	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Central Decontamination Unit	4.64	166,759	0	166,759	TBC

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 Quality Supervisor post by 0.1 FTE to release £2961	Carol Barclay	April 2016	To meet target 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.

5.3 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 FTE staff (made up of 1 FTE 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 FTE Psychiatric Nurse, 1 FTE Primary Mental Health Worker, 0.7 FTE 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 (FTE) [9]	Expenditure	Income	Net Budget	Savings target [10]
Child Health	28.98	1,359,669	0	1,359,669	TBC

The indicative savings target for planned care services in 2016-17 is **£42,470.** This is equivalent in staffing costs to a reduction of FTE 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

[9] Establishment is taken from 2015/16 workforce plans

[10] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

- 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

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

5.4 Laboratory

Policy context

To comply with UKAS accreditation standards it is essential to maintain the current clinical governance relationship with NHS Grampian.

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.

Current Services

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.
This is 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.

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.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Laboratory	9.62	761,461	0	761,461	TBC

Needs/Unmet needs/Drivers for change

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.

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, and there is limited point of care test (POCT) capability. These issues are being addressed by the joint managed service contract (MSC) for laboratory services.

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

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 Targets with links to National Outcomes

TBC

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

5.5 Medical Imaging

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[11] 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.

[11] 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 (FTE) [12]	Expenditure	Income	Net Budget	Savings target [13]
Medical Imaging	8.96	663,449	0	663,449	TBC

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 FTE 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:

- 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

[12] Establishment is taken from 2015/16 workforce plans

[13] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

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).

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
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

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Email: 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

5.6 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 (FTE)	Expenditure	Income	Net Budget	Savings target
Physiological Measurements	1.0	66,616	0	66,616	TBC

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

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Current draft model: Grampian to provide implanted cardiac device follow-up service Employ a BSE accredited echocardiographer Move community services done 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

5.7 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[14] 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

[14] 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 Rehabilitation Services**
- Planned Critical Care Services (e.g. pre-operative optimisation and post operative care)
- 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 are also shown in separate plans.

A range of specialist NHS services are provided to Shetland residents by Scottish mainland NHS (off island), through Service Level Agreements (SLAs) primarily with NHS Grampian, also as regional and national specialties with Boards across Scotland. This costs the Board around £7 million per year. Change is agreed through specialist service commissioning at national level via the National Specialist Services Committee (NSSC) and regionally via North of Scotland Planning Group (NoSPG).

Funding & Resources

Other Planned Care Services & Support Functions in the Acute & Specialist Services Directorate

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Planned Care	75.50	5,219,060	530,583	4,688,477	TBC

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 FTE 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	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	Public services contribute to reducing health inequalities Resources are used effectively and efficiently

Description	Lead Officer	Start/Target	Expected Outcome(s)	National Outcomes
specialists in Grampian			level)	
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	Public services contribute to reducing health inequalities Resources are used effectively and efficiently

Description	Lead Officer	Start/Target	Expected Outcome(s)	National Outcomes
			Reduced cost of on call for BMS staff (moving towards point of care testing and sample analysis automation)	
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).

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
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 from being added to Inpatient waiting list to having procedure (count)	M	2015 Jul	0	2015 Jun	0	**G**	→	0	2016-03	0
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	M	2015 Aug	0	2015 Jul	1	**G**	↑	0	2016-03	0

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
	time was greater than 6 weeks (count)										
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 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
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

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
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

Contact Details

Kathleen Carolan, Director of Nursing & Acute Services, kcarolan@nhs.net

Further Reading (available at http://www.shb.scot.nhs.uk)

Older Peoples Strategy
Corporate Action Plan
Unscheduled Care Strategic Plan

5.8 Public Health

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 2016). There is also a North of Scotland review to strengthen public health in the north with a focus on the future resilience of public health in the Island Boards which will inform future service redesign and succession planning.

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 currently 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
Consultant in Public Health Medicine
Public Health specialist
Senior Planning & Information Officer
Information Analyst Public Health Intelligence
Public Health secretary & admin support (shared with Director of Pharmacy)
and the Health Improvement team.

