Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	External Audit Reports – Care Inspectorate
Reference Number:	CC-19-16-F
Author / Job Title:	Denise Morgan- Executive Manager Community Care Resources

Decisions / Action required:

The IJB considers the reports on the above services and agrees that the required actions of each care home will be monitored by the Executive Manager Community Care Resources.

High Level Summary:

This report presents the findings of the Care Inspectorate's unannounced full inspections of Edward Thomason & Taing Support Service, Fernlea Care Home, Nordalea Care Home, Overtonlea Care Home and Walter & Joan Gray Care Home. It also includes an update on the follow up inspection of Islehavn Care Home and North Haven Care Home.

All establishments that were subject to the full inspection received grades of good or very good. Those subject to follow up inspections have not been regraded at this stage.

Those establishments who have received recommendations for improvement have submitted electronic action plans. These plans will be monitored by the Executive Manager Community Care Resources.

Corporate Priorities and Joint Working:

Shetland Single Outcome Agreement 2013:

- We have supported people to achieve their full potential at all life stages – from birth and early years through working lives to old age.

Community Health and Social Care Directorate Plan has the following relevant priorities:

- Developing person-centred services, with personalisation driving the shape of all public services and a strong focus on developing a person centred approach to care and care planning.
- Implementing changes to services and our workforce to support the delivery of safe, efficient, sustainable services.

Key Issues:

The inspection reports provide independent evidence of the good standard of care being provided by Shetland Islands Council and its commissioned service. Action plans have been submitted for all recommendations made.

Implications :	
Service Users, Patients and Communities:	The Care Inspectorate seeks views and feedback from service users and family members as part of the inspection process. Inspection reports are available to the general public through the Care Inspectorate website and customer and family members are made aware of this. Paper copies can also be provided on request. Actions arising from the inspections will assist with service improvement and ensure the best possible outcomes for service users, families and the community.
Human Resources and Organisational Development:	The delivery of good quality care services is dependent on well trained and supported employees. The service will work closely with Human Resources to ensure that all staff within the different service areas receives appropriate support and guidance in performance management and that recruitment systems are robust and effective. We will work closely with the Workforce Development service to ensure that training and development is provided that meets the needs of individuals and the service.
Equality, Diversity and Human Rights:	Shetland's Joint Strategic (Commissioning) Plan supports and promotes equalities, health and human rights.
Legal:	There are no implications for legal.
Finance:	Is intended that all improvements will be achieved within current budget.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The Council has a statutory duty to ensure that local authority care homes are registered and adhere to care standards. Failure to meet care standards could result in closure of establishments. The testing of equipment and records of maintenance and monitoring conform to best practice guidance. The Council also has a number of Health and Safety policies and procedures in place to support the service where necessary.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration

	Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility for operational oversight of the day care and care home/residential services for adults
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

1

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	External Audit Reports – Care Inspectorate
Reference Number:	CC-19-16-F
Author / Job Title:	Denise Morgan – Interim Executive Manager Community Care Resources

1. Introduction

1.1 The purpose of this report is to present to the Integration Joint Board the findings of the Care Inspectorate's unannounced Full Inspections of ET & Taing, Fernlea, Nordalea, Overtonlea and Walter & Joan Gray Care Home Services. There are also two follow up inspections for Isleshavn and North Haven Care Homes.

2. Background

2.1 The following establishments inspection reports can be found on the Care Inspectorate website:

- Walter & Joan Gray Care Home Service: Unannounced Full Inspection 14 October 2015 http://www.careinspectorate.com/index.php/index.php/care-services/#inspection-reports
- Nordalea Care Home Service: Unaccounced Full Inspection 15 October 2015 http://www.careinspectorate.com/index.php/index.php/care-services/#inspection-reports
- ET & Taing Care Home Service: Unannounced Full Inspection 1 December 2015 http://www.careinspectorate.com/index.php/index.php/care-services/#inspection-reports
- Overtonlea Care Home Service: Unannounced Full Inspection 10 December 2015 http://www.careinspectorate.com/index.php/index.php/care-services/#inspection-reports
- Fernlea Care Home Service: Unannounced Full Inspection 11 December 2015 http://www.careinspectorate.com/index.php/index.php/care-services/#inspection-reports

- North Haven Care Home Service: Unannounced Follow Up Inspection 29 January 2016 http://www.careinspectorate.com/index.php/index.php/care-services/#inspection-reports

- Islehavn Care Home Service: Unannounced Follow Up Inspection 11 February 2016 http://www.careinspectorate.com/index.php/index.php/care-services/#inspection-reports

2.2 The level of full inspections carried out were low intensity. Low intensity inspections are undertaken when the Inspectorate is satisfied that services are working hard to provide consistent standards of good care. The grades across the four quality themes range from Very Good to Good.

2.3 Follow Up Inspections take place when establishments have received an adequate score in their full Inspection.

2.4 The Walter and Joan Gray Home is run by Crossreach and its day care and residential services are commissioned by Shetland Islands Council. The Home is producing good grades and any recommendations made are monitored as part of the Service Level Agreement.

2.5 All service areas are committed to continuous improvement and strive to provide the best possible service. A table of current and previous grades is attached in Appendix One. Individual service summaries, recommendations and actions are recorded in Appendix Two.

2.6 During the past six months the community care resource service has implemented a supervision procedure and audit and monitoring tool, which has helped improve consistency across the locality areas. A quality assurance procedure is due to be implemented over the next 4 weeks. Training is being delivered on having strength based conversations and recording outcome based assessments as part of the implementation of the new Understanding You assessment. Staff have welcomed this training and we hope to do something similar when the review of support plans is complete.

3. Conclusions

3.1 The inspection reports are an essential component of the Council's ability to monitor the provision of care across Shetland. The attached reports highlight the positive aspects of care, improvements made and areas for development across the different service areas. These inspections follow on from some significant difficulties faced within the care sector and the findings are a testament to the staff's hard work and commitment to continuous improvement and the provision of quality services. The recommendations are duly noted and progress will be monitored by the Executive Manger Community Care Resources and through follow up inspections.

Contact Details:

For further information, contact:
Denise Morgan, Interim Executive Manager Community Care Resources
denise.morgan@shetland.gov.uk
Telephone: 01595 744449

8 March 2016

Appendices
Appendix 1 – Table of Grades 2015-16
Appendix 2 – Service Summaries and Recommendations

APPENDIX ONE

Table of Grades 2015-16

Service	Quality of Care and Support	Previous Grade	Quality of Environment	Previous Grade	Quality of Staffing	Previous Grade	Quality of Management and Leadership	Previous Grade
Nordalea Care Home Service	5 Very Good	4 Good	5 Very Good	4 Good	4 Good	4 Good	4 Good	4 Good
ET & Taing Care Home Service	4 Good	4 Good	5 Very Good	4 Good	4 Good	4 Good	4 Good	4 Good
Overtonlea Care Home Service	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good
Fernlea Care Home Service	4 Good	4 Good	5 Very Good	5 Very Good	4 Good	4 Good	4 Good	4 Good
North Haven Care Home Service		3 Adequate		4 Good		3 Adequate		3 Adequate
Islehavn Care Home Service		3 Adequate		4 Good		4 Good		4 Good
Walter & Joan Gray Care Home Service	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good

Appendix 2

Individual Inspection Summaries

Nordalea Care Home Summary

Service Grades:

Quality of Care and Support: 5 Very Good
Quality of Environment: 5 Very Good
Quality of Staffing: 4 Good
Quality of Management and Leadership: 4 Good

What the service does well: Interactions between residents and staff were respectful, friendly and supportive. Staff were caring and understanding in their approach.

What the service could do better: There is a continued need to ensure residents stay at Nordalea remains meaningful and supportive.

What the service has done since the last inspection: There were no recommendations made following the previous inspection visit. The service continues to deliver a very good standard of care to those who access the various strands of the service.

Conclusion: Residents found the staff and management supportive, kind and helpful. The service continues to deliver a very good service which is appreciated by the residents. The service continues to support and enable very good local community involvement.

Recommendations: None made

ET & Taing Care Home Summary

Service Grades:

Quality of Care and Support: 4 Good
Quality of Environment: 5 Very Good
Quality of Staffing: 4 Good
Quality of Management and Leadership: 4 Good

What the service does well: The service, staff team and management work hard to listen and respond to the views of residents and their representatives. Residents and relatives' said staff and management were kind and helpful and improvements had been made in supporting people with more complex needs.

What the service could do better: The management team should continue with their plans to improve opportunities, ensuring residents days are meaningful. There needs to be more standardisation between the combined services to aid communication.

What the service has done since the last inspection: The service is more stable and despite some staffing difficulties, there have been continued improvements though the management team have recognised that there is a need to make further improvements and are working towards this. The management team were keen to progress with this as were the staff team.

Appendix 2

Conclusion: The management and staff were caring in their approach and committed to improving the quality of the service and were open to suggestions.

Recommendations made: The management and staff must review present provision for interests and activities, ensuring that there are opportunities for interests to be supported individually and that outcomes are monitored better. The team must ensure that interests are person-centred and meaningful.

Action: Questionnaire to all stakeholders for input on how best to support interests and activities. Key workers to review individual social interests and ensure they are recorded in care records.

The service continues with the plans to make improvements with standardisation across the service, including supervision and practice. The Responsible Person (RP) duties should be reviewed by detailing all aspects of the additional responsibilities and expectations of the service.

Action: Review of processes across the service; rota review to ensure appropriate skill mix and guidance folder established for Responsible Person duties.

Overtonlea Care Home Summary

Service Grades:

Quality of Care and Support: 4 Good
Quality of Environment: 4 Good
Quality of Staffing: 4 Good
Quality of Management and Leadership: 4 Good

What the service does well: There is a warm welcoming atmosphere within the home and staff are very supportive to the needs of residents and their families.

What the service could do better: The service could further develop staff supervision to have more of a reflective practice approach. The service should continue with the present plans to develop team and keywork meetings.

What the service has done since the last inspection: All recommendations made from the following inspection have been met and the service continues to develop and is keen to make improvements with regard to supervision, team meetings and meaningful days for residents.

Conclusion: This is a service that continues to deliver a good standard of care. The residents are supported to maintain relationships with family, friends and the local community.

Recommendations: The staff team should continue with the present approach to ensure residents' days are meaningful and person centred.

Action: Introduction of person centred outcome focussed support plans; continuation of Playlist for life project and further training and better recording of meaningful activity.

Appendix 2

Fernlea Care Home Summary

Service Grades:

Quality of Care and Support: 4 Good
Quality of Environment: 5 Very Good
Quality of Staffing: 4 Good
Quality of Management and Leadership: 4 Good

What the service does well: There is a welcoming atmosphere within the home and staff are very supportive to the needs of residents and their families.

What the service could do better: The service should review the present senior post roles and responsibilities for the shared post of residential and care at home services, and ensure there is appropriate support and time allocated to carry out the dual role.

The service should continue to develop localised protocols between the home and community health services. The service should implement the forthcoming new support plan documentation as soon as possible.

What the service has done since the last inspection: The staff have held various fundraising events to improve the home environment. This has resulted in the development of the inner courtyard area within the home.

The service continues to develop and is keen to make improvements with regard to practice, supervision and meaningful days for residents. The staff continues to promote meaningful participation to involve stakeholders in accessing and improving the service.

Conclusion: The service continues to deliver a good standard of care. The residents are supported to maintain relationships with family, friends and the local community. The management team are keen to make improvements within the service and promote good practice.

Recommendations: None made.

North Haven Care Home Summary

The follow up inspection focussed on the requirements and recommendations made on the 27th August 2015. This is as follows:

Requirement 1: The provider must make sure staff understand their roles and responsibilities and ensure safe medication administration practices. Appropriate and regular audit systems must be put into place to note concerns, issues and omissions and take relevant action to address issues.

Following the last inspection the management team drew up an action plan to address the shortfalls. It was evidenced that the senior team were performing better as a team and roles and responsibilities were clearer. Audit and monitoring systems are now in place and care staff had completed medication administration refresher training. It was evidenced that improvements had been made and regular audits were undertaken. This recommendation has been met within timescales provided

Appendix 2

Requirement 2: The provider must ensure that effective arrangements are in place to identify the health, welfare and safety needs of residents, and to monitor how well those needs are met:

Audit and monitoring systems are now in place and care plans have been updated. Improvements have been made with the care plan recording and they are now more person-centred. The recommendation has been met within timescales provided

Recommendation 1: The management and staff team should continue with the work with support plans to ensure the improvements continue.

The inspector noted that there had been an improvement and keywork staff were working on further developing the support plans: The recommendation has been met

Recommendation 2: The management staff must review the present provision for interests and activities, ensuring that there are opportunities for interest to be supported individually and that outcomes are monitored better. The team must ensure that interests are person-centred and meaningful.

The key work staff have worked hard to bring the care plans up to a better standard. Care plans were more detailed and highlighted what makes residents' days more meaningful. This recommendation has not been fully met as work continues to further develop both the care plans and meaningful days. This recommendation has been reinstated to ensure the work continues.

Recommendation 3: The service should ensure any charts or logs are accurate and regularly audited.

This recommendation has been met though monitoring and auditing must continue.

Recommendation 4: An audit should be undertaken of staff 'Continuing Professional Development' (CPD) to ensure employees are up to date with training. Training must be specific to the service in order to meet the needs of service users.

Regular supervision was now being held and an audit had been carried out of staff training needs. A plan had been put into action and additional training would be held over the forthcoming year. This recommendation has been met.

Recommendation 5: The management and staff team must continue the work and implementation of the audit and monitoring tools to ensure there is continuity and consistency across the service including the development of quality indicators.

This recommendation has been met.

Recommendation 6: The manager must ensure that an appropriate supervision system is in place for senior staff and an audit should be undertaken by the management team to look at remit of roles and expectations of staff in order to clarify and highlight tasks and specific responsibilities.

Improvements had been made, the manager was now holding regular supervision sessions with senior staff and general improvements had been made across the service. This recommendation has been met.

Appendix 2

Islehavn Care Home Summary

The follow up inspection focussed on the requirements and recommendations made on the 10 August 2015. This is as follows:

Recommendation 1: The staff team should continue to make progress within this area ensuring residents' days are meaningful.

Whilst some improvements were noted in care plan recording the recording and development of meaningful days has not been as good. The staff said they were keen to make improvements and further develop care plans to highlight what makes residents' days meaningful. This recommendation has not been fully met and will be closely monitored at the next inspection.

Walter & Joan Gray Support Services Summary

Service Grades:

Quality of Care and Support: 4 Good
Quality of Environment: 4 Good
Quality of Staffing: 4 Good
Quality of Management and Leadership: 4 Good

What the service does well: Residents said that staff were kind and helpful and this observation had been made. Positive feedback had been received from relatives.

What the service could do better: The management team must ensure that there is a robust system in place to ensure that medication administration is properly recorded and regularly audited.

What the service has done since the last inspection: The management team have recognised that there is a need to make further improvements and are working toward this. The management team are keen to progress with this as were the staff team.

Conclusion: The management team recognised that there was a need to improve the service and build on successes made.

Requirement 1: The staff and management must ensure that residents' days are meaningful and there continues to be opportunities to support interests.

The provider must make sure staff understand their roles and responsibilities and ensure safe medication administration practices. Appropriate and regular audit systems must be put into place to note concerns, issues and omissions and take relevant action to address issues.

Action: Medication training is being delivered by the NHS Principal Pharmacist and this will audited by the management team. A daily audit has been established to rectify any errors and highlight which employees require more support.

Recommendation 1: The staff and management must ensure that residents' days are meaningful and there continues to be opportunities to support interests.

Appendix 2

Action: An activities coordinator has been established and individual interest checklists are being created. A meeting with the Friends Group has taken place and the home has stressed the importance of residents being visited by friends.

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Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	External Audit Reports – Care Inspectorate Newcraigielea Services
Reference Number:	CC-24-16 F
Author / Job Title:	Clare Scott, Executive Manager Adult Services

Decisions / Action required:

That the Integration Joint Board considers the reports on the above services and notes the standards of care provided by these services.