Funding and Resources

Table of budget and savings targets, including workforce details

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Core Public Health	3.14	194,420	0	194,420	TBC

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 which will change in a redesigned team for 2016/17.
We also have a recurring savings target of £18,200 for 2016/17 plus a predicted reduction in government public health allocations which currently fund core services within the PH team – at an estimated 7.5% and a potential total estimated savings target of £37,000.

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	Continued delivery of sustainable public health function
Team staffing restructure to achieve savings targets	DPH	Sept 2015 / March 2017	Efficiency savings achieved with minimal loss of service. 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 to achieve the savings targets for 16/17 through planned staff turnover and restructuring of the remaining workforce. The workforce plan for 2016/17 will detail the redesign necessary to achieve this, with an inevitable reduction in service, but aiming to minimise the impact on achieving national outcomes.

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 need to 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 been used, so future reductions in programme budgets (such as the reduction in national bundled allocations) will result in loss of staff, and the dept budget will need to absorb any associated costs unless the Board reaches Board-wide agreement on supported funding. If we are faced with future restructuring and staff redeployment, we will need a lead-in time to achieve savings.

The workforce plan will detail our management of these risks.

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.

There is also a risk of reduced service delivery from failure or delays in re-recruitment to the DPH role.

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:
http://www.shb.scot.nhs.uk/board/strategies.asp

Appendix 1 Integrated Impact Assessment

Part 1 – Background Information

Name of Responsible Authority:	Shetland Integration Joint Board, NHS Shetland, Shetland Islands Council
Title of Plan, Programme or Strategy (PPS):	Joint Strategic Commissioning Plan 2016-19
Contact Name, Job Title, Address, Telephone Number, Email:	Simon Bokor-Ingram Director of Community Health & Social Care NHS Shetland Board Headquarters Burgh Road Lerwick Tel: 743087 e-mail: simon.bokor-ingram@nhs.net
Signature:	
Date of Opinion:	18th January 2016
Purpose of PPS: Please give a brief description of the policy, procedure, strategy, practice or service being assessed	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.
Why PPS was written: What is the intended outcome of this policy, procedure, strategy, practice or service?	Joint strategic planning document for Integrated Joint Board (IJB) business. Statutory requirement for IJB when planning services.
Period covered by PPS: (i.e. years, months)	3 financial years: 2016-2019
Frequency of Updates (when PPS will next be updated):	Annual
Area covered by PPS (geographically and/or population):	Shetland

The degree to which the PPS sets a framework for projects and other activities, either with regard to the location, nature, size and operating conditions or by allocating resources:	Plan will set a framework for all service activities including planning change and delivery within localities and decisions on resource deployment.
The degree to which the PPS influences other PPS including those in a hierarchy:	Overarching strategic planning document for integrated health and care services, and for NHS service planning.
Summary of content:	It is a strategic commissioning plan which is structured around the client groups / services that are included within the delegated authority of the IJB. 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.
Objectives of PPS:	To improve national health and wellbeing outcomes for people in Shetland through the joint commissioning of services that are included within the delegated authority of the IJB, and as a single system approach to health and care service planning through NHS Shetland.

What are you trying to achieve?	Service change and redesign to improve health and wellbeing outcomes.
Is this a new or an existing policy, procedure, strategy, practice or service being assessed?	New strategic plan
Please list any existing documents which have been used to inform this Integrated Impact Assessment.	N/A
Has any consultation, involvement or research with people impacted upon by this change, in particular those from protected characteristics, informed this assessment? If yes please give details.	Yes in relation to specific client groups: Health Improvement - ongoing consultation/dialogue with people with learning difficulties, lower paid men in mainly manual type work, people of ethnic minorities, people with mental health issues. Adult Services Learning Disability and Autism - Progression of the Day Services New Build (EGRC).Stakeholder engagement has taken place in the form of regular meetings and consultation with the Eric Gray Users Group; the new Eric Gray Resource Centre Working Group which includes nominated family, carer and users. OT - Informal feedback from clients and stakeholders

	has helped us to define areas for improvement. Primary Care - Issues of importance to local communities have been identified through the round of Locality Planning meetings. Additional service specific information has been held by engagement with various groups eg patient satisfaction survey for ANP service at Lerwick Health Centre, General Satisfaction survey across all of District Nursing and Continence Service, discussions with Community Councils re health issues. Podiatry services produce annual patient satisfaction surveys for a % of caseload. Feedback from survey enables service to produce and implement action plans.
Is there a need to collect further evidence or to involve or consult people, including those from protected characteristics, on the impact of the proposed policy? (Example: if the impact on a group is not known what will you do to gather the information needed and when will you do this?)	Ongoing process of needs assessment in Health Improvement. The proposed audit of Adult Service Learning Disability and Autism service is anticipated to include engagement with people with learning disability, autism spectrum disorder, families and carers through meetings and gathered feedback. It is anticipated that this will be undertaken between April and June '16. Further engagement work will be undertaken with island Communities to explore / discuss sustainable service models for the future. The PPF will be used to discuss changes in nursing services based on the outcome of the national Review of District Nursing services. Podiatry service will continue to use both formal and informal feedback from service users to redesign and develop service provision.

Part 2 – People and Communities

	Impact (+ve / -ve / no impact / not known)	**Next Steps**
Economic	No impact/+ve – in Health Improvement all our programmes are adapted to suit individual circumstances as far as possible. For Primary Care; not known at this stage – potential limited -ve impact if reduction of employment in small communities through changes in service provision.	Discussions with partner agencies / other stakeholders as part of service reviews

Cultural	Primary Care – potentially –ve: Communities may perceive changes in service provision as having negative impact on their culture	Discussions with stakeholders as part of service reviews & engagement with communities in any major service change
Environment	No impact/+ve	
Poverty	No impact/+ve. Primary Care - Not known, may have –ve impact if changes in access to services rely on car ownership or availability of public transport. Podiatry – not known.	Engagement with communities in any major service change. Podiatry will seek service user feedback on this.
Health	No impact/+ve as services are more targeted in their approach to the provision of services to those in greatest need.	
Stakeholders	No impact/+ve. Primary care – not known.	Discussions with partner agencies / other stakeholders as part of service reviews
Equalities		
Ethnic Minority Communities (consider different ethnic groups, nationalities, language barriers)	No impact/+ve	
Gender	No impact/+ve	
Gender Reassignment (consider transgender and transsexual people. This can include issues such as privacy of data and harassment)	No impact/+ve	
Religion or Belief (consider people with different religions, beliefs or no belief)	No impact/+ve	
People with a disability (consider attitudinal, physical and social barriers)	No impact/+ve	
Age (consider across age ranges. This can include safeguarding, consent and child welfare)	No impact/+ve	
Lesbian, Gay and Bisexual	No impact/+ve	

Pregnancy and Maternity (consider working arrangements, part-time working, infant caring responsibilities)	No impact/+ve	
Other (please state)		

Part 3 - Resources

	Impact (+ve / -ve / no impact / not known)	**Next Steps**
Staff	+ve / -ve – Staff in some services will have to spread themselves more thinly with fewer resources	
Finance	+ve / no impact – we will continue to deliver within current or available resources. Some services identify that savings still need to be identified	Podiatry planning to investigate alternative methods of service delivery.
Legal	+ve / no impact	
Assets and Property	Not Known currently but potentially opportunities for sharing assets and property through integration, especially at locality levels	Consider as part of all developments being progressed

Appendix 2

NHS SHETLAND

SHETLAND ISLANDS COUNCIL

Draft Joint Strategic (Commissioning) Plan 2016-19

SUMMARY

Version 1

Introduction

The Joint Strategic (Commissioning) Plan for 2016-19 is developed jointly in partnership with stakeholders, for adoption by the Integration Joint Board (IJB). It is structured around the client groups / services that are included within the delegated authority of the IJB. 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 direction as outlined in the Shetland Single Outcome Agreement, Shetland NHS Local Delivery Plan (LDP), Shetland Islands Council (SIC) Housing Strategy, Shetland Community Plan and other local corporate plans.