High Level Summary:

This report presents the findings of the Care Inspectorate's unannounced inspections of:

- Newcraigielea Care Home Service (Short Break and Respite)
- Newcraigielea Support Service (Day Care)

Newcraigielea provides short break and respite services and day care services for adults with learning disability, autistic spectrum disorder and multiple complex needs.

The full inspection reports can be found on the Care Inspectorate website:

Newcraigielea Care Home Service;
http://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=279192

Newcraigielea Support Services;
http://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=280918

Both services have received overall grades of Grade 4 – Good across Quality Themes. No requirements or recommendations were made. Recommendations made following the last inspection on 3 February 2015 have been met. Newcraigielea Services, with support from the Executive Manager Adult Services, should continue to monitor quality and performance to maintain and build on the good level of person-centred service provided.

Corporate Priorities and Strategic Aims:

Community Health and Social Care Joint Strategic (Commissioning) Plan Summary 2016–19: 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.

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.
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.http://www.shetland.gov.uk/Health_Social_Care_Integration/StrategicPlan.asp

Shetland Islands Council. Our Plan 2016 – 2020:
People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer.

Our Integrated Health and Social Care services will be providing the services people need in a more efficient way, improving standards of care and keeping people healthier for longer. http://www.shetland.gov.uk/documents/OurPlan2016-20final.pdf

Key Issues:

Newcraigielea Care Home Service (Short Break and Respite) and Newcraigielea Support Service (Day Care) services received overall grades of Grade 4 – Good across Quality Themes. No requirements or recommendations were made. Newcraigielea Services should continue to maintain and build on the good level of person-centred services they provide.

Implications :	
Service Users, Patients and Communities:	Each service area is inspected on a regular basis by the Care Inspectorate to ensure care standards are being met. Both service areas inspected received Grade 4 – Good in relation to quality of care and support; environment; staffing; management and leadership. No requirements or recommendations were made
Human Resources and Organisational Development:	No implication for Human Resources and Organisational Development.
Equality, Diversity and Human Rights:	The Council and Health Board are required to make sure that systems are monitored and assessed for any implications in this regard. Shetland's Joint Strategic (Commissioning) Plan supports and promotes equalities, health and human rights.

Partnership Working	The good standard provided supports individuals who access the services and those who provide unpaid care. People who use health and social care services have positive experiences of those, and have their dignity respected services (Health and Wellbeing Outcome 3). 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. (Health and Wellbeing Outcome 6). The Care Inspectorate seeks views and feedback from service users and family members as part of the inspections. Inspection reports are available to the general public through the Care Inspectorate website and customers and family members are made aware of this. Paper copies can also be provided on request.
Legal:	No Legal implications arising from this report.
Finance:	No financial implication arising from this report.
Assets and Property:	No Assets and Property implications arising from this report.
Environmental:	No Environmental implications arising from this report.
Risk Management:	There are no Risk Management Implications arising from this report.
Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility and oversight of short break, respite and day care services for adults.
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

2

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	External Audit Reports – Care Inspectorate Newcraigielea Services
Reference Number:	CC-24-16 F
Author / Job Title:	Clare Scott, Executive Manager Adult Services

1. Introduction

1.1 This report presents the findings of the Care Inspectorate's unannounced inspections of:

- Newcraigielea Care Home Service (Short Break and Respite) for adults with learning disability, autistic spectrum disorder and multiple complex needs.

- Newcraigielea Support Service (Day Care) for adults with learning disability, autistic spectrum disorder and multiple complex needs.

2. Background

2.1 Care services in Scotland cannot operate unless they are registered with the Care Inspectorate. The Care Inspectorate inspect and grade elements of care under four quality themes; Quality of care and support; Quality of environment; Quality of staffing; Quality of management and leadership. Under each quality theme are 'quality statements' against which services are inspected and graded. Any improvements are set out as a 'Recommendation' which sets out an action that a care service provider should take; or as a 'Requirement' which sets out what a care service must do to improve outcomes for people who use services.

3. Inspections

3.1 The following establishments were inspected and the full inspection reports can be found on the Care Inspectorate website:

- Newcraigielea Care Home Service (Short Break and Respite): Unannounced inspection, Monday 28 September 2015 to Thursday 1 October 2015 and concluded their inspection on the Tuesday 6 October 2015
  http://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=279192

- Newcraigielea Support Service (Day Care): Unannounced inspection on Thursday 28 January 2016 and Wednesday 3 February 2016
  http://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=280918

The level of inspections carried out in both service areas was low intensity. Low intensity inspections are undertaken when the Inspectorate is satisfied that services are working hard to provide consistent standards of care.

3.2 **Newcraigielea Care Home Service**
Newcraigielea is a purpose-built short stay and respite facility for people with learning disabilities, autism spectrum disorder and multiple complex needs located in the Seafield area of Lerwick. The accommodation is modern, accessible and spacious in design.

The care service is registered to provide a respite service to a maximum of nine people. Both the respite and day care services share the same staff and management. Newcraigielea Care Home Service was awarded the following grades:

- Quality Theme 1: Quality of Care and Support
  Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service*." Grade 4 – Good
  Statement 3 - "*We ensure that service users' health and wellbeing needs are met*." Grade 5 - Very Good
  Statement 5 - "*We respond to service users' care and support needs using person centred values*." Grade 4 – Good

  Overall grade awarded for this theme: 4 – Good

- Quality Theme 2: Quality of Environment

Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of the environment within the service*." Grade 4 – Good
Statement 3 - "*The environment allows service users to have as positive a quality of life as possible*." Grade 5 - Very Good

Overall grade awarded for this theme: 4 – Good

- Quality Theme 3: Quality of Staffing-
  Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of staffing in the service*" Grade 4 – Good
  Statement 3 - "*We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice*" Grade 4 – Good
  Statement 4 - "*We ensure that everyone working in the service has an ethos of respect towards service users and each other*." Grade 4 – Good

  Overall grade awarded for this theme: 4 – Good

- Quality Theme 4: Quality of Management and Leadership
  Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service*." Grade 4 - Good
  Statement 4 - "*We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide*" Grade 4 - Good

  Overall grade awarded for this theme: 4 – Good

The inspection noted that staff and management team were working better together to ensure good outcomes for service users. The service continues to develop and implement audit tools. The service should continue with the improvements that have been made and build on these successes. Two recommendations were made following the last inspection on 3rd February 2015 both have been met.

3.3 **Newcraigielea Support Service**
Newcraigielea is a purpose-built service which includes day care. The accommodation is modern, accessible and spacious in design. The care service is registered to provide a support service to a maximum of 10 adults with learning disability, autistic spectrum disorder and multiple complex needs. Day care services include the 'Gold Group' which operates during the week. This group creates opportunities for an older client group to access a quieter, relaxed, social activities based service.

Both services (care home service and support service) share the same staff and management system.

Newcraigielea Support Service was awarded the following grades:

- Quality Theme 1: Quality of Care and Support
  Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.*" Grade 4 – Good
  Statement 3 - "*We ensure that service users' health and wellbeing needs are met.*" Grade 5 - Very Good
  Statement 5 - "*We respond to service users' care and support needs using person centred values*." Grade 4 – Good

  Overall grade awarded for this theme: 4 – Good

- Quality Theme 2: Quality of Environment
  Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of the environment within the service*." Grade 4 – Good
  Statement 3 - "*The environment allows service users to have as positive a quality of life as possible*." Grade 4 - Good

  Overall grade awarded for this theme: 4 – Good

- Quality Theme 3: Quality of Staffing
  Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of staffing in the service*."
  Grade 4 – Good
  Statement 3 - "*We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.*" Grade 4 – Good
  Statement 4 - "*We ensure that everyone working in the service has an ethos of respect towards service users and each other*." Grade 4 – Good

  Overall grade awarded for this theme: 4 – Good

- Quality Theme 4: Quality of Management and Leadership
  Statement 1 - "*We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service*." Grade 4 - Good
  Statement 4 - "*We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide*" Grade 4 - Good

  Overall grade awarded for this theme: 4 – Good

The inspection found that staff structure, internal auditing and planning of the support service has improved. Staff are more confident in supporting and developing the service and there are better opportunities for service users in order to make their day meaningful. Staff and management should continue with the present approach to ensure service users receive a person-centred service. Recommendations made following the last inspection in February 2015 have been met.

4. Conclusions

A table of current and previous grades is attached in Appendix One. Inspection reports are an essential component of the Integration Joint Board's ability to monitor the provision of care across Shetland.

Newcraigielea Care Home Service and Newcraigielea Support Service have both received an overall Grade 4 – Good across all Quality Themes. Since the last inspection the grade awarded for Quality Theme 4: Quality of Management and Leadership has improved from Grade 3 – Adequate to Grade 4 – Good. No requirements or recommendations were made in either inspection reports.

Newcraigielea Services are committed to continuous improvement and strive to provide the best possible service. The inspection reports highlight the positive aspects of care and improvements made.

Contact Details:
Clare Scott,
Executive Manager Adult Services,
clare.scott@shetland.gov.uk
2 April 2016

Appendices:
Appendix 1 - Newcraigielea Care Home Service and Newcraigielea Support Service Inspection and Grading History

Background Documents:
Newcraigielea Care Home Service (Short Break and Respite): Inspection report available at:
http://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=279192

Newcraigielea Support Service (Day Care): Inspection report available at:
http://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=280918

Appendix 1 - Newcraigielea Care Home Service and Newcraigielea Support Service Inspection and Grading History

Newcraigielea Care Home Service		
Date	Type	Gradings
6 Oct 2015	Unannounced	Care and support 4 - Good Environment 4 - Good Staffing 4 - Good Management and Leadership 4 - Good
3 Feb 2015	Announced (Short Notice)	Care and support 5 - Very Good Environment 4 - Good Staffing 4 - Good Management and Leadership 3 - Adequate
7 Nov 2014	Unannounced	Care and support 4 - Good Environment 4 - Good Staffing 4 - Good Management and Leadership 3 - Adequate
10 Dec 2013	Unannounced	Care and support 4 - Good Environment 4 - Good Staffing 4 - Good Management and Leadership 3 - Adequate
17 May 2013	Unannounced	Care and support 4 - Good Environment 4 - Good Staffing 4 - Good Management and Leadership 3 - Adequate
13 Dec 2012	Unannounced	Care and support 3 - Adequate Environment 4 - Good Staffing 3 - Adequate Management and Leadership 3 - Adequate
10 Dec 2010	Unannounced	Care and support 5 - Very Good Environment Not Assessed Staffing Not Assessed Management and Leadership Not Assessed
Newcraigielea Support Service		
3 Feb 2016	Unannounced	Care and support 4 - Good Environment 4 - Good Staffing 4 - Good Management and Leadership 4 - Good
3 Feb 2015	Announced (Short Notice)	Care and support 4 - Good Environment 4 - Good Staffing 4 - Good Management and Leadership 3 - Adequate
17 Jan 2012	Unannounced	Care and support 4 - Good Environment Not Assessed Staffing Not Assessed Management and Leadership 4 - Good
2 Jul 2010	Announced	Care and support 5 - Very Good Environment Not Assessed Staffing 5 - Very Good Management and Leadership 5 - Very Good

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Action Plan: Mental Health Review (2013)
Reference Number:	CC-21-16-F
Author / Job Title:	David Morgan / Service Manager Mental Health

Decisions / Action required:

That the Integration Joint Board review and discuss the content of the Mental Health Review (2013) Action Plan and agree that a refreshed and updated Mental Health Action Plan is presented to the IJB in six months from the date of this meeting.

High Level Summary:

The Mental Health Review (2013) Action Plan was originally developed in response to a review of Shetland's Mental Health services undertaken in the latter part of 2013. Since then, the plan has undergone a series of revisions in response to a fast changing strategic and operational environment. As a consequence of the developments some actions have been delayed and/or become redundant. A new and refreshed plan will be developed to reflect the current situation. It will set out the key actions for 2016/17 and align these to the content in the Strategic Plan for 2016-19.

Corporate Priorities and Joint Working:

The Mental Health Review (2013) Action Plan was jointly commissioned by NHS Shetland and Shetland Islands Council as part of Shetland Health and Social Care Partnership. The actions identified in the Plan reflected the Council and Health Board commitment to work together to deliver quality services for the Shetland community.

Key Issues:

- There have been difficulties in procuring clinical psychology services and these have contributed to long waits for some conditions.
- Achieving safe and sustainable staffing levels has been a significant factor in the development of an agreed Psychiatric Emergency Plan (PEP).
- The recently appointed Clinical Director for Mental Health has recommended additional service review and redesign work.
- The current Action Plan needs to be refreshed to take account of the rapidly evolving needs and priorities of mental health service delivery in Shetland.

Implications :	
Service Users, Patients and Communities:	Successful implementation of the Mental Health Review (2013) Action Plan will deliver necessary improvements to Shetland's mental health services and contribute to improved outcomes for service users, patients and the community.
Human Resources and Organisational Development:	Shetland's mental health services are in a period of sustained change and redesign. Consultation and engagement with staff and other stakeholders remains vital to the maintenance of staff welfare and service morale. Any changes required by redesign will be subject to full engagement with staff and their representatives in both NHS Shetland and Shetland Islands Council.
Equality, Diversity and Human Rights:	The Council and Health Board are required to ensure that systems are monitored and assessed for any implications in this regard. The objectives of the Mental Health Review (2013) Action Plan support and promote equalities, health and human rights.
Legal:	The Mental Health (Care and Treatment) (Scotland) Act 2003, assigns specific responsibilities to the Local Authority and the Health Board for the care and treatment of people with a mental disorder.
Finance:	Any costs associated with the development and maintenance of the Action Plan will be met from within existing budgets of the Community Health and Social Care Directorate.
Assets and Property:	The plan does have implications for the use of existing property. Risks associated with the need for and use of assets and property will be recorded in the appropriate risk registers maintained by the Council and the Health Board and reported to the IJB where relevant to the delegated functions.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Embedding a culture of continuous improvement and customer focus are key aspects of the Council's and Health Board's improvement activity. Effective performance management is an important component of that activity and requires the production and consideration of these reports. Failure to promote and embed a continuous improvement culture increases the risk of the Council and NHS Shetland working inefficiently, failing to focus on customer needs and being subject to negative external scrutiny.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration

	Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility for operational oversight of a range of integrated mental health services which support adult service users in Shetland.
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Action Plan: Mental Health Review (2013)
Reference Number:	CC-21-16-F
Author / Job Title:	David Morgan / Service Manager Mental Health

1. Introduction

1.1 The report provides the IJB with an update on the current status of the Mental Health Review (2013) Action Plan (Appendix 1).

1.2 It is proposed that the IJB agree that a refreshed and updated Mental Health Action Plan will be presented in six months from the date of this meeting.

2. Background

2.1 A Mental Health Review was conducted in November and December 2013, and the work concluded in January 2014.

2.2 The Review Report was presented to the CHP Committee on 17th February 2014 (Appendix 2).

2.3 Based on the Review Report, the local management response identified eight improvement recommendations that formed the basis of the Mental Health Review Action Plan:

1. Leadership for Mental Health to be provided by the newly created post of Director of Community Health and Social Care
2. Recruit a second psychiatrist at staff grade/consultant grade
3. Integrate the CMHT and Annsbrae teams into one Community Mental Health Service
4. Increase the number of CPN's
5. Create a crisis response service and establish a pool of Control and Restraint (C&R) trained staff
6. Explore options for crisis support accommodation
7. Establish a visiting psychology service and progress the development of cCBT and Third Sector initiatives for talking therapies
8. Explore how best to use the resources that were allocated to the post of the then vacant post of Executive Manager Mental Health

2.4 The Mental Health Review Report proposed the possibility of outsourcing Tier 3 psychological therapy services. Whilst this was considered worth pursuing, there was some management uncertainty about the practicality of this solution. It was decided to revisit the proposal once the more integrated service had been established and a "Visiting Psychology Service" was in place.

2.5 The original Mental Health Review (2013) Action Plan has been subject to a series of revisions in response to a fast changing strategic and operational environment.

3. Current Situation

3.1 The provision of safe, effective and person centred mental health services is an increasingly important national priority. It remains the focus of existing and new Scottish Government initiatives.