In future the Strategic Commissioning Plan will increasingly describe how people's lives, health and wellbeing will be improved. 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 Strategic (Commissioning) Plans to increasingly reflect our engagement with stakeholders and local communities in Shetland, through Locality Planning and links to Community Planning, professional involvement, working with users and carers, and through strategy development on particular themes such as older people and primary care). The IJB's Communication and Engagement Plan sets out more detail of how this will be done.

The Strategic Plan is informed by work done to analyse the needs of local populations, known as Joint Strategic Needs Assessments (JSNAs). 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 strategic needs assessment work, which is also being developed through the Locality Profiling done to inform Locality Planning. This will be an area of development in future iterations of the Strategic Plan, taking into account more detailed information about local populations and their needs.

Similarly, financial analysis of service delivery and change, and to support analytical processes such as programme budgeting / marginal analysis and Locality Planning, will be developed as part of the Joint Finance work in place to support the development of Integration.

This summary highlights the key areas of change and improvement within this Shetland Joint Strategic Commissioning Plan, and provides an easy-read, overarching summary of the strategic commissioning plan with details of the vision for Shetland. The full plan is available at:
http://www.shetland.gov.uk/Health_Social_Care_Integration/Consultation.asp

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

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.

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 disability including physical disability and learning 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 the Local Authority area over the period of the plan:

- The arrangements for each locality established for locality planning purposes.

- The process of strategic planning, including the Strategic Planning Group set up to prepare future strategic commissioning plans

- Further development work:
    - Replacing the current CHCP Procurement Strategy with a Joint Commissioning and Procurement Strategy to provide one strategy for health and social care that will be adopted by the Council, NHS Shetland and Shetland's Integration Joint Board.
    - Developing an agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions.
    - Considering the need for development of a Market Facilitation Plan in line with national guidance (in the form of expected Advice Notes) and as relevant to the Shetland context in its first year of operation.

Summary of the Plan

The vision for Shetland, as described in the Community Plan and Single Outcome Agreement (SOA), is that we aim to make Shetland the best place to live and work by helping to create communities that are: wealthier and fairer, learning and supportive, healthy and caring, safe, vibrant and sustainable.

For health, NHS Shetland's 2020 Vision is:
"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, 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."

The Community Health & Social Care Directorate's vision is:
"To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community"

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.

Mental Health:
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD
Establish a person centred Consultation & Engagement Framework (including a Mental Health Website) to facilitate Co-Production

Substance Misuse:
Review of Tier 1 and 2 substance misuse services

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Increase the number of polypharmacy reviews by 20%

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015

Community Nursing:
Continue to support implementation of eKIS Anticipatory Care Planning across the services

Sexual Health:
A range of initiatives to be introduced to help to reduce unplanned pregnancy

Adult Services:
Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from theappraisal.

Nutrition and Dietetics Service
Complete development and implementation of bariatric pathway
Complete development of and implement general Weight Management plan, and roll out sessions in specific Health Centres
Complete development of diabetes pathway and roll out as appropriate

Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.
Implement podiatric aspects into falls prevention strategy.

Orthotics Service:
Development of referral criteria and introduction of self referral in line with the Allied Health Professional National Delivery Plan.

Occupational Therapy:
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community

Health Improvement:
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.

Public Health:
Team staffing restructure to achieve savings targets

Child & Family Health:
Impact of the Children and Young Person's Act 2014 and new Health Visitor pathway to be quantified and evaluated – including the workforce needed to deliver the legal requirements of the act
Redesign of the CAHMS team and links to specialist services

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.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Implement the 2015-18 Dementia Strategy Action Plan
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Increase the number of polypharmacy reviews by 20%

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Further develop model of case management within Community Nursing services
Continue to support implementation of eKIS Anticipatory Care Planning across the services

Adult Services:
Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.

Community Care Resources:
Review current models of care in Shetland to ensure sustainability of service.

Criminal Justice:
To contribute to the National outcomes, performance and improvement framework.

Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.

Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Orthotics Service:
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.

Occupational Therapy:
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Provide rapid response to A&E in order to facilitate discharge straight home
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community

Health Improvement:
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.
Community capacity building and work in partnership with voluntary sector partners.

Child & Family Health:
Redesign of the CAHMS team and links to specialist services
Move to an electronic child's record to allow the secure sharing of information between services when required under the Children and Young Person's Act (2014)

Physiological Measurements:
Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service.

Adult Social Work
Extend the input and presence of social work in localities.

Intermediate Care
Extend intermediate care model to all localities using investment opportunities and through redesign of teams.

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Mental Health:
Extend the availability and responsiveness of Out of Hours support for psychiatric emergencies
Establish a purpose built room in GBH for the management of psychiatric emergencies
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Establish and develop access to Clinical/Counselling Psychology Services
Redesign psychological therapy services and increase local capacity by training a wider range of existing staff
Implement the 2015-18 Dementia Strategy Action Plan
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress
Introduce role appropriate "Equal Partners in Care" (EPiC) training for all staff
Establish a person centred Consultation & Engagement Framework (including a Mental Health Website) to facilitate Co-Production

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Increase the number of polypharmacy reviews by 20%

Primary Care
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18
Implement agreed actions from both local and national Out of Hours reviews

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Further develop model of case management within Community Nursing services

Adult Services:
Progression of the Day Services need for new premises to replace the current EGRC

Community Care Resources:
Work with locality partnerships to plan / deliver local services.

Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Orthotics Service:
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.
Review service and implement actions to reduce the rate of non-attendees (DNAs) to below 5%, thereby making better use of professional resource.

Occupational Therapy:
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community
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.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Establish and develop access to Clinical/Counselling Psychology Services
Redesign psychological therapy services and increase local capacity by training a wider range of existing staff
Implement the 2015-18 Dementia Strategy Action Plan
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress
Establish a person centred Consultation & Engagement Framework (inc a Mental Health Website) to facilitate Co-Production

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
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Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Increase the number of polypharmacy reviews by 20%

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Further develop model of case management within Community Nursing services
Continue to support implementation of eKIS Anticipatory Care Planning across the services

Domestic Abuse:
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17

Adult Services:
Progression of the Day Services need for new premises to replace the current EGRC

Criminal Justice:
Participate in the transition phase of the Redesign of Community Justice at a local and national level.
Work with local partners and partnerships to plan / deliver local services.
Contribute to the National outcomes, performance and improvement framework.

Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Occupational Therapy:
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Provide rapid response to A&E in order to facilitate discharge straight home
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community

Health Improvement:
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.
Community capacity building and work in partnership with voluntary sector partners.

Unscheduled Care:
Review Nursing, Midwifery & Allied Health Professions (NMAHP) skill mix to support sustainable workforce (incorporating the medical staffing review)

Staff Development:
Support the delivery of Service Improvement within the Board.

Child & Family Health:
Redesign of the CAHMS team and links to specialist services
Review of available on-island paediatric outpatient care options to sustain input from medical specialist team
Move to an electronic child's record to allow the secure sharing of information between services when required under the Children and Young Person's Act (2014)

Planned Care:
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)

Physiological Measurements:
Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service.

Audiology:
Service redesign and improvement including: training one post holder to Associate Audiologist level, therefore increasing the skill mix; secure a permanent second clinical room and associated equipment for Associate Audiologist; triage of ENT referrals to help reduce ENT waits/demand; review clinic for patients fitted with cochlea implants at mainland cochlea implant centre.

5. Health and social care services contribute to reducing health inequalities.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary Community Mental Health Team (e.g. Occupational Therapy, Social Work and GP)
Redesign psychological therapy services and increase local capacity by training a wider range of existing staff
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD
Introduce role appropriate “Equal Partners in Care” (EPiC) training for all staff

Substance Misuse:
Review of Tier 1 and 2 substance misuse services

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Develop a training and support programme for Remote and Rural pharmacists

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015
Continue to support the growth of the Scalloway practice

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service

Sexual Health:
A range of initiatives to be introduced to help to reduce unplanned pregnancy

Domestic Abuse:
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17

Speech & Language Therapy:
Implement fast track referral to facilitate discharge
Implement designated phone-in advice and information sessions to ensure more efficient use of qualified Speech and Language therapy resources.
Implement monthly drop-in sessions at Independent Living Centre for patients/ parents with SLT related concern
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.