3.2 The SIC Executive Manager Mental Health Health and the NHS Mental Health Team Manager posts were amalgamated to create a single Mental Health Service Manager post. This initiative released resources to support the recruitment of additional frontline staff.

3.3 In response to the Review Report recommendations on leadership and the need for an increase in psychiatry staffing, the Consultant Psychiatrist post was redesigned as a Consultant Psychiatrist/Clinical Director post and a second staff grade psychiatrist employed. The new Clinical Director for Mental Health was appointed in June 2015. The Clinical Director has recommended that additional service review and redesign work is required and the postholder is playing a key role in supporting improvements to clinical pathways and governance processes.

3.4 The implementation of the Psychiatric Emergency Plan (PEP) has been delayed due to difficulties in establishing a) the most appropriate service model for responding to psychiatric emergencies in a remote and rural setting, and b) recruiting sufficient staff to deliver that model in a safe and sustainable manner.

Work on the service model is making good progress under the leadership of the Clinical Director and the staffing situation has now improved. The number of Community Psychiatric Nursing (CPN) staff has increased from 4.5 WTE to 7.5 WTE. It is important to note that these 3 posts are 3 year fixed term posts and resources will need to be identified to ensure the long term sustainability of these appointments. An additional 0.5 WTE CPN will be recruited from resources made available from the Scottish Government Mental Health Innovation Fund aimed at developing improved services for people who present in distress.

3.5 Improving access to clinical psychology services is recognised as key to making the most effective use of existing talking therapy resources. There are continuing difficulties with providing access to clinical psychology services and these difficulties are contributing to long waits for some conditions. A recent NHS Education Scotland offer has created an opportunity to recruit a full-time, Shetland based, clinical psychologist.

3.6 A new and refreshed Action Plan will be developed to reflect the recommendations of the Clinical Director and the evolving strategic and operational situation. It will set out the key actions for 2016/17 and align these to the content in the Strategic Plan for 2016-19.

4 Recommendations

4.1 **It is recommended that the IJB:**

4.1.1 **Review** and discuss the content of the Mental Health Review (2013) Action Plan;

4.1.2 **Agree** that a refreshed and updated Mental Health Action Plan is presented to the IJB in six months from the date of this meeting.

5. Conclusion

5.1 The original Mental Health Review (2013) Action Plan has been subject to a series of revisions in response to a fast changing strategic and operational environment.

5.2 A new and refreshed Action Plan will be developed to reflect the current and evolving needs of mental health services in Shetland.

Contact Details:
For further information please contact:
David Morgan, Service Manager Mental Health
david.morgan3@nhs.net
25 March 2016

Appendices

Appendix 1 – Mental Health Review (2013) Action Plan
Appendix 2 – Response to the Mental Health Review presented to CHCP Committee

Community Mental Health Service Review
Action Plan 2014/15

Action	Responsible Post holder	Start Date	Target Date	Resource	Risk	Status R/A/G C = Completed	Completion Date	Progress/Comment
Director of Community Health and Social Care to provide leadership for Mental Health Services with support from the Chief Executives of NHS Shetland and Shetland Islands Council	CE's of NHS Shetland and Shetland Islands Council	February 2014	February 2014	Within Existing Resources	No Risk	C	February 2014	Completed
Recruitment of an additional Staff Grade or Consultant Psychiatrist	Medical Director	February 2014	January 2014	£120,000	Additional finance allocated. Currently a national shortage of psychiatrists	C	June 2015	Completed.
Integrate CMHS and Annsbrae Services to form a single integrated Community Mental Health Service.	Director of Community Health and Social Care	February 2014	April 2015	Within Existing Resources	No Risk	A	August 2016	An ongoing process of mental health service redesign and integration will fully incorporate Annsbrae into the Service. Line management to Service Manager Mental Health.
Integrate Adult Social Work & Mental Health Officer functions	Executive Manager Adult Social Work	February 2014	February 2014	Within Existing Resources	Loss of leadership & knowledge. Recruitment.	C	March 2014	Completed

Community Mental Health Service Review
Action Plan 2014/15

Action	Responsible Officer	Start Date	Complete Date	Resource	Risk	Status R/A/G	Complete Date	Progress/Comment
Increase number of CPN's to 5.5 WTE	Mental Health Service Manager	February 2014	November 2014	Government allocation received which has funded additional posts	Additional or reallocated finance required	C	August 2015	CPN staff increased from 4.5 WTE to 7.5 WTE to address staffing level concerns using 3 x 3 year fixed term posts. An additional 0.5 WTE CPN is to be recruited from SG Innovation Fund allocation.
Create a 24/7 Psychiatric OOHs Service with staff trained in the use of Physical Interventions (C&R) • *Identify the number of qualified staff required for a safe and sustainable service.* • *All OOH staff to achieve (and maintain) recognised "C&R" qualification.*	Service Manager Mental Health	February 2014	December 2014	Up to £52,500 needed for standby and call out Training costs to be established	Insufficient staff able to participate in C&R	A	June 2016	Not progressed as planned because the management of disturbed behaviour will be addressed as part of the PEP which is still in process of being finalised. On call for OOHs led by consultant psychiatrist. See PEP (below)
Comprehensive Psychiatric Emergency Plan (PEP)	Clinical Director Mental Health	February 2014	December 2014	Within Existing Resources	Failure to secure the support of key stakeholders	R	June 2016	A draft PEP has been developed and is at final stage. Further updates will develop this document. An Operational Policy is in place.
Identify options for appropriate community crisis support accommodation	Executive Manager Adult Social Work and Mental Health Service Manager	February 2014	March 2015	From existing assets	Suitable building not available	C	Suspended	This is not currently being considered with the current staffing levels

Community Mental Health Service Review
Action Plan 2014/15

Action	Responsible Officer	Start Date	Target Date	Resource	Risk	Status R/A/G	Complete Date	Progress/Comment
Establish more appropriate "Place of Safety" in GBH	Service Manager Mental Health & Director of Nursing	April 2014	March 2015	Allocated	Suitable GBH space not available.	R	June 2016	Design for a specialist GBH suite agreed. Work to commence April 2016.
Identify accommodation for an Integrated Community Mental Health Service	Head of Estates	April 2014	March 2015	Amount to be established	Suitable space not available.	R	Estimating April 2016	Revised options appraisal in progress. Awaiting feasibility details.
Establish Visiting Adult Psychology Service	Service Manager Mental Health	February 2014	January 2015	Within Existing Resources	National availability of staff etc	R	June 2016	This has not been achieved and all options for obtaining psychology input are being explored
Address current PTS backlog and meet PT HEAT Target	Service Manager Mental Health	February 2014	March 2015	NES funding secured to support addressing the backlog	Additional or reallocated finance required. Availability of qualified staff.	R	Estimating September 2016	December 2014 HEAT Target missed. Aiming for September 2016 compliance. This is being addressed through the current process of Mental Health service development and redesign and links to deficit of Clinical Psychology
Participation in 3 year EU Funded "Mastermind" cCBT Pilot	Service Manager Mental Health	April 2014	September 2014	Within Existing Resources	Sustainability post pilot	C	September 2014	Shetland wide service in place.

Shetland NHS Board

Meeting:	CHCP Committee		
Paper Title:	Response to the Mental Health Review		
Author:	Stephen Morgan David Morgan	**Job Title:**	Interim Executive Manager CMHT Manager
Executive Lead: (if different from Author)		**Date:**	
Response required from the meeting:			
The Committee is asked to approve the recommendations in the report.			
Summary of paper:			
The report is a response to the review of Mental Health Services in Shetland carried out by Mr Kevin Hurst. The review was commissioned by both Shetland Islands Council and NHS Shetland. The report gives a basis on which to build an action plan to address the findings in the report.			
Assessment of implications to the organisation in respect of:			
Patient Safety:	Yes – in terms of better access to mental health services		
Staffing/Workforce:	YES – in terms of increasing numbers in some areas and amalgamation of teams in others. Overall there should be a positive impact on staff and of service delivery and quality		
Finance/Resource:	YES – in terms of additional investment, either from additional or re-allocated funds		
Risk:	YES – the status quo in mental health services has been criticised in Kevin Hurst's review, many areas of criticism having previously been identified by local managers and practitioners. Lack of action now will leave both NHS Shetland and the Shetland Island's Council open to public criticism		
Equality & Diversity:	YES- ensuring that mental health needs are addressed.		
Community Planning / SOA:			
Legal Issues:			
Fit with Corporate Objectives/Action Plan:	YES- To redesign services where appropriate, in partnership, to ensure a modern sustainable local health service		
Previously considered by: (e.g.Board/Standing Committee/Group)	N/A		

Response to the Mental Health Review completed by Kevin Hurst

Mr Kevin Hurst, a consultant social worker and accredited mental health officer undertook a review of Mental Health Services in Shetland during November and December 2013, the review report is attached at Appendix 1. He presented his report in January 2014 and this is a response to the findings and recommendations of his report. This paper has been prepared by the Community Mental Health Manager and the Interim Executive Manager, Criminal Justice who is also currently managing community care social workers including the mental health officers. The paper follows the recommendations of the report, responding to each in turn.

The authors of this paper have consulted with their teams and the Chief Social Work Officer in relation to the responses and recommendations

Substance of report and recommendations

We agree that in general terms the substance of the report is good and reflects what many practitioners and managers in the field have been saying for a number of years, this in itself asks a question and influenced the first area of discussion: Leadership.

The report states that there has been a lack of leadership in the area of Mental Health in Shetland, and although there is no specific recommendation in the report we believe that this issue should be addressed as an outcome of the review. It is our opinion that leadership for Mental Health should sit with the Director of Community Health and Social Care, with operational and some strategic responsibility delegated to an appropriate manager. Given the criticism in the report around lack of progress and / or development we feel it crucial that the Chief Executives of the Health Board and the Council delegate appropriate authority to the Director of Community Health and Social Care (DCHSC) to implement the cross-cutting changes required to establish safe and effective Mental Health Services. Taking the delays in the ratification of the PEP as an example, the DCHSC will require authority to make final decisions in areas relating to Mental Health which may be outwith the direct responsibilities of the post and yet are essential for a strategic aim to be achieved.

There was some debate with colleagues around this area with some people believing a Mental Health Director would be the best option given the changes required in the recommendations of the report. On balance we feel that this is not required. We believe implementing the recommendations in this paper and robustly reviewing progress would evidence leadership. This will ensure rapid improvement to services for people suffering from mental health problems.

Recommendations in the Review

On Island Psychiatry

We agree with the analysis of the issues facing this single handed post and also the workload and issues in relation to work – life balance. We also agree with the recommendation that a staff/Consultant grade psychiatrist should be recruited.

The financial comments in relation to this cost will require further examination in relation to off island admissions and in any case would likely require an initial spend over and above current

budget. The comments in relation to the addictions review are valid and we would welcome further discussion.

Creation of an Out of Hours / Crisis Service

We acknowledge that this has been discussed for some time without tangible progress. We also agree that such a service would be beneficial to a number of people in Shetland. We do not agree with the model proposed. It is our opinion that asking one small service area to provide two staff for up to 72 hours is not viable. Given that the people requiring such a service will be in some type of crisis it is right to assume that a minimum two staff will be required for safe working practises. For such work, we would recommend a maximum of 8 hours per shift which means a minimum six members of staff per day. This is a lot of staff to 'back-fill' for one service area. Our own recommendation in relation to this links to a further recommendation later in the report in relation to integration and we will touch on it here. We believe that the report does not go far enough in relation to mental health and social care integration and we would recommend that the services based at Annsbrae and currently managed by the Mental Health Executive Manager, should be integrated into the Community Mental Health Team. This would give a single point of management for all community mental health services and would make services more 'joined up' and give the opportunity for better responses, particularly in relation to crisis support, for example being able to call upon a larger pool of staff to meet the needs. This will require an increase in the number of NHS/SIC staff (hospital and community) who are trained and available to provide "C&R" (Control and Restraint) interventions.

What is not addressed in the review report is crisis accommodation. When an individual requires support in their own home or in hospital the response is relatively simple. The problem we have is when support is required in Shetland out with the person's home or hospital. Further investigation into options is required here and there is potential need for capital investment.

In terms of revenue funding options in the review report, these require further analysis.. The author makes reference to the Council's budget for Domestic Services and the charging policy, but the analysis does not fit with current policy. In relation to Domestic services there is no recommendation as to how this budget can meet crisis support needs and the reference to the contributions to support not being allocated is inaccurate. Projected income has been included in the budget and goes towards achieving Community Care's budget.

The reference to off-island placements picks up on work already carried out and is by no means straight forward. All placements have been reviewed. There may be options for offering some individuals a return to Shetland, but services would have to be developed locally with additional costs. There may be savings but there may not be; further analysis is required in this area.

CMHT staffing levels and Social Work Integration

We agree that there needs to be integration of CMHT and social care staff. We think the recommendations in the review report could be built on to gain the best outcomes for people with mental health problems. The review report concentrates on statistical data and numbers of certain types of staff. We need to match this with role functions to ensure that every opportunity is taken to capitalise on local resources that already exist.

We agree that CPN numbers are currently low and that further investment, or change in resource, is required to increase the number. Given the absence of Liaison and Crisis Resolution Teams we believe 6.5 WTE is an appropriate estimate to establish a responsive and sustainable service.

The statement of numbers of social worker who are MHOs whilst, on the face of it, is accurate, in real terms this is not the case. The review report states we have 3.5 FTE MHOs including 1 FTE manager. What we actually have is 2.5FTE social workers who are accredited MHO's (one post is vacant) and 1FTE senior social worker who is an accredited MHO. The social workers do not hold 'pure' mental health caseloads, they contribute to the overall community care social work team and fulfil the MHO functions when required. The senior is a senior for the MHOs and also for social workers in the community care team. Our recommendation would be to amalgamate the services operated at Annsbrae to the CMHT and also locate 1 or 2 social workers (MHOs) in the CMHT, with professional line management coming from the senior social worker based in the community care social work team. Ideally we would like to locate the community care social work team and the CMHT together as we believe this would give the best environment for integrated working, but we acknowledge that accommodation is a significant issue in this regard.

The current CMHT Manager would hold responsibility for the CMHT and Services currently operated from Annsbrae.

We agree that the number of CPN's should increase and that recruitment should begin as soon as possible.

Psychological Therapies Imbalance

The report recommends an exploration of the possibility of outsourcing Tier 3 psychotherapy services. Whilst this is worth pursuing, there is some uncertainty about the practicality of this solution for a number of reasons, both clinical and technical.

The level of "out sourcing" required can be reviewed once the more integrated service described above has been established and a "Visiting Psychology Service" has been introduced. An increase in the number of CPNs would allow Tier 3 patients to receive a more effective shared care approach during the "chaotic" phases of their illness. During such phases the balance of care would move from more structured PT interventions to more flexible CPN/Social Care support, which would free PT resources and reduce the current levels of DNA & CNA. The availability of Clinical Psychology would support practitioners in more effective/timely use of "step up"/"step down" if the 3 main levels of the Tiered Model are available locally.

The recent Addaction proposal to develop a pilot project at Tier 1/2 level is a welcome step towards meeting the recommendation to continue working with Third Sector partners to increase the availability of high volume, low intensity interventions and should be explored.

Further recommendation

It is our opinion that if the recommendations above are accepted and implemented, the role of the Executive Manager for Mental Health could be very different to the current remit. We believe that

the social work function, which supports all adults with a social care need should be strengthened. This will have a positive impact for services such as mental health, dementia and the broader social work function. An Executive Manager with a remit for the Community Care Social Work Team, including the MHO accredited social workers would give a more robust and safer structure to that which we currently have. We believe further consideration of the best use of the Executive Manager for Mental Health resource is required and this should take into account other work / reviews currently being carried out such as the 'Dementia Deep Dive ' and the review of Substance Misuse Service.

Recommendations

1. Leadership for Mental Health to sit with Director of Community Health and Social Care, with appropriate support from the Chief Executives
2. Recruit a second psychiatrist at staff/consultant grade
3. Integrate the CMHT and Annsbrae teams into one CMH Service
4. Increase numbers of CPN's as a priority
5. Create a crisis response service from the above and establish a pool of Control and Restraint trained staff
6. Explore options for accommodation for crisis support
7. Establish a visiting psychology service and progress the Addaction proposal
8. Explore how best to use the resources currently allocated to the Executive Manager Mental Health

Action Plan

Action	Responsible Officer	By When	Resource
Director of Community Health and Social Care to provide leadership for Mental Health Services, with appropriate support / permissions from the Chief Executives of NHS Shetland and Shetland Islands Council	CE's of NHS Shetland and Shetland Islands Council	Immediately	Within Existing Resources
Recruitment of a staff / consultant grade Psychiatrist	Director of Community Health and Social Care	Process to start in February 2014	£90 000 - 130 000 additional or reallocated resource required
Integrate CMHT and services operated from Annsbrae into one Community Mental Health Service, Management to be	Director of Community Health and Social Care	Immediately	Within Existing Resources

provided by the current CMHT Manager			
Increase number of CPN's	CMHT Manager	Process to start February	Additional or reallocated resource required
Create crisis response service from the pool of "C&R" trained staff	CMHT Manager	Immediately	Within Existing Resources, plus additional spend when resource is utilised, estimated to be in the region of £52000 Additional resources need to be identified to provide and maintain Control and Restraint training
Explore options for appropriate accommodation for crisis support	CMHT Manager and Director of Community Health and Social Care	Process to start immediately	To be established
Establish visiting psychologist service and progress the Addaction proposal	CMHT Manager	Process to start immediately	To be funded from existing 0.5 WTE vacancy in PTS. Transitional resource needed to address current backlog.
Explore how best to use the resources currently allocated to the Executive Manager Mental Health	Director of Community Health and Social Care	Immediately	Within Existing Resources

Stephen Morgan, Interim Executive Manager for Criminal Justice

David Morgan, Community Mental Team Manager

31st January 2014

Appendix 1

NHS Shetland and Shetland Islands Council

Mental Health Services Review 2013:
Strategy and Plan

Prepared By:
Kevin Hurst (Hurst Business Solutions Ltd)
BA Jt Hons, PG Dip SW, MBA, Practitioner Prince2, Fellow IFSW
Former Social Work Advisor to the Scottish Government

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1 EXECUTIVE SUMMARY

1.1 Background

In April 2013, the Director of Community Services of Shetland Islands Council resigned and the current Director of Clinical Services for NHS Shetland, Simon Bokor-Ingram, agreed to manage Council Community Care Services on an interim basis additional to his substantive post. Prior to this the Director of Community Services reported to the Health Board through the Director of Clinical Services, and although concerns were raised previously regarding Mental Health Services, lines of accountability were not sufficiently robust.
The Interim Director sought agreement from the Chief Executives of both NHS Shetland and Shetland Islands Council to commission a review of services to ascertain what actions should be taken.

1.2 Need for Change

The history of the identification for an urgent need for changes in Mental Health Services, combined with no activity, goes back many years.

2004 – The CPN complement was reduced by 0.5FTE (from 4.5 FTE including a manager to 4.0 FTE) when a specialist Dementia post, partly funded by Alzheimer's Scotland was established
2005 – The CPN complement was further reduced by 0.5FTE to 3.5 FTE when the resource was transferred to 1.0 FTE specialist addictions nursing post, partly funded with newly available funding for addictions services
2007 – A safe house arrangement using an apartment in Ansbrae, (a Council Community Support service) was discontinued following the departure of the then psychiatrist, and an increase in the SLA for the use of inpatient beds at Royal Cornhill Hospital was agreed
2007 – The Joint Mental Health Strategy 2008 to 2012 contained a clear action plan for the establishment of an out of hours/crisis service with an action plan for establishment in 2010 (Appendix 1)
2008 – A report was produced detailing inadequacies in out of hours and crisis services (see Appendix 2)
2010 – "A Review of Shetland Mental Health Crisis Response Services and NHS Shetland Out of Hours Mental Health Provision (Appendix 3)
2010 – Shetland NHS Board Clinical Strategy 2010 (Appendix 11)
2010 – Internal Psychological Therapies HEAT Target Review reported the proposed retargeting of Talking Therapies to people requiring secondary treatment may lead to missing the HEAT target (Appendix 12)

2011 – Following a number of serious complaints, HIS held a 2 day seminar which drew together a number of recommendations for action on improvement in service delivery (Appendix 4)
2012 – A costed protocol for the establishment of an out of hours/crisis service was produced. (Appendix 5)
Other – At present there is no active Psychiatric Emergency Plan, as the most recent Draft Plan has not been ratified.

Note - The Remote and Rural Areas Resource Initiative (RARARI) Bid 79 Document, published in September 2003, makes a number of recommendations regarding psychiatric emergencies in remote areas. The major recommendation is for a Psychiatric Emergency Plan to be in place in each NHS Board area. NHS Boards would have responsibility for drawing this up in conjunction with service users, carers, advocates and other agencies, and should include agreed protocols, standards and training.

Additional to the above, from 2007 to the time of writing, NHS Shetland and previous Board configurations has attempted to underpin the Islands Psychiatric service by employing a singleton psychiatrist. This clinical model has not been successful, with no clinician remaining on island for more than two years. Letters of resignation and end of locum commentary have consistently pointed out that a singleton placement is unworkable. It isolates the incumbent psychiatrist professionally; it requires an on call availability which is incompatible with a sustainable work life balance, and creates unacceptable levels of risk to both patients and professionals.

Staff feel isolated and perceive that service failings are viewed as staff inadequacies, rather than a service that has lacked investment and development over a number of years.

Given the above, it is essential that the foundations of the Shetlands Mental Health service are strengthened to ensure the whole range of necessary services can function effectively. A root and branch reform of services, appropriately targeted and resourced, will improve service delivery, reduce the necessity of off-island placements improve service user and carer service satisfaction and thereby reduce the necessity of complaints – outcomes which are both necessary and measurable

<u>NB – Alternative Models</u>

An Inpatient Ward On-Island Model

This model would be designed to avoid the transfer of patients to off island in-patient wards. Patients, families and carers have expressed a strong interest in such an approach. However, the pattern of demand and need for

inpatient treatment in the Royal Cornhill Hospital over the past seven years demonstrates that such a service would be impractical for a number of reasons:

- The level of demand for inpatient service varies widely from month to month. Some months require 5 inpatient admissions, and other months require one admission. (In one exceptional month in 2007 there were 12 inpatient admissions.) The overall variability of demand alone shows that such an inpatient service would at times be underused, whilst still requiring funding for staff payments and all other overheads. The current SLA (Service Level Agreement) with NHS Grampian for inpatient services is based on a payment per bed per night – in other words, payment is only made when the service is used, which is a more cost effective arrangement
- The figures above suggest a minimum of a six bed ward would be required. The cost of the staff team alone would be more than is currently paid out on the current SLA. However, such a small unit could not cope with all patient needs, and some patients with very complex needs would still require inpatient treatment off island which would require a further payment.

The Orkney Model

The Orkney model of Mental Health services operates a service model with no permanent on island clinician. Operating with a team of 8 CPNs and 2 social workers, a psychiatrist visits the islands on a sessional basis from Grampian Health Board twice a month, and all emergency detentions and admissions to Royal Cornhill Hospital are managed via General Practice. (This sustainability of this model of service delivery is currently under consideration by NHS Grampian, as it requires a high level of flexibility and personal commitment for the clinician involved.)

This model has not been legally challenged because access from the islands to the mainland is very rarely disrupted for more than one day, which is not the case on the Shetland Islands, which can be isolated for the mainland services for several days. (The Mental Health legislation requires a specialist clinician to consent to a detention for longer than 72 hours, which in practice requires the presence of a psychiatrist on island.). Discussion with Legal Services suggests that the possible inability to guarantee access to Section 22 trained doctors could lead to problems in fulfilling the legal requirements of the Mental Health (Care and Treatment) (Scotland) Act 2003 in terms of ensuring sufficient Section 22 trained clinicians are available to undertake clinical assessments for Short Term Detention Certificates. This could result in the General Practitioners facing two contradictory imperatives – the need to detain a person more than once

on an emergency basis for the same treatable illness, whilst being fully aware that such an action would be contrary to law.

The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 2, Chapter 7, Part 5, states:

"**Who may not be made subject to a period of emergency detention?**

Section 36 of the Act states that an emergency detention certificate may not be issued if, immediately before the medical examination is carried out, the person is detained in hospital by way of any of the following authorities:

an emergency detention certificate;

a short-term detention certificate;

an extension certificate granted under section 47 of the Act;

section 68 of the Act"

A Psychiatric Emergency Plan which required practicing physicians to make such decisions would not be competent.

Section 22 MH Act training for GP(s)

It is possible for a General Practitioner with several years' experience of Mental Health could apply to complete the RCP training for Section 22 Doctors – i.e. clinicians qualified to undertake assessments for Short Term Detention Certificates under the Mental Health (Care and Treatment) (Scotland) Act 2003. This approach would present several challenges. Even if a GP was willing to undertake such training, and agree to a number of sessions, such a course of action would deplete the pool of available General Practice time, and the costs would be prohibitive. Two sessions per week would cost circa £17k per annum for the sessions alone – the backfill requirement would effectively double the cost. This is not a viable option in comparison with the appointment of an additional psychiatrist which would be more efficient, resilient and more cost effective.

Establishment of a psychiatric clinical training position

The establishment of a psychiatric training placement is an attractive medium term option, once the services are stabilized. Shetland could offer an interesting remote island placement, linked to NHS Grampian, and the current Medical Director, NHS Grampian would be minded to support such placements, but of the current nine places available for senior trainees,

there are only two trainees currently in training. This is likely to improve in the next two to three years as junior trainees progress.

1.3 Key Recommendations

The Recommendations below are the essential ingredients for the development of a more robust and resilient Mental Health service.

I have included a brief financial impact assessment for each recommendation with possible ways to offset costs based on a cursory budget analysis.

On Island Psychiatry – Recruitment, Retention and Risk Management

1.97 FTE psychiatrists is the recommended number for the population of the Shetlands Isles, as detailed in the body of the report.

The appointment of an additional (staff grade) psychiatrist would increase the ability of on island psychiatric services to provide a more robust service. The inclusion of two sessions for addictions prescribing would remove the specialism form GP services. This would create more clarity of prescribing practice. It would also provide a better clinical linkage between Mental Health and Addictions services, where a significant number of out of hours or Crisis Mental Health cases involve alcohol or substances (See Appendix 5)

This action will provide a degree of short and long term stability to Mental Health services. It will enable clinicians to have a more measured and anticipatory approach to service delivery, and also provide a more reliable input in terms of clinical governance

The cost of a staff grade psychiatrist with on costs is likely to be @£90,000.per annum

This cost can potentially be offset in two ways:

1. The SLA for admissions to Royal Cornhill Hospital is £243,557. A reduction of off island inpatient admissions by a third would result in a potential saving of £81,86 per annum.
2. The current addictions service review has raised the possibility of employing a General Practitioner for 2 sessions per week to undertake addictions prescribing. This has a potential cost of circa £17,000 with equivalent backfill costs.. The incorporation of the

addictions prescribing function into the job description of an additional psychiatrist would be a more effective use of resources both financially and strategically.

Creation of an Out of Hours/Crisis Service

The benefit and utility of an out of hours/Crisis service has been formally recognized from 2008, and has been a joint commitment of both Council and Health Board from 2009.

Annsbrae Community Support Service currently has a group of 11 support staff, trained in control and restraint. This staff group could provide one or two members of staff, for up to 72 hours. This service could be delivered in the person's own home; in a designated place of safety outwith the hospital; in the A&E Relatives Room; in the Ward 1 relatives room; or in Ward 3 if appropriate. They would work under an agreed clinical governance protocol. However, where an A&E admission was occasioned by a GP emergency detention, the clinical governance could rest with GP and psychiatric services, with hospital physicians becoming involved only should a full inpatient admission to Ward 3 be required.

An out of hours on call CPN service could be piloted. The on call CPN could be contacted before the crisis service, offering advice and guidance.

The establishment of two psychiatrists would agree a clinical governance arrangement with Hospital Physicians and General Practitioners, to ensure all involvement with out of hours services has effective support and oversight.

The cost of each 72 hour episode of care could cost up to £3,138. There has been an average of 25 off island admissions per annum over the last seven years. Anecdotal evidence suggests it is highly unlikely all episodes will require full 72 hour support. **Assuming an average of 25 episodes requiring 2 full day and night time support, the average annual cost of this service would be £52,300**

This cost can potentially be offset in a number of ways:

3. See 1 and 2 above
4. The Council budget for 2013 has an amount of £1,240,000 set aside for Domestic Services. This has been reduced to £442,866 in 2014.

The Council charging policy appears to include a sophisticated tapering mechanism which limits charges of up to 70% of assessed liability. A collection rate of 50% of recorded cost would result in an income stream of some £221,000 which is as yet uncommitted and could easily offset the above out of hours costs

5. Another interesting option, and one which is attractive at several levels, is to review the off island placements currently in place. In 2013/2014 Council and NHS Shetland have committed £1,090,000 to 10 placements. A review of these placements could identify a spend to save opportunity of establishing specialist services on island, thereby boosting local infrastructure, delivering services within the local community, and producing more local service resilience. Also it is quite possible service users may be offered services on island which are assessed as meeting their needs, which they may refuse. This would change the ordinary residence obligations of Council. These actions could assist in reproviding resources which could support the development of an out of hours/crisis service

Review CMHT staffing Levels and Social Work Integration

The current level of CMHT staff (excluding psychiatry and admin) is as follows:
3.5 FTE CPNs (including 0.5 FTE manager)
3.0 FTE psychotherapy staff (including 0.5FTE manager)
1.0 FTE manager (including 0.2 FTE therapist)
0 FTE social workers

National estimates of Community Mental Health service requirements suggest the CMHT for Shetland Isles should contain:
6.5 FTE CPNs
3.0 FTE social workers
1.5 FTE clinical psychologists
1.0 FTE Occupational Therapists

An increase in psychiatry and the establishment of the Out of Hours/Crisis service will go some way to provide a basis for a review of the CMHT to establish a more generalist approach, and may provide the sufficiently robust service. Furthermore, the current Dementia service is funded via Alzheimer's Scotland. This funding is due to end in 2015, and any exit strategy will potential impact on the CMHT as one of the Dementia posts is filled by a staff member with a 1.0 FTE substantive post in the CMHT, but with only 0.5 FTE funding protected in the Team budget.

However, the inclusion of three social work staff embedded in the Team is a clear requirement. The Team needs to be able to respond to Health and

Social Care needs. There are at present 3.5 FTE social worker (MHOs) including 1 FTE manager, who supervises other non MHO social workers. During my period with the CMHT, the lack of social work input and involvement has been an obvious gap. Housing the current Mental Health social work staff with the Team would build resilience, lead to more effective Team Work, and establish a basis for greater synergy in the future.

Address Psychological Therapies Imbalance

The Shetland Health Board Clinical Strategy for 2010 changed the priority of psychological therapies from Primary Care to concentrate on people with a diagnosed mental disorder of sufficient severity to merit treatment in a secondary care setting. An internal report warned of the likely consequence of such a reallocation. It predicted that without a further commitment of resources to Primary Care it was likely the HEAT Target would not be met – a situation which now exists.

There is a necessity to explore the possibility of outsourcing Tier 3 psychotherapy services. These cases are challenging for local services, as they require an input of up to two years and by the very nature of the presenting problems can result in a high frequency of non attendance. This inevitably means local services with limited resources can suffer from a proportionally very high lack of service use, which both extends waiting times, and is not the best use of limited resources.

The Psychological Therapies Steering Group should continue discussions with Health Improvement, GPs and Third Sector partners to increase the availability of Tier 1 services as this would be expected to reduce the demand for Tier 2 interventions and contribute to the development of a more sustainable and balanced system.