Podiatry Service:
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Orthotics Service:
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.
Implement appropriate appointment booking procedure to ensure equity of access to service.
Ensure access to service operates in line with other services in Scotland by adopting consensus documents under development by Scottish Orthotics Leads (ScOL)

Health Improvement:
Increase 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.
Community capacity building and work in partnership with voluntary sector partners.

Public Health:
Team staffing restructure to achieve savings targets

Planned Care:
Increase access to tele-health appointments to avoid unnecessary follow up and travel
Identify 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
Develop an enhanced Day Surgical Unit (DSU) and ambulatory care facility
Put in place a managed service contract for Laboratory Services (joint arrangement with NHS Grampian and NHS Orkney)

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.

Mental Health:
Introduce role appropriate “Equal Partners in Care” (EPiC) training for all staff

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Review local oral health care for people with special/ additional needs
Review local availability of specialist oral health care

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015

Adult Services:
Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.

7. People using health and social care services are safe from harm.

Mental Health:
Extend the availability and responsiveness of Out of Hours support for psychiatric emergencies
Establish a purpose built room in GBH for the management of psychiatric emergencies
Establish and develop access to Clinical/Counselling Psychology Services
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress

Substance Misuse:
Review of Tier 1 and 2 substance misuse services

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Increase the number of polypharmacy reviews by 20%

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015
Continue to support the growth of the Scalloway practice

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care
Further develop model of case management within Community Nursing services

Domestic Abuse:
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17

Nutrition & Dietetics Service
Complete and evaluate pilot training programme to care homes and roll out across care home estate**.**

Podiatry Service:
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Physiotherapy Service:
Multi-disciplinary Falls Pilot (within current resources)

Occupational Therapy:
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.

Unscheduled Care:
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)

Staff Development:
Support the delivery of Service Improvement within the Board.

Public Health:
Team staffing restructure to achieve savings targets

Child & Family Health:
Impact of the Children and Young Person's Act 2014 and new HV pathway to be quantified and evaluated – including the workforce needed to deliver the legal requirements of the act
Redesign of the CAHMS team and links to specialist services
Review of available on-island paediatric outpatient care options to sustain input from medical specialist team
Move to an electronic child's record to allow the secure sharing of information between services when required under the Children and Young Person's Act (2014)

Planned Care:
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)

Medical Imaging:
Diagnostic Imaging Equipment Replace Programme - Replacement of x-ray equipment in 2017-18
Replacement of CT scanner (by 2021)
Replacement of current ultrasound machine (by 2018)

Physiological Measurements:
Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service.

Adult Social Work
Quality assurance framework to be further developed for the service to ensure that rapid changes across the sector can be responded to in a way that minimises risks

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.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish a person centred Consultation & Engagement Framework (inc a Mental Health Website) to facilitate Co-Production

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Develop a training and support programme for Remote and Rural pharmacists

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015
Continue to support the growth of the Scalloway practice

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care
Conduct review of local District Nursing services in line with national “Transforming Nursing Roles” project
Review of skill set across Nursing and Care staff

Community Care Resources:
Review roles and responsibilities within the care sector.

Podiatry Service:
Implement podiatric aspects into falls prevention strategy.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Occupational Therapy:
Provide rapid response to A&E in order to facilitate discharge straight home

Occupational Health:
Introduction of Fit for Work Service

Staff Development:
To support the continued mainstreaming and embedding of the NHS Knowledge and Skills Framework (KSF) and Personal Development Review (PDR) process
Support the delivery of Service Improvement within the Board.

Child & Family Health:
Redesign of the CAHMS team and links to specialist services
Review of available on-island paediatric outpatient care options to sustain input from medical specialist team
Move to an electronic child's record to allow the secure sharing of information between services when required under the Children and Young Person's Act (2014)

Audiology:
Service redesign and improvement including: training one post holder to Associate Audiologist level, therefore increasing the skill mix; secure a permanent second clinical room and associated equipment for Associate Audiologist; triage of ENT referrals to help reduce ENT waits/demand; review clinic for patients fitted with cochlea implants at mainland cochlea implant centre.