A visiting Clinical Psychology service, similar to that provided for CAMHS, would ensure that staff delivering talking therapies have the support of a more robust governance structure and this could be funded from the exiting 0.5 WTE vacancy. The availability of this service would also provide some local capacity to address the currently unmet need of adults presenting with Autistic Spectrum Disorders

Follow on Benefits following Key Recommendations Implementation

Any changes should be seen in the context of continual improvement. There are other area which require consideration and development, such as:

• management with clear lines of authority, responsibility and accountability,
• good quality PEP,
• operational policy and procedure audit,
• more widespread use of robust Care Programming combined with a Wellness Recovery Action Plan (WRAP)
• a uniform and co-ordinated recording procedure for all unscheduled care interventions and support
• introduction of stepped care model for psychological therapies
• and so on.

These and other points are considered in more detail in the body of the report.
However, the key recommendations provide a solid foundation upon which the service can develop and improve.

2 STRATEGIC OVERVIEW

2.1 National Legislation

the Mental Health (Care & Treatment) (Scotland) Act 2003 remains a national clinical priority and "Delivering for Health" sets out a new direction for services, emphasising the need for better prevention, better health promotion and improved services to meet the mental and physical health needs of people.

The MH(C&T) (Scot) Act 2003 aimed to promote a change in culture of mental health practice towards a more rights based approach to the provision of services and care. This cultural change has been maintained with the introduction of the Adults with Incapacity (Scotland) Act (2000) and the Adults requiring Support and Protection (Scotland) Act (2007).

The MH(C&T) (Scot) Act 2003 operates within a set of general principles. These principles have been established to guide those administering functions within the legislative framework. These principles are listed as follows:-

• Non-Discrimination:- People with a mental disorder should wherever possible retain the same rights and entitlements as those with other health needs.

• Equality: - All powers under the act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.

• Respect for diversity:- Service users should receive care and treatment and support in a manner that accords respect for their individual qualities, abilities and diverse background and properly takes into account their age, gender, sexual orientation, ethnic group, social , cultural and religious background.

• Reciprocity: - Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

• Informal Care: - Where ever possible care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.

• Participation: - Services users should be fully involved so far as they are able to be in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all information and support necessary to enable them to participate fully. Information should be provided in a way, which makes it most likely to be understood.

• Respect for Carers:- Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice and have their views and needs taken into account.
• Least Restrictive Alternative:- Service users should be provided with any necessary care, treatment and support both in the least invasive manner and the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.
• Benefit: - Any intervention under the act should be likely to produce for the service use a benefit that cannot reasonably be achieved other than by intervention.
• Child Welfare: - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the act.

Statutory Obligations

The MH(C&T) (Scot) Act 2003 places certain responsibilities on statutory sector providers.

Under section 33 of the MH(C&T) (Scot) Act 2003, Local Authorities have a duty to inquire into the case of a person with mental disorder where certain criteria are met (essentially where they are at risk of harm of some kind). Under sections 34 and 35, Local Authorities are able to apply for a range of warrants (such as a warrant to enter premises) in order to enable them to carry out their inquiries.

In certain circumstances a Sheriff or a Justice of the Peace may grant a warrant authorising someone with appropriate authority, such as an MHO, to enter specified premises in order to take a person to a place of safety or into custody (for example, under emergency detention).

Psychiatric Emergency Plan

The Bid 79 project funded through Remote and Rural Areas Resource Initiative (RARARI), examined issues relating to psychiatric emergencies across remote and rural Scotland.

The first recommendation to emerge from the report is that NHS Boards should be responsible for ensuring that a Psychiatric Emergency Plan (PEP), endorsed by all appropriate agencies and professional groups, is in place for each locality. It should include statements on: the skills and competencies required of staff; minimum staffing levels, and clear

arrangements on the availability of Mental Health Officers (MHOs). (BID 79, 2002).

In response to these recommendations, the Scottish Government, through the Code of Practice accompanying The Act recommends, as good practice, that relevant local agencies and service providers, who might potentially be involved in psychiatric emergencies, should work together to develop and agree on a Psychiatric Emergency Plan (PEP). This would allow potential local difficulties to be addressed and contingency procedures put in place before they arise for real. The development and aim of such a plan would be to, agree procedures that would manage the transfer and detention processes in a manner which minimises distress and disturbance for the person and to ensure as smooth and safe transition as possible from the site of the emergency to the appropriate treatment setting (Code of Practice, Volume 1, 2003: paragraph 56).

2.2 Current and Future Requirements

The National Framework for Service Change in Scotland defined unscheduled care as 'care, which cannot reasonably be foreseen in advance of contact with the relevant health care professional, which can occur at any time and for which services must be provided 24 hours per day'.

An ICP mapping exercise was conducted during 2008-9 to review the PEP and the mental health crisis pathway. A further HIS supported review in 2011 following a serious complaint regarding statutory mental health services offered some insight into the complex and at times inconsistent and disjointed way in which existing service interventions are provided.

National Standards for Crisis Services were launched in December 2008 in the form of a crisis services practice tool kit. NHS Scotland QIS produced a 'best practice statement' Admissions to Adult Mental Health Inpatient Services March 2009. The lack of adherence to this toolkit was raised in HIS review 2011 (see Appendix)

According to the toolkit, the time, place, circumstance and person dealing with the issue all appear to impact significantly for unscheduled care episodes. Where statutory powers are being invoked the Psychiatric Emergency Plan was recognised as being the best practice guide, however currently it contains limited supplementary information the bulk of the existing information focusing primarily on the medical issues arising from the emergency.

There is a clear need for a robust and well defined system that swiftly identifies the need for intervention and then signposts people and persons requiring assistance to the most appropriate resource should not be beyond the capability of all parties

The complexity and number of issues requiring clarification would lend itself well to being broken down and each piece examined and then placed into an operational policy and procedure for unscheduled care that meets an agreed criteria.

The Mental Health in Scotland 'National Standards for Crisis Service Practice Tool Kit' highlights that a recent review of the Orchard Centre by Stirling University provided insight into the links between social crisis and mental health crisis, it concluded that service user's often saw social crisis as linked to and often preceding a more severe mental health crisis rather than distinct from it. The Practice Tool Kit concluded that it was not an easy task developing an arbitrary point, at which an individual is deemed to be in one form of crisis or another, and that this therefore reinforced the need for voluntary sector and statutory sector services to work collaboratively to form a whole systems-approach to crisis support.

A common theme evident in literature relating to unscheduled care and crisis response is the need to develop **user-centred approaches**. In 2008 using a quality assurance briefing relating to the Lifeline project led by the then Chief Social Work Officer supported by the Service Manager Mental Health **it was recognised that statutory agency responsibilities were by default being attended to by the voluntary sector**. This situation could lead to a critical incident and would not be in the best interests of any party. It is therefore recommended that senior managers discuss viable options regarding crisis support and unscheduled care pathways in order to bring clarity to these key areas.

Services need to accept responsibility for 'signposting' or referring the service user to other more appropriate services if they cannot meet their needs and be fully able to explain the rationale behind this. The Mid Staffordshire Trust report strongly recommends that statutory services ought not to attempt to provide services that are not adequately resourced. Service Specifications and Operational policies ought therefore play an important part in (i) describing the type and range of unscheduled response services, (ii) describing the way in which such services are delivered and commissioned and (iii) ensure that pathways are clear and robust.

The current 'choices' for people experiencing either form of 'crisis' (social crisis or mental health crisis) have a number of entry points to services/responses. There are a number of on-island and off-island

services, telephone help-lines and websites, including the Samaritans, Breathing Space, Mind your Head, Advocacy Shetland, CAB, CADS all voluntary sector based and offering support. Some of the voluntary sector services are 24 hour and can be accessed at any time. The widest circulation of a leaflet designed to help those seeking assistance for people experiencing mental distress will assist in signposting the public to appropriate support networks.

The current route for a medical psychiatric emergency has the following entry points:-
• During normal office hours (Monday-Friday); the local GP, however if that person is known to the Community Mental Health Team a duty system operates daily and assistance can be sought directly from that secondary and specialist service.
• The Accident and Emergency Department at the Gilbert Bain Hospital is a 24 hour resource that people requiring mental health support can access.
• Out with normal office hours NHS 24 is another primary care resource.
• On occasions the local Police Force also contributes to the support and management of those experiencing mental distress.
• The on call duty social work system is also available to people and through that system a Mental Health Officer (MHO) can also be contacted.
• The With You For You referral point plays an important role, as will FACE when it is fully operational.

The more widespread use of robust Care Programming combined with a Wellness Recovery Action Plan (WRAP) and linked to out of hours service provision could provide a more appropriate response in managing crisis/unscheduled care issues in partnership with existing service users. Access to the medical records and previous assessment information of those seeking to support people presenting for assistance is a crucial element in that new type of service (as highlighted in the QIS best practice statement march 2009).

A clearer into service pathway that signposts people to the most appropriate response would be advantageous for those people seeking assistance out side normal office hours and who are not already known to services. The With You For You process and procedure ought to be considered in the first instance as the vehicle to assess and then process a request for assistance.

Additional resources and reconfiguration of current resources MUST be considered and developed could be 24 hour access to the Annsbrae respite facility and staff support. Also 24 hour access to staff with particular skills an example of this being out of hours mental health trained staff cover or alternatively out of hours drop in facilities (statutory or voluntary agency provided) or 24 hour help lines etc.

The philosophy of support to independence is crucial. In order to ensure that this outcome is being achieved greater governance at all levels will be required and quality assurance outcomes agreed in the first instance. The absence of a uniform and co-ordinated recording schedule for all unscheduled care interventions and support continues to make it difficult to measure like for like and to ensure that engagements are made to the highest standard.

The Mid-Staffordshire report highlighted in particular that in future 'that trust must continue the work it has started to recruit additional nursing and medical staff, to ensure that care provided to patients throughout the trust, including at night and at weekends, is safe and keeps to accepted standards'. Additionally, the report stated that 'Boards of NHS trusts need to be focused at all times on the safety and quality of the services provided to patients. This includes having information available to boards that properly captures the experience of patients, so that non-executives can scrutinise and challenge the care received by patients'. The conclusions of this most recent report only serve to drive the sensitivity felt by those commissioning all services to ensure that they are adequately resourced and that no corners are cut. The Report indicates it is better to acknowledge that no service can be provided rather than provide one which is under funded and carries inherent risks.

Most Recent Complaint Report Recommendations

The recommendations below are form the most recent serious complaint, which prompted the HIS Service Review. It must be noted that the complaint resonates with concerns reported on reviews of this area of service over the years.

- Ensure that the current review of mental health provision includes a robust analysis of the staffing required to deliver safe, effective, person centered and recovery focused services capable of meeting current and predicted demand.

- Introduce a single shared electronic patient record (FACE) for all services involved in the delivery of mental health care and treatment (i.e. CMHT, Annsbrae Social Care Support Service and MHOs).

- Establish a multi-disciplinary working group with stakeholder participation (including GP and Carers representatives), that will develop an agreed and assured process for the administration of submissions to the Mental Health Tribunal for Scotland.

- Ensure that all relevant staff have received appropriate training in regard to the responsibilities of health and social care staff as defined in "Caring Together: The Carers Strategy for Scotland 2010 - 2015".

- Work in partnership with patients, carers and staff to develop an agreed and adequately resourced action plan to address identified issues and concerns.

3 ON ISLAND PSYCHIATRY – RECRUITMENT, RETENTION AND RISK MANGEMENT

NOTE – SHETLAND HAS BEEN UNABLE TO RETAIN A PSYCHIATRIST FOR MORE THAN TWO YEARS FOR A SIGNIFICANT PERIOD OF TIME. ALL REPORTS, EXIT INTERVIEWS AND LETTERS OF RESIGNATION HAVE HIGHLIGHTED THE IMPRACTICALITY OF MAINTAINING A SINGLE HANDED PSYCHIATRIST. A SECOND PSYCHIATRIST IS NECESSARY TO IMPROVE CURRENT SERVICES AND BUILD A MORE RESILIENT SERVICE FOR THE LONG TERM.

Mental health policy in the UK has been undergoing modernisation in recent years. The direction of travel has been towards community based, person centred services, within a context of social inclusion. The need for capability development to work in partnership with people who use services and their families, using recovery, values and evidence based practice has been areas that have also emerged.

In Scotland the development of functional teams of Assertive Outreach, Crisis Resolution/Home Treatment and Early Intervention has challenged traditional ways of providing services, in particular the role of Community Mental Health Teams and Acute Inpatient Centres. These new service configurations bring with them the potential for fragmentation and discontinuity of care. NHS Shetland, in collaboration with Shetland Island Council, must develop their consultant psychiatric, primary care and other health and social care practitioners and partner agencies to re-engineer services and staff roles into a system that is understandable and effective for service users. The development of the role of the psychiatrist needs to be considered in this context.

Mental health services on the mainland operate within a variety of subspecialties in primary, secondary and tertiary care settings. general adult and community psychiatry, child and adolescent psychiatry, forensic psychiatry, liaison psychiatry, psychiatry of learning disability, psychiatry of old age, psychotherapy, rehabilitation and social psychiatry and substance misuse. Shetland faces the challenge of configuring on island services to “fit” this breadth of mainland services such that quality and communication are protected within an environment of minimal resources.

It is important to note that Mental Health reform has put a greater emphasis on services based in the community, which are expected to provide the following:
(1) Treatment and care that are close to home, including acute hospital care and long term residential facilities;
(2) Response to disabilities as well as to symptoms;

(3) Treatment and care specific to the diagnosis and needs of each individual; (4) consistency with international conventions on human rights;
(5) A focus on the priorities of service users themselves;
(6) Coordination between mental health professions and agencies; and
(7) Services which are mobile rather than static
(Thornicroft & Tansella 2004).

General adult and community psychiatry operates in primary, secondary and tertiary care settings. The consultant psychiatrist role in primary care is complex and evolving, where a key challenge lies in establishing and managing effective partnerships with other local care agencies. In community mental health teams, psychiatrists offer therapeutic interventions, prioritising adults with severe mental illness, co-working with others, including community psychiatric nurses, social workers, psychologists, occupational therapists, and new roles.

The role of the consultant is changing, with more emphasis being placed on the following:
(1) direct clinical management of people with the most complex problems;
(2) greater use of advice and consultation with other members of the multidisciplinary team for those with less complex disorders; and
(3) clinical leadership in the development of services

In recent years three main alternatives to acute inpatient care have been developed: acute day hospitals, crisis houses and Home Treatment/Crisis Resolution teams. Acute day hospitals offer programmes of day treatment for those with acute and severe psychiatric problems, as an alternative to admission to inpatient units. Crisis houses are houses in community settings that offer services for those who would otherwise be admitted to hospital. Crisis Resolution/Home Treatment teams offer intensive support and treatment at the service user's home or at an acute day hospital. The team can function as a gatekeeper to inpatient services, so that only those presenting higher levels of risk or difficulty in management are admitted to hospital. Assertive Outreach Teams focus on those with serious mental illness who have a repeated pattern of inpatient admissions and disengagement from traditional community services. Such teams have been shown to engage users more successfully in services, produce greater user satisfaction and fewer days spent in hospital. Early intervention services focus on those developing a psychotic illness, with the aim of early identification and treatment. The aim is to reduce the duration of untreated psychosis and produce better outcomes.

Such developments may require new roles for consultants within the multidisciplinary team. At the same time, more traditional services, such as inpatient care and the generic community mental health team are being re-evaluated. The increased number of functionally specialised teams is raising questions about how far consultants themselves should become specialised within adult psychiatry.

This view presents challenges locally in terms of recruitment and retention. Any consultants appointed must be supported and encouraged to pursue professional development, and maintain good professional communication links.

Traditionally, the Royal College of Psychiatrists developed norms for the numbers of consultant psychiatrists needed to provide a service for any given population. These norms were created by the faculties of the College based on 'best practice', but with no firm validity. Those norms have been applied too rigidly in the past, and now, evidence as to their new ways of working and the development of new teams and services, it is no longer appropriate to judge consultant workload in isolation.