9. Resources are used effectively and efficiently in the provision of health and social care services.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish a person centred Consultation & Engagement Framework (inc a Mental Health Website) to facilitate Co-Production

Substance Misuse:
Review of Tier 1 and 2 substance misuse services

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Increase the number of polypharmacy reviews by 20%

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015
Continue to support the growth of the Scalloway practice.
Identify permanent arrangements for Practice Management at the Lerwick Health Centre, utilising the capacity across all salaried practices to support primary care management of services
Review the skill mix required in the Lerwick Health Centre following the extension of the ANP model, to ensure efficiency and to identify opportunity for savings

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care
Further develop model of case management within Community Nursing services
Continue to support implementation of eKIS Anticipatory Care Planning across the services
Review of skill set across Nursing and Care staff

Domestic Abuse:
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17

Adult Services:
Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.

Community Care Resources:
Review current models of care in Shetland to ensure sustainability of service.
Sector review of procedures and processes

Criminal Justice:
Review of processes and procedures to ensure they remain fit for purpose.
Continue to promote increased use of fiscal and police direct measures.

Speech & Language Therapy
Implementation of designated phone-in advice and information sessions to ensure more efficient use of qualified Speech and Language therapy resources.
Implementation of monthly drop -in sessions at Independent Living Centre for patients/ parents with SLT related concern.
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.

Nutrition & Dietetics Service
Design web page on the Dietetic service including referral criteria and pathways for all referring clinicians.

Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Orthotics Service:
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.
Continue to review and revise technician's activity to release time to service community equipment, thereby reducing spend on community equipment.
Development of referral criteria and introduction of self referral in line with the Allied Health Professional National Delivery Plan.
Ensure access to service operates in line with other services in Scotland by adopting consensus documents under development by ScOL

Physiotherapy Service:
Review of neurophysiotherapy service
Review of physiotherapy musculoskeletal outpatients service

Occupational Therapy:
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Provide rapid response to A&E in order to facilitate discharge straight home
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community
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.

Health Improvement:
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.
Community capacity building and work in partnership with voluntary sector partners.

Unscheduled Care:
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)
Reviewing out of hours service provision (including medical staffing, primary care configuration and locality based services)
Reviewing the management structure for Acute & Specialist Services
Reviewing the management structure for Community Care services

Occupational Health:
Introduction of Fit for Work Service

Staff Development:
Support the delivery of Service Improvement within the Board.

Public Health:
Team staffing restructure to achieve savings targets

Child & Family Health:
Impact of the Children and Young Person's Act 2014 and new HV pathway to be quantified and evaluated – including the workforce needed to deliver the legal requirements of the act
Redesign of the CAHMS team and links to specialist services
Review of available on-island paediatric outpatient care options to sustain input from medical specialist team
Development of Joint commissioning and joint budgeting for Integrated Children's Services
Move to an electronic child's record to allow the secure sharing of information between services when required under the Children and Young Person's Act (2014)

Planned Care:
Increase access to tele-health appointments to avoid unnecessary follow up and travel
Increase capacity in the renal unit to meet demand

Identify 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
Develop an enhanced Day Surgical Unit (DSU) and ambulatory care facility
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)
Put in place a managed service contract for Laboratory Services (joint arrangement with NHS Grampian and NHS Orkney)
Review the management structure for Acute & Specialist Services

Medical Imaging:
Reviewing the medical imaging staffing skill mix and team structure
Diagnostic Imaging Equipment Replace Programme - Replacement of x-ray equipment in 2017-18
Replacement of CT scanner (by 2021)
Replacement of current ultrasound machine (by 2018)

Physiological Measurements:
Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service.

Audiology:
Service redesign and improvement including: training one post holder to Associate Audiologist level, therefore increasing the skill mix; secure a permanent second clinical room and associated equipment for Associate Audiologist; triage of ENT referrals to help reduce ENT waits/demand; review clinic for patients fitted with cochlea implants at mainland cochlea implant centre.