To aid this process, a toolkit called 'Creating Capable Teams' is being devised by the National Steering Group. This will enable mental health teams/providers, through a stepped process:

- to review the needs of service users in the locality served;
- to consider the possible options for staff configuration within the team, based on identified competencies necessary to meet need, rather than on the traditional professional roles;
- to make the most effective use of the capabilities identified within existing staff groups;
- to identify gaps within the skill mix;
- to outline possible solutions in terms of roles, including the consultant role, that may be applicable for the team in the context of its organisation; and/or
- to enable the team to seek new and creative solutions that meet its needs but fall within the wider context of the grading, pay and reward systems, and career development.

It is envisaged that, as the job planning process and annual reviews become established and more robust, these processes should be the mechanism for defining what is expected of the consultant psychiatrist. However, the Creating Capable Teams Toolkit will be a further aid to achieving greater

clarity about team function in the context of the local service user needs, and about the number and mix of skills required within mental health teams to meet this demand. This will enable the role of the consultant psychiatrist to be considered and agreed to maximise the use of NWW. This will result in an effective, efficient and cohesive whole team approach that places service user need at the centre of modern mental health services.

Given the above toolkit it is no longer appropriate to describe idealised numbers of posts as 'norms'. However they do indicate the approximate level of demand and resource required to meet the average level of service need within any given population.

Simplified Version of Consultant Indicators

(From the Joint guidance on the Appointment of Consultant Psychiatrists, 2009)

General adult 5.0 per 100,000 of the total population (to include rehabilitation, liaison and substance misuse)

CAMHS 1.5 per 100,000 of the total population

Forensic 0.8 per 100,000 of the total population

Learning disability 1.0 per 100,000 of the total population

Old age 1.8 per 100,000 of the total population

Psychotherapy 1.0 per 100,000 of the total population

Bases on a population of 23,000 in Shetland, the roles that currently fall to adult psychiatry would require:

General Adult	1.15
Forensic	0.18
Old Age	0.41
Psychotherapy	0.23
Total	**1.97 FTE**

Recommendation

The above explanation of the demands on a modern psychiatric service, combined with the well reported concerns about the fragility of the current singleton post provides a compelling set of arguments for the recruitment of another psychiatrist. Such an appointment would provide the strength and resilience the Mental Health service requires.

There is also an opportunity to establish a clinical link between Mental Health and Addictions services. By including the Addictions prescribing function to this post, with two sessions per week set aside in the contract, this would formalise the clinical relationship between Mental Health and Addictions Services. There is a clear overlap between some Mental Health and Addictions cases, but particularly in relation to out of hours/crisis services. Effective clinical governance of an out of hours response is essential, and such an arrangement will assist the service in developing a more anticipatory approach to crisis management

The 0.2 FTE element for the post could be offset in part against the Forensic and Psychotherapy elements of the Consultant Indicator above.

NB. The establishment of two psychiatrists could not overcome all of the difficulties in delivering an all embracing 24 hour seven day on call service. However, the introduction of an out of hours on call CPN service, an out of hours/crisis service and the use of General Practitioners to undertake out of hours Emergency Detentions with next day Clinical Psychiatric assessment (which is common practice in many of the mid size mainland Health Boards) would go a long way to providing a satisfactory seven day psychiatric service.

The cost of a staff grade psychiatrist with on costs is likely to be @£90,000.per annum

This cost can potentially be offset in two ways:

1. The SLA for admissions to Royal Cornhill Hospital is £243,557. A reduction of off island inpatient admissions by a third would result in a saving of £81,186 per annum
2. The current addictions service review has raised the possibility of employing a General Practitioner for 2 sessions per week to undertake addictions prescribing. This has a potential cost of £72,576 per annum. The psychiatric team of consultant and staff grade would undertake these two sessions, reducing costs by some £60,000

4 OUT OF HOURS/CRISIS SERVICE(S)

NOTE – THIS AREA OF SERVICE HAS FOUND TO BE INADEQUATE AND TO REQUIRE SIGNIFICANT IMPROVEMENT IN REPORTS DATED 2008, 2009, 2010, 2011 AND 2012. THIS AREA OF SERVICE HAS ATTRACTED THE HIGHEST LEVEL OF COMPLAINTS SEEN DURING THIS REVIEW

4.1 Summary

Annsbrae Community Support Service currently provides support to vulnerable adults with mental health and other issues, including dementia, in the community. It is proposed to fund the service to provide 24 hour support for three days to enhance out of hours/crisis care. Two staff will be in attendance for up to 72 hours, for all adults identified as presenting with significant mental health issues including dementia, where the person concerned requires to be supported in their own home or in a place of safety which could include a hospital facility – a ward or some other safe area. The cost for a three day 72 hour support session will be £3,138. The possibility of additional costs for on call CPN service and places of safety is touched on later in the report, but should be manageable within mainstream budgets.

4.2 Background

NHS Fife and NHS Tayside undertook a joint unscheduled care mental health review over a year in 2006. Those Boards mapped successfully the competencies that they believed were required by service providers for each stage of the patient's Out of Hours Journey, using the Skills for Mental Health database. That review was shared with NHS Shetland.

In order to simplify the more comprehensive Skills for Mental Health competencies the following list is attached. Even when reduced to the most basic headings, the list is extensive, challenging and complex.

Basic Broad principles
I. Child Protection
II. Mental Health Legislation
III. Suicide and Self harm
IV. Acute mental illness and acute mental distress
V. Violence and aggression
VI. Domestic violence

VII. Risk and Dangerousness
VIII. Offending behaviour
IX. Medication
X. Psychological therapies
XI. Trauma
XII. Substance Misuse and Alcohol misuse
XIII. Reflective practitioner

In addition to a broad knowledge base covering the above topics, any practitioner undertaking unscheduled care assessment and support would benefit from having specific knowledge of at least one preferred intervention, have completed break away technique training and have a working knowledge of associated agencies and voluntary sector partners.

Specific Risk assessments and Risk Management processes ought to be adopted and the wide dissemination of DICES (or equivalent) and 'signs of safety' principles adopted also.
Safe Talk, Assist and suicide talk need to be the starting point for suicide intervention and self harm awareness for self harm intervention.
Protocols for the safe management of adults at risk should be agreed with Police locally.

Annsbrae community support staff is the logical choice to deliver a 72 hour out of hours/crisis service. They can offer the degree of flexibility and commitment required to ensure the service would be available 24 hours a day, seven days per week. They have a group of staff already trained in Control and Restraint, and would be able to undertake the 2 day Health and Care training available on basic medications and Health treatments

4.3 Recommendation

To develop an out of hours/crisis service whereby adults with significant mental health issues, including dementia, can be maintained for up to 72 hours to stabilise, assess and where possible avoid unnecessary transfer to RCH.

Over the last five years, an average of 25 people per year has been admitted to Royal Cornhill Hospital Aberdeen from Shetland with 10 of these patients discharged within two weeks. By providing a service where two 2 staff trained in control, and restraint can be available for up to 72 hours, (the duration of an Emergency Detention Certificate) in an agreed place of safety, with appropriate clinical governance for e.g. rapid sedation.

This would give local services an opportunity to stabilise the situation, and provide a more thorough assessment, reduce the number of admissions to RCH, and provide a more effective service.

Example of Service Development

• Annsbrae to build backfill capacity to be able to provide 2 times 72 hour staff support from the wider staff group without affecting mainstream services
• Appropriate clinical governance via enhanced Island based psychiatry input
• Availability of one or more agreed places of safety – one of which will require an acceptable environment for rapid sedation and e.g. CPR etc. Costs and possible offset revenue – this will include hospital but the service could also be delivered in a home environment following an appropriate risk assessment

NB Support staff will attend and complete a two day course entitled: "Mental Health Crisis Training for Frontline Staff"

On completion, the staff will be able to:

- Demonstrate an understanding of the main pathologies that affect mental health.
- Demonstrate critical understanding and clinical skill in the assessment of risk in relation to suicide.
- Identify and apply an evidence-based approach to assessment in relation to mental health crisis.
- Demonstrate an ability to listen and respond with empathy to a person in a mental health crisis.
- Demonstrate a working knowledge and understanding of the formal and informal networks that exist to support a person in mental health crisis.

- Develop an awareness of how to maintain personal safety when working with individuals in crisis.

Each 72 hour intervention of 2 waking staff (on shifts) would have a direct staffing cost of some £3,180.

This funding could available through creative service design or income collection/reallocation, a cursory review of the CHCP annual budget suggests two areas of possible reallocation. SIC and NHS Shetland jointly spends over £1,000,000 on 10 off island placements. It is likely more than one high cost service could be delivered on island. It is also possible the service users would refuse such an offer of service. This would then potentially release SIC from its funding obligation, thereby releasing funding. Another area is that of Domestic Services. The CHCP budget for 2012 - 2013 indicates SIC commits £1,124,000 on this non essential service area. A revised budget for 2013 – 2014 suggests the actual sum for Domestic services is £443,000. As Council can legitimately require payment for this entire amount, and as such repayments are not yet recognized in the budget, this would again provide sufficient funds for the proposed service.

NB - In 2011 costings that were presented in the Shetland Lifeline Evaluation Report outlined anticipated costs for a voluntary sector crisis response service at around £100k. The Lifeline project had attracted pilot funding each year around £50k per year and the very useful end of project report highlighted the need to substantially increase funding for sustainable management and practitioner costs.

Though Shetland Lifeline was an important contributor to the understanding of crisis support across Shetland and the impact of that service in shaping future service provision should not be under-estimated, it would have been unable to undertake the statutory roles and responsibilities expected of the Health Board, in particular the functions of ‘robust support’ for people presenting a danger to either themselves or others and statutory actions required under the Mental Health Act i.e. medication and control and restraint. It is for these reasons that the statutory functions to be covered by the staff to be employed in this proposal could not be delegated.

It was anticipated that the triage function of the duty Mental Health Practitioner will be an important aspect of ‘signposting’ patients in crisis to the relevant Community based support networks and ensuring appropriate transfer using the With You For You procedures, and that voluntary sector

partners will play an important role in developing and providing alternative support networks. However the local voluntary agency Mind Your Head is applying for a post to provide Tier One signposting, support and guidance

The Local Authority operates a Social Work on call rota and a 'voluntary MHO rota', the functions undertaken by the staff within that jurisdiction are linked primarily to statutory functions and although sharing a common Mental Health practice boundary do not at this time overlap duties. The current costings include an element for on call payments for professional on call staff e.g. CPNs, social workers and Mental Health Officers.

Best Value

The option as outlined above is therefore regarded as best value on a number of key points. It can be regarded as a safe model, it is sustainable with the staff numbers available, it can be demonstrated as efficient (when compared to other models) and it delivers an opportunity to offer a solution to Board statutory requirements that are currently being fulfilled using 'goodwill and ad hoc crisis response delivery'.

5 COMMUNITY MENTAL HEALTH TEAM STAFFING LEVELS AND SOCIAL WORK INTEGRATION

In the past, there was often a clear distinction between 'frontline' primary care for mental health conditions, such as GPs and community mental

health nurse (CMHN), and more specialised services, such as psychiatrists or clinical psychologists, who often only worked out of psychiatric units.

However, over the years there has been a shift to providing some of these specialised services in a community setting, such as a day centre, or in your own home.

As hospitalisation for a mental health condition can be traumatic it is only used when it is thought to be absolutely necessary.

Whenever possible, mental health services are now delivered using a multi-disciplinary approach, calling upon the skill and expertise of a number of different departments and teams.

Community mental health teams (CMHTs) focus on working to help people with complex mental health conditions. They aim to provide the day-to-day support that is needed to allow a person to remain living in the community.

Crisis resolution teams

Crisis resolution teams (CRTs) treat people with serious mental health conditions who are currently experiencing an acute and severe psychiatric crisis which, without the involvement of the CRT, would require hospitalisation. Psychotic episodes, or suicide attempts, are examples of acute psychiatric crises.

Due to the nature of their work, CRTs offer a 24 hour service, and cases are often referred to them via accident and emergency (A&E) departments or the police service.

The CRT will aim to treat a person in the least restrictive environment possible, ideally near the person's home. This may be in a person's own home, in a dedicated crisis residential home or hostel, or in a day centre.

CRTs are also responsible for planning after-care once the crisis has passed in order to prevent a further crisis occurring.

Assertive outreach teams

Assertive outreach teams (AOTs) aim to help people who have had a previous history of serious mental health problems, but are no longer in regular contact with mental health services.

The concern is that a person may still require regular treatment but, for a number of possible reasons, they are no longer seeking it and therefore might become a risk to themselves or others.

AOTs will work in cooperation with other agencies in trying to locate people who are thought to be at risk. Once they have been located, a member of the team will try to persuade them to resume their contact with mental health services, and also find out why they lost contact in the first place.

After these issues have been resolved, the person's treatment can then usually be transferred to a community mental health team.

If the person still refuses treatment, and it is thought that they pose a significant risk to themselves, or others, the AOT may have to liaise with social services in order to get the person sectioned under the Mental Health Act. Health condition, such as schizophrenia or bipolar disorder, or as a result of drug or alcohol misuse.

The early intervention by the psychosis team (EIPT) is designed to work with people who are between 18-35 years of age, and who have experienced their first episode of psychosis. In the past, it could take up to two years after the onset of psychotic symptoms before someone started receiving treatment and help.

However, the EIPT now focuses on the early detection and assessment of psychotic symptoms, and then provides support and counseling in order to treat the underlying causes.

Early intervention in psychosis teams

Psychosis is a term that is used to describe a mental condition where someone is unable to distinguish between their imagination and reality. An episode of psychosis is usually caused by an underlying serious mental

Early intervention is often crucial because it is during the first few years that people with psychotic symptoms are at greatest risk of harm to both themselves and to others. Also, the earlier a serious mental condition is treated, the better the long-term outcomes tend to be.

Forensic mental health services

Forensic mental health services work with people who have mental health conditions and have committed a criminal offence, or are thought to be at high risk of committing an offence.

Forensic mental health services are delivered in secure hospitals and prisons because most of the people who are in need of such services are thought to be a risk to both themselves and others.

An important goal of forensic mental health is to treat any mental health problems that may have contributed to a pattern of criminal behaviour and, whenever possible, release a person back into the community after they have completed their sentence, if it is thought safe to do so.

However, a small number of people are held indefinitely in secure hospitals because they are thought to pose a serious and immediate threat to the public, due to a previous history of physical and/or sexual violence

Implications for Shetland

The Mental Health Policy Implementation Guide for CMHTs (Department of Health, 2006) views these teams as the mainstay of the system and the core around which newer services are developed. They should offer people short-term contact services and continuing treatment, care and monitoring. Their Functions include:

- work with primary care to provide a single point of entry
- assessment
- a multidisciplinary team approach
- regular review, including multidisciplinary and multi-agency review
- a range of interventions
- liaison with other parts of the health system and other agencies
- provision of discharge and transfer arrangements.
-

The Mental Health Policy Implementation Guide (PIG) for CMHTs recommends that each CMHT serve a population of 10,000 – 60,000 depending on the local levels of morbidity and travelling distances. It suggests a staffing of eight whole-time equivalent (WTE) care co-ordinators, each with a maximum Caseload of 35 people and a maximum caseload for the team as a whole of 300–350.

The suggested staff mix is estimated at
:
3–4 community psychiatric nurses (CPNs)
2–3 social workers (MHOs} Care co–ordinators
1–1.5 occupational therapists (OTs)
1–1.5 clinical psychologists
1 consultant psychiatrists
1–1.5 other medical staff

1–3 support workers
1–1.5 secretaries
Reception staff
IT and audit support

For the purposes of the above calculations it is assumed that:
1. CMHTs need to cover two separate functions: assessment and continuing care.
2. Most assessments will be requested by primary care.
3. Users needing continuing care will be those with severe and enduring mental illness.
4. The caseload per team is 325. This is based on a *maximum* caseload size as opposed to an *ideal* size.

The above figures do not include the availability of Crisis Intervention, Assertive Outreach, Forensic, and Early Intervention Teams. These services are designed to operate over a population of 250,000. For the Shetland population, this type of service would require an additional

3.7 Community Psychiatric Nurses
1.0 social workers
0.2 Psychologists
0.2 psychiatrists
0.2 other medical staff

Combining these figures, Shetland Community Mental Health Team requires a minimum of:

6.5 FTE Community Psychiatric Nurses
3.0 FTE Social workers (MHOs)

6 SUBSTANCE MISUSE AND MENTAL HEALTH

Background

Confusingly, the term ‘dual diagnosis’ is used to describe several combinations of physical, psychological or developmental conditions;

But for the purpose of this briefing, it refers to the co-existence of Substance misuse and mental health problems. 'Mental Health problems' refers to severe or enduring conditions, while 'Substance misuse' refers to chronic or complex substance use problems.

Mental health and substance misuse problems are major public health and social issues. They are commonly encountered in the general Population, but are perhaps more apparent to health and social care services.

Individuals may present during an episode of intoxication or withdrawal; may be dependent on one or more substances; and may suffer from more than one psychiatric symptom or syndrome as a result. It may, therefore, be challenging to distinguish 'what comes first' for all of these reasons, and a pre-occupation with 'what comes first' often results in potential service users being excluded from help. Service organisation tends to revolve around specific disorders (e.g. mental health, physical health, substance use), which does not take account of the complicated realities of the individuals concerned, even though this feature may, in part, contribute to poor outcomes. Services are likely to have different histories, and differing philosophies and ways of working with people who use those services. Most significantly, they may have little experience of each other's field.

For example, recovery approaches that currently predominate in mental health services have not been fully embraced in substance use services. The nature of the co-morbidity may bar some service users from a particular service. For example, the criteria for accessing a mental health service may exclude those who misuse substances and vice versa. Without access to specialist services, people with a dual diagnosis, who may already find it difficult to engage with services, will not only continue to have serious health and social care needs, but are even more likely to be resistant to approaching services in the future.

Professionals involved in health and social care services are likely to face ethical and legal dilemmas. For instance, while seeking to encourage service users to engage with services (and minimise disengagement) difficult issues relating to risk (either to the individual, those within their social network or the public) may have to be addressed, and where the service user is a primary carer, child protection procedures must be given due attention.

This may involve complex intra-agency working between adults' and children's services, and the importance of challenging traditional

separations between services in situations where there are parents with mental health problems is challenging.

Recommendation

Shetlands Islands Addictions Service is currently under review, and given conflicting timescales, it is not possible to synchronize both Reviews. However, from the evidence collected for both Reviews, it is possible to evidence that Shetland has an incidence of co-morbidity which suggests the provision of an additional Addictions CPN based within the CMHT would be entirely appropriate.

Furthermore, a one year Review of the Out of Hours/ Crisis Care service is recommended, to ascertain whether and what incidence of substance induced psychosis is referred to and dealt with by the Team. Presentations involving substance misuse can frequently be difficult to assess immediately, and it is quite likely that a newly established out of hours/crisis service is called upon to deal with cases where the mental health component is not obvious, although the level of risk may be high.

The psychiatric involvement with addictions prescribing should necessarily provide a better linkage between Mental Health and Addictions Services, and should therefore help support an Anticipatory Care Model of support and treatment.

7 PSYCHOLOGICAL THERAPIES – ACCESS AND TARGETING

The Delivery of Psychological Therapies in Scotland

Values-based care and a Recovery focus

The Scottish Government is strongly committed to ensuring values-based practice across all professions within the Mental Health services in Scotland.

Any psychotherapeutic intervention must be rooted in respect for the individual, ethical practice, service user-centred care and respecting diversity and promoting equality and must have a Recovery focus. Values-based training- developed by NHS Education for Scotland, and based on the '10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland)'- has been rolled out for all Mental Health nursing staff as part of the programme of work arising from 'Rights, Relationships and Recovery: A Review of Mental Health Nursing in Scotland'.

There is an expectation that professional training for all mental health staff will demonstrate effective coverage of the learning outcomes in the 10 Essential Capabilities- Learning Materials (Scotland). This is now a requirement for pre-registration training in nursing.

There has also been an increasing emphasis in Scotland on Recovery focused practice, led by the Scottish Recovery Network (SRN). The SRN, in partnership with NHS Education for Scotland, have published a framework for learning and training in Recovery focused practice, and a set of national learning materials which will help support all staff in operating from a recovery-based perspective.

The modules in 'Realising Recovery' (which comprise 'Understanding Recovery', 'Using Self to Develop Recovery-focused practice', 'Enabling Self-direction' 'Sharing Responsibility for Risks and Risk-taking' and 'Connecting with Communities') build on the sound foundations laid down in the 10 ESCs.

What are 'Psychological Therapies'?

There is a recognition that the phrase 'Psychological Therapies' is used to describe a wide range of practices, and that there is a degree of confusion over the meaning of the term. At the higher tiers of the stepped-care system (see below), staff may be accredited to a specialist level in one of

the major therapeutic approaches. Further down the pyramid they may simply be required to use circumscribed elements of any particular approach.

The term 'Psychological Therapies' generally refers to a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functioning. The skills and competencies required to deliver these interventions effectively are acquired through training, and maintained through clinical supervision and practice.

A range of different psychological models have been applied to mental health problems, and different 'schools' or modalities of therapy have grown up around these models. The modalities of therapy most commonly provided within the Health Service in Scotland are Cognitive Behavioural Therapy (CBT), Systemic and Family Therapy, Psychodynamic Psychotherapy, Inter-Personal Therapy (IPT) and Person-Centred Therapy.

There are a range of other therapies on offer, many of which are offshoots or developments from the main modalities, some of which offer an integrative approach.

Effective psychological interventions tend to share the following key characteristics:

- A clear underlying model/structure for the treatment being offered;
- A focus on current problems of relevance to the service user; and
- Recognition of the importance of a good therapeutic alliance between patient and therapist.

For any particular patient population it is possible to review the scientific evidence, based on published research trials, for the effectiveness of any particular therapy.

Different levels of skills and competences are required at the various tiers of patient care, and this need to be clearly articulated for each therapeutic modality to ensure that appropriate care is delivered at each stage of the patient journey.

Supervision and Governance

Training and skills development are key to the Psychological Therapies strategy which is based on increasing the capacity of the current workforce to deliver effective interventions at the required volume.

Until recently we have not had any recognized national qualifications or training standards specifically for Psychological Therapies which map clearly onto the levels of psychological intervention required at different levels of matched/stepped care systems.

Nor have we had clarity around what skills are required by those providing the clinical supervision necessary to guarantee safe practice. This has made it difficult for service managers to plan training for staff within services and to ensure the educational and clinical governance of systems.

With this in mind, NHS Education for Scotland, working in partnership with 'Skills for Health' (the Sector Skills Council for the UK Health Sector) and partners in England to articulate the competences necessary to deliver Psychological Therapies safely and effectively.

Three Competence Frameworks have already been produced and are recommended for use:

- Cognitive and Behavioural Therapy for Depression and Anxiety (which differentiates between the competences needed at the 'Low Intensity' and 'High Intensity' levels within stepped care);
- Psychoanalytic / Psychodynamic Competences; and
- Supervision Competences.

Delivering Evidence-based Psychological Therapies

The concept of delivering 'evidence-based 'interventions have a number of implications for any service. The evidence base is derived from the results of key therapeutic research trials, and to deliver an 'evidence-based' therapy we must be able to demonstrate that we are replicating the conditions operating within those trials as closely as possible.

In practice this means having therapists:

- trained to recognise standards, and having the competences necessary to deliver psychological interventions effectively to the tier of service within which they work;
- delivering well-articulated therapy, and adhering to the appropriate model; and
- operating within a well-governed system which offers regular high quality, model-specific clinical supervision, support and relevant CPD.

NHS Education for Scotland (NES) has been working in partnership with the UK-wide organization 'Skills for Health', and with NIMHE and CSIP from England, to articulate the competences necessary both to deliver

Psychological Therapies, and to supervise others who are in training or delivering within the service (see Section 3).

It is important to bear in mind that the standards for the delivery and supervision of Psychological Therapies within a stepped-care system will be based around these competences, and services will be expected to work towards complying with these standards to demonstrate that they are providing evidence-base care. All NHS Boards are currently being encouraged to review their service provision, staff training and supervision arrangements in the light of these developments.

The Key Role of Clinical Supervision

It is important to distinguish between traditional work-related supervision, which may cover a range of managerial and related issues, and the term 'Clinical Supervision' as used in relation to Psychological Therapies.

Clinical supervision is essential to the delivery of Psychological Therapies services, both during training and to ensure the ongoing safety and quality of subsequent practice. It is a requirement of all professional bodies accrediting psychological therapists.

Clinical Supervision:

- Ensures that the supervisee practices in a manner which conforms to ethical and professional standards;
- Promotes fidelity to the evidence base (The therapeutic trials from which the evidence base is derived routinely insist on close supervision of individual cases and outcomes);
- Ensures adherence to the therapeutic model;
- Provides support and advice in dealing with individual cases where the therapy may be stuck, or where there are elements of risk; and
- Acts as a vehicle for training and skills development in practice.

In order to deliver safe and effective Psychological Therapies, NHS Boards have to ensure that there are enough adequately trained psychological therapies supervisors within the system, and the capacity for regular supervision of both trainees and practicing staff.

Matched/Stepped-care models of service delivery

Stepped care is a tiered approach to service provision, best described as pyramidal in structure, with high-volume low intensity interventions being provided at the base of the pyramid to service users with the least severe difficulties.

Subsequent 'steps' are usually defined by increasing levels of case complexity, and increasingly intensive forms of treatment. In 'matched' stepped-care models, there is a system for matching the appropriate level of treatment to the level of complexity of the service user's problem, and the service user receives the minimum input compatible with effective treatment.

In providing treatment to any service user population presenting with problems spanning a spectrum of severity, evidence suggests that a matched/stepped care model is the best way to make use of limited resources.

The tiered approach to delivering mental health services in Scotland is laid out in the Framework for Mental Health Services (1997), and in the CAMH SNAP report (2003). Historically, however, a variety of stepped-care models have been developed to deliver Psychological Therapies, with different definitions of the steps and of the skills needed at each level. Some are described it terms of the severity of problem and its impact on functioning, some in terms of the level of expertise of professional involved, some in terms of the nature or of the service delivered in that tier, or the likely duration of input etc.

However, most service-level based PT models would have levels of service delivery corresponding to:

- Information

This is generally accessed directly, does not involve one-to-one contact with mental health staff, and does not require GP referral. Would include information available on mental health issues in general, on common mental health problems, and on different treatment approaches.

It would include information leaflets available through GPs surgeries or other health and social care agencies. It may also cover library/reading schemes, large-scale psycho-educational groups, and direction to high quality Psychological Therapy websites.

- 'Low Intensity' interventions

Most commonly accessed through GPs, would cover Doing Well Advisors/Self-Help Coaching, solution-focused problem solving, supported self-help, structured anxiety management groups etc.

Aimed at transient or mild mental health problems with limited effect on functioning, time-limited and normally lasting between 2-6 sessions.

- 'High Intensity' interventions

Secondary care based. Standardised psychological therapies-CBT, IPT etc, delivered to protocol.

Aimed at common mental health problems with significant effect on functioning, and normally lasting between 6 and 16 sessions.

- Specialist Interventions

Most commonly accessed through secondary care and specialist services. Standardised high intensity psychological therapies developed and modified for specific patient groups.

Aimed at moderate/severe mental health problems with significant effect on functioning e.g. substance misuse, eating disorders, bi-polar disorder and normally lasting between 10 and 20 sessions.

- Highly Specialist Interventions

Highly specialist, individually tailored interventions based on case formulations drawn from a range of psychological models.

Accessed through secondary, tertiary and specialist services. Aimed at service users with highly complex and/or enduring problems, and normally lasting 16 sessions and above.

It is expected that a range of evidence-based therapeutic approaches would be available within each 'step'-particularly at the lower levels-as it is recognised that no one therapeutic modality produces significant change for all patients.

The outcomes from well-designed research trials would predict a response rate of around 60% for most evidence-based therapies, leaving 40% of patients who may well respond better to an alternative evidence-based approach. The aim would be to try to match patients with the treatment which is most likely to be effective, and considerations of patient preference are important here.

Users and carers should be informed of the available options, and fully engaged in the process of decision making around their care.

There are also significant numbers of service users experiencing more than one problem, often with very complex presentations, which do not fit neatly into traditional diagnostic categories. It is important that a range of therapeutic approaches are available for this group, and there is evidence that experienced and highly skilled therapists able to work flexibly using a range of models are more successful in engaging these patients in psychological therapy.

The full range of 'steps' are required within any Psychological Therapies service, although the proportions of care delivered within each step may vary according to the context. Careful thought need to be given to this aspect of service design in order to balance the availability of care at each level with the aspiration to maximise access to the service as a whole.

Expected Service Structures and Processes

It is recognised that there is a considerable gap in most areas between what is currently available and the level of service required to meet the aspirations of the Scottish Government.

Where there is such a discrepancy, up-skilling of staff alone will not be enough to produce the necessary increase in capacity. Organisational change and service re-design will be essential, and some re-configuration of resources may well be necessary.

In relation to mental health services for children and young people, alongside training and re-design, the SGHD now recognises that, in many NHS Boards, CAMHS staffing levels will have to increase to bridge this discrepancy.

Strategic

It is expected there is Board level ownership and oversight of this area of service. An appropriate mechanism-for example a local multi-professional and multi-agency psychological therapies management group- comprised of senior clinicians and managers- will exist for Psychological Therapies

planning across a NHS Board area. This group should have formal links with local service users and carers to ensure meaningful engagement in the planning process.

The remit of this grouping should include:

- Planning the sustainable development of the Psychological Therapy services to meet published targets and commitments, and in line with Scottish Government priorities;
- Auditing availability of appropriately trained Psychological Therapy
- practitioners and supervisors;
- Prioritising and commissioning training based on service need, available evidence of effectiveness of treatment approaches for particular service user groups, cost-effectiveness and issues of equity and accessibility;
- Facilitating and contributing to local service re-design to support the implementation of the strategic plan;
- Putting in place appropriate governance to ensure safe service delivery, including ensuring necessary clinical supervision and CPD both for those in training and those practicing in the service;
- Promoting service-based research and audit to advance the evidence base and audit effectiveness of local delivery models, including appropriate activity and outcome measures. This includes acting to alter systems based on the result of audit exercises; and
- Facilitating the implementation of properly funded research trials to evaluate new and innovative therapeutic approaches.

Service Delivery

The expectation is that a matched/stepped-care model will be adopted as the most cost-effective way of delivering the service.

To ensure sustainability of this approach, and maximum service impact:

- Services will be designed based on consultation with all stakeholders, including service users and carers;
- There will be investment at system level to foster change. Engaging with the Mental Health Collaborative would be one way of achieving this;
- appropriate training will be provided to enable staff to deliver psychological care and therapy at each tier of the service;
- There will be an educational infrastructure to support training and supervision
- The service will be structured in such a way as to support and enable trained staff to deliver PTs safely and effectively;
- Staff will have protected time in which to make use of their skills; and

- There will be access to, and protected time for, regular supervision and CPD appropriate to level of service delivery.

Good access to the service depends on well-defined care pathways to psychological therapy, on the effective functioning of all tiers of the service, and on efficient communication between tiers.

To operate matched/stepped care systems effectively, to design appropriate training for staff, and to ensure sustainability in the long-term, it is essential to have:

- Clarity about the most effective way of describing the various 'steps' or tiers;
- Clearly defined inclusion criteria for each 'step', well-defined pathways from one step to the next, and good communication between different tiers of the service;
- Clear patient pathways based on explicit mechanisms for allocation to particular therapies or tiers of the service, taking into account issues of patient preference;
- Robust measures of complexity for allocating service users to levels of the system;
- Routine collection of valid and reliable outcome measures both to determine the appropriate pathway for individual service users and to monitor the effectiveness of the service;
- Clear understanding of the knowledge and competencies necessary for staff to operate safely and effectively at each tier of the system; and
- Well-defined career pathways for staff.

The aim is to match the level of intervention as far as possible to the level of service user need, taking into account such factors as problem severity, chronicity, history of previous treatments and service user's preference.