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	4 February 2016
Report Title:	IJB Business Programme 2016/17
Reference Number:	IJB-1617 dates *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 financial year to 31 March 2017, 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 financial year to 31 March 2017, 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 assumed responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting on 24 November 2015. 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 2016/17 as set out in this report.
Previously considered by:	The Business Programme for 2015/16 was considered by the IJB at its meeting on 24 November 2015.

END

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	4 February
Report Title:	IJB Business Programme 2016/17
Reference Number:	IJB-1617-dates
Author / Job Title:	Jan Riise, Executive Manager – Governance and Law

1. Introduction

1.1 This report presents a draft IJB Business Programme 2016/17 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 2017 for the IJB to consider and advise regarding any changes or additions required to that programme.

2.2 The Business Programme will be presented on a quarterly basis for discussion and approval.

3. Establishing the IJB Business Programme for 2016/17

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.

- 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 2017, and RESOLVES to approve any changes or additions to the Business programme.

4. Conclusions

4.1 The presentation of the IJB Business Programme for 2016/17 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:
For further information please contact:
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1 February 2016

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, 01 February 2016

Integration Joint Board		
Quarter 1 1 April 2016 to 30 June 2016	**Date of Meeting**	**Business**
	Wednesday 27 April 2016 at 2 p.m.	• Delays in Discharge from Hospital to Community Setting • Equality Outcomes • Update on Lerwick Health Centre Action Plan • Audit Scotland Care Inspectorate Reports • Area Management • Action Plan: Mental Health Review • 2016/17 Business Programme
	Wednesday 8 June 2016 at 2 p.m.	• Performance Report • Audit Commission report on health and social care integration • 2016/17 Business Programme
	Friday 24 June 2016 at **12 Noon**	• Draft 2015/16 Accounts
Quarter 2 – 1 July 2016 to 30 September 2016	Wednesday 7 September 2016 at 2 p.m.	• Delays in Discharge from Hospital to Community Setting • Audit Scotland Care Inspectorate Reports • LUCAP 2015/16 • Update on Lerwick Health Centre Action Plan • Care Inspectorate and Healthcare Improvement Scotland Joint Inspection of health and social work services for older people in Shetland • Q1 Financial Accounts • 2016/17 Business Programme
	Friday 23 September 2016 at **12 Noon**	• Final 2015/16 Accounts
Quarter 3 - 1 October to 31 December 2016	Wednesday 23 November at 2 p.m.	• Winter Plan • Public Health Annual Report • Q2 Financial Accounts • Directorate Plan 2017-18 • 2016/17 Business Programme
	Friday 9 December 2016 at 2 p.m.	• Budget 2017/18
Quarter 4 1 January 2017 to 31 March 2017	Wednesday 25 January 2017 at 2 p.m.	• Delays in Discharge from Hospital to Community Setting • Audit Scotland Care Inspectorate Reports • Update on Lerwick Health Centre Action Plan • 2016/17 Business Programme
	Wednesday 15 March 2017 at 2 p.m.	• Q3 Financial Accounts

Planned business still to be scheduled - as at Monday, 01 February 2016

None

END OF BUSINESS PROGRAMME as at Monday, 01 February 2016

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, 01 February 2016

IJB Audit Committee		
Quarter 1 1 April 2016 to 30 June 2016	**Date of Meeting**	**Business**
	Friday 27 May 2016 at 11 a.m.	• 2016/17 Internal Audit Plan
	Friday 24 June 2016 at 11 a.m.	• Draft 2015/16 Accounts
Quarter 2 – 1 July 2016 to 30 September 2016	Friday 26 August 2016 at 11 a.m.	
	Friday 23 September 2016 at 11 a.m.	• Final 2015/16 Accounts
Quarter 3 - 1 October to 31 December 2016	Friday 11 November at 11 a.m.	
Quarter 4 1 January 2017 to 31 March 2017	Friday 3 March 2017 at 11 a.m.	

Planned business still to be scheduled - as at Monday, 01 February 2016
None
END OF BUSINESS PROGRAMME as at Monday, 01 February 2016