Regular review of service user's progress should be built into the system to compensate for any shortcomings in the assessment and allocation process, so that individuals requiring a higher level of intervention, are 'stepped-up' speedily and efficiently. To facilitate this process health and social outcomes should be routinely and regularly recorded.

The Development of 'The Matrix'

The Matrix is intended to provide a summary of the information on the evidence base for the effectiveness of particular Psychological Therapies for particular service user groups.

Given that the evidence base for many common mental health problems has already been interrogated using a transparent and rigorous process in the production of the various SIGN and NICE guidelines, it was decided that these published documents would form the basis of the Matrix tables.

Within each diagnostic classification the evidence from the various guidelines was collated by specialists in that area, and further input was sought from individuals with identified expertise, and from the members of the Scottish Government Psychological Therapies Group.

Psychological therapies play a particularly important role in mental health services for children and young people. Although this remains an under-researched area compared to mental health overall, much of the evidence of "what works for whom" in relation to children and young people comes from the psychological therapies literature.

It is also the case that various forms of psychological therapy contribute to "generic" CAMHS clinical practice, given the need for clinicians to develop skills in communicating effectively, for example, with small children or with families.

Use of the Matrix to Achieve Effectiveness and Cost-Effectiveness

The evidence base for any intervention, as currently defined in SIGN and NICE guidelines, will generally tell us one of three things:

1) That there is evidence in the literature for the effectiveness of that intervention; and If this is the case the intervention will then be ranked on the quality of the available evidence.

2) That there is no evidence in the literature for the effectiveness of that intervention; It is recognised that the absence of robust evidence for any particular approach does not prove that the approach is ineffective-it may simply be that the evidence has not yet been collected. However, in an environment where resources are limited it is prudent to focus on where we can have the greatest confidence in the maximum return for our investment.

3) That there is evidence in the literature that the particular intervention is ineffective, or indeed harmful

In the first and last cases the implications are clear:

- **NHS Boards should provide interventions for which there is good evidence of effectiveness; and.**

- **Clearly, where an intervention has been proven ineffective or harmful, it should not be provided within the NHS**.

Where two or more treatment options are comparable in terms of effectiveness, then issues of cost-effectiveness should be considered. Factors which need to be taken into account include:

- the cost of treatment in terms of therapist time and other resources, taking account models of service delivery and service user turnover;
- the investment required in training staff to deliver the intervention, taking into account levels of skills/knowledge already available within the system;
- the sustainability of training to maintain service in the long term;
- the efficiency of training-i.e. what percentage of time the trained staff are able to deliver the intervention within the service;
- the capacity of the system; and
- issues of patient choice.

Which Therapies? The Evidence Base and the ICPs

At Scottish Government level the strategic focus has been on CBT in the first instance because it is the therapeutic modality which currently has the widest evidence base and is most cited in the literature.

A strong CBT foundation will put NHS Boards in a good position both to provide many of the 'high intensity' interventions necessary to accredit the ICPs, and to deliver psychological interventions at the 'low intensity' level appropriate for mild/moderate mental health problems and with **maximum likely impact on the anti-depressant target**. Most of the evidence-based 'low intensity' options, including self-help, problem-solving and computerised or online packages are CBT based.

Beyond this it is expected that the requirement to accredit the ICPs will drive the choice and provision of a wider range of evidence-based therapeutic approaches, and the information presented in this document focuses on the diagnostic categories covered by the ICPs in addition to the common mental health problems.

It is not expected that NHS Boards will provide all of the therapeutic approaches recommended in the tables for any particular patient

group. The Psychological Therapies they choose to provide will be guided by:

- **the services they already have;**
- **the expertise available locally; and**
- **the advice of the local Psychological Therapies planning group**.

It is important that service users and careers are engaged meaningfully in this decision making process, and that issues of patient preference are given due consideration.

It is also crucial that the field of Psychological Therapy continues to evolve, and we want to avoid the situation where either therapeutic advances or innovative service developments are stifled by the rigid application of current guidelines. Trials of new therapies, or of new applications of existing therapies, will generally be organized by national research networks, and local Psychological Therapies planning groups can contribute to this process by facilitating access to patients.

The Delivery of Psychological Therapies in Shetland

The category of interventions which fall under Psychological Therapy can be subdivided into:

- Tier 1; 'Low Intensity' therapy;
- Tier 2; 'High Intensity' therapy;
- Tier 2; Specialist' therapy; and
- Tier 3: Highly Specialist' therapy.

The mapping of competences and levels of training against the tiers of the stepped-care system is currently best articulated for the Cognitive-Behavioural Therapies in the context of common mental health problems, and the model described below focuses primarily on this area. However, NES and the Scottish Government are supporting the development of stepped-care approaches for a range of conditions and incorporating a range of therapeutic modalities. The principles of the stepped-care approach can be applied to different patient groups, and different therapeutic modalities.

NHS Shetland has a limited range of modalities available and talking therapy services are not organised in accordance with the stepped-care model described above. The absence of a) Tier 1, "low intensity" services capable of delivering 2 – 6 sessions for transient/mild mental health problems and b) Tier 3, "highly specialist" services for those with highly complex and/or enduring problems (lasting a minimum of 16 sessions) has

resulted in the “blockage” of the existing Tier 2 service and a consequent growth in access waiting times.

Some T1/T2 talking therapy provision (e.g. bereavement, domestic violence, addictions) is available from Third Sector partners, however these services are considered vulnerable due to the difficulties they have in securing funding. It is of note that the NHS talking therapies staff do not have routine access to a Clinical Psychologist and they have been operating with a 0.5 WTE therapist vacancy for the past 18 months (due to the delay in commencing the review).

The impact on waiting times of the missing Tier 1 and Tier 3 services has been established by a DCAQ analysis of 2013 data. Based on the current service configuration and existing waiting lists, a total of 246 therapist days would be required to clear the back log and an additional 2.0 WTE staff would be needed to achieve a balance between demand and capacity.

Recommendation

Although there are some practical challenges to be overcome, it is proposed discussions take place, driven by CMHT, with NHS Grampian specialist services in Stirling and Telehealth Telecare staff in SIC and NHS Shetland to explore the possibility of outsourcing Tier 3 psychotherapy services. These cases are challenging for local services, as they require an input of up to two years and by the very nature of the presenting problems can result in a high frequency of non attendance. This inevitably means local services with limited resources can suffer from a proportionally very high lack of service use, which both extends waiting times, and is not the best use of limited resources.

The Psychological Therapies Steering Group should continue discussions with Health Improvement, GPs and Third Sector partners to increase the availability of Tier 1 services as this would be expected to reduce the demand for Tier 2 interventions and contribute to the development of a more sustainable and balanced system.

A visiting Clinical Psychology service, similar to that provided for CAMHS, would ensure that staff delivering talking therapies have the support of a more robust governance structure and this could be funded from the exiting 0.5 WTE vacancy. The availability of this service would also provide some local capacity to address the currently unmet need of adults presenting with Autistic Spectrum Disorders.

The above recommendations also clearly allow, if not encourage, a more generalist use of staff in areas where resources are limited.

8 REFERENCES

(1) The Shetland Mental Health Partnership Mental Health Strategy 2008 to 2012
(2) Mental Health Crisis Services in Shetland. Fieldhouse, 2008
(3) A Review of Shetland Mental Health Crisis Response Services and NHS Shetland Out of Hours Mental Health Provision including Out of Hours Action Plan 2010

(4) Report of HIS 2 day seminar 2012
(5) Costed protocol for the establishment of a Shetland Out of Hours Service 2012
(6) Shetland Lifeline Evaluation Report 2010
(7) Shetland CHCP – "Commissioning Mental Health Services outwith Core Service Hours" 2011
(8) Service review statistics paper copy 2013
(9) Advocacy Shetland Carers Research Findings 2013
(10) NHS Shetland Place of Safety MWC Site Visit review
(11) 2010 – Shetland NHS Board Clinical Strategy 2010
(12) 2010 – Internal Psychological Therapies HEAT Target Review reported the proposed retargeting of Talking Therapies to people requiring secondary treatment may lead to missing the HEAT target
(13) 2010 - Draft Psychiatric Emergency Plan

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Draft Primary Care Strategy
Reference Number:	CC-25-16 F
Author / Job Title:	Lisa Watt / Service Manager Primary Care

Decisions / Action required:

That the Integration Joint Board (IJB) approve the draft Primary Care Strategy and agree that a detailed Implementation Plan is presented to the IJB in six months time.

High Level Summary:

The draft Primary Care Strategy has been developed to give a direction of travel for Primary Care in Shetland and a high level implementation plan is attached. It should be noted that at the same time as the Strategy will be implemented, it is anticipated that national guidance on a new Scottish GP contract will be released and this guidance will need to be incorporated into the detailed implementation plan once received.

Corporate Priorities and Joint Working:

The draft Primary Care Strategy was developed through a literature review, policy analysis, gathering data on population health, the local workforce and activity in primary care, and extensive engagement with staff, partners and the public.

Key Issues:

- There have been difficulties in recruiting GPs to all practices in Shetland for several years.
- There are already transitional GP contract arrangements in place for 2016/17, which will impact on how GP practices work together.
- It is as yet unknown what the detail of the new GP contract will be and what impact this will have on GP Practices

Implications :

Service Users, Patients and Communities:	Successful implementation of the draft Primary Care Strategy will improve recruitment and retention and contribute to improved outcomes for service users, patients and the community.
Human Resources	Shetland's primary care services are entering a period of

and Organisational Development:	sustained change and redesign, particularly given the expected announcement of a new GP contract. Consultation and engagement with staff and other stakeholders remains vital to the maintenance of staff welfare and service morale.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications in this regard. The objectives of the draft Primary Care Strategy support and promote equalities, health and human rights.
Legal:	The conditions of any new GP contract will be legally binding and it will be for NHS Shetland to monitor the implementation and adherence to that contract.
Finance:	Any costs associated with the development and maintenance of the Action Plan will be met from within existing budgets of the Community Health and Social Care Directorate. The draft Strategy sets out an efficiency target of £300,000 that needs to be met as part of the overall NHS Shetland savings plan, which is reflected in the Recovery Plan that has been presented at a previous meeting of the IJB.
Assets and Property:	The draft Strategy has no immediate impact on existing property, although as noted the detail of the new GP contract will need to be examined once this is released.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Embedding a culture of continuous improvement and customer focus are key aspects to meeting the aspirations of the IJB, and ensuring the delivery of the Strategic Plan within the available resources. Failure to promote and embed a continuous improvement culture increases the risk of the Council and NHS Shetland working inefficiently, failing to focus on customer needs and along with the IJB being subject to negative external scrutiny.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility for the planning of integrated services, and for overseeing implementation of the Primary Care Strategy in Shetland. The Chief Officer is responsible for the operational management of integrated services
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Draft Primary Care Strategy
Reference Number:	CC-25-16 F
Author / Job Title:	Lisa Watt / Service Manager Primary Care

1. Introduction

1.1 This paper provides the IJB with the draft Primary Care Strategy for Shetland, together with a high level implementation plan.

1.2 It is proposed that the IJB agree the Strategy and that further updates be provided on a six monthly basis.

2. Background

2.1 The draft Primary Care Strategy has been developed during 2015/16 and this is the first time the Strategy has been presented to the IJB. The Primary Care Strategy was developed through a literature review, policy analysis, gathering data on population health, the local workforce and activity in primary care, and extensive engagement with staff, partners and the public. It sets out the findings in chapters on the local context, the principles and assumptions on which the strategy is based, the vision for primary care in Shetland and the case for change.

3. Current Situation

3.1 There have been ongoing recruitment issues in Shetland to GP posts for some years, which is mirrored elsewhere in Scotland; there are real problems with the sustainability of GP services in a number of areas in the mainland as well as remote and rural Scotland, including a national picture of small practices closing.

3.2 There are specific challenges in Shetland given the remoteness, the small scale of services, and in the need for services to cover sometimes large geographical areas with the associated travel and transport implications.

3.3 A new GP contract is expected to be presented during 16/17, with an expected implementation date from April 2017. During 16/17, there are transitional arrangements in place which will require GP Practices to work in a different way, namely in a Cluster Group, to provide peer review and other quality work.

4 Recommendations

4.1 **It is recommended that the IJB:**

4.1.1 **Review** and agree the content of the draft Primary Care Strategy;

4.1.2 **Agree** that an updated Action Plan is presented to the IJB in six months from the date of this meeting.

5. Conclusion

5.1 This Strategy has been prepared in collaboration with Primary Care Practitioners in Shetland.

5.2 An Action Plan will be developed to reflect the current and evolving needs of primary care services in Shetland.

Contact Details:
For further information please contact:
Lisa Watt, Service Manager Primary Care
e.watt1@nhs.net
25 March 2016

Appendices

Appendix 1 – Draft Primary Care Strategy for Shetland Executive Summary
Appendix 2 – High Level Implementation Plan

Background Documents
Draft Primary Care Strategy
http://www.shb.scot.nhs.uk/board/planning/PrimaryCareStrategyForShetland-FinalDraft.pdf

PRIMARY CARE STRATEGY for Shetland

EXECUTIVE SUMMARY

Contents

PRIMARY CARE STRATEGY for Shetland: EXECUTIVE SUMMARY

INTRODUCTION

This Executive Summary outlines the process of developing the strategy and the key themes which inform its recommendations. These are expanded on in the full report.

The Primary Care Strategy was developed through a literature review, policy analysis, gathering data on population health, the local workforce and activity in primary care, and extensive engagement with staff, partners and the public. It sets out the findings in chapters on the local context, the principles and assumptions on which the strategy is based, our vision for primary care in Shetland and what we do well already, and the case for change. We describe our findings under key themes which emerged from the engagement processes undertaken during strategy development, and the additional data gathered to inform the strategy's findings. Our recommendations take account of all these strands, and include action on implementation.

KEY THEMES: Conclusions and Key Messages

Workload:

Prevention & Anticipatory Care: We need to develop our capacity to do prevention, early intervention, supported self-management and anticipatory care effectively and as a core part of the service we deliver. We know that this will pay dividends in terms of better health and quality of life, and reduce the demands on services in the longer term. To get ahead of the curve of demographic demand and shift the balance of care to close to home and into local communities, the majority of people need to be more independent and resilient and self-manage, whilst we focus support and specialist skills on those with the greatest needs. Primary care has a key role in supporting this approach.

Leadership, engagement and behaviours: Throughout the development of the strategy, staff, managers, patients and partners have given us examples of helpful and unhelpful behaviours. We need to maintain, learn from and develop the helpful behaviours, and challenge constructively to change the unhelpful behaviours. This links to the capacity of primary care management to support and develop primary care professionals and services, and to model positive behaviours to take forward the strategy.

Workforce: In order to implement this strategy, we need to recognise the value of and invest in good quality administration, management and clinical leadership in Primary Care. We need specifically to build a Primary Care management team that can develop strategic thinking for primary care, lead implementation of the strategy, and deliver on the operational changes that are needed for sustainable future primary care services in Shetland. We need a more strategic approach to workforce development in primary care, and a primary care workforce plan to develop professional roles, plan for retirements and turnover, and improve the recruitment and retention of GPs in Shetland. We should value

all of our local workforce, and do more to support and enable them to contribute to a more integrated approach to Primary Care in Shetland, specifically using the planned review of Nursing in the Community, and developing the contribution to Primary Care of other members of the workforce including pharmacists, health improvement practitioners, social care and allied health professionals. Work needs to be done to determine future services provided to small islands in Shetland.

Evidence emerged on issues relating to infrastructure and quality improvement which have been presented under the other main themes.

Resources:

The Board has an annual efficiency target of 2% for 2016/17 and then 3% efficiency targets for subsequent years, which is designed to make savings that are reinvested in cost pressures or service improvement. This is currently set at 1.5% target to come from clinical services including primary care, so a higher percentage comes from non-clinical services.

In addition to this we have a current savings target to find to bring the Board into recurring financial balance i.e. the recovery plan. For 2016-17 the overall savings challenge is around £4 million (9.5% of the Board's baseline funding) with a challenge of just over £300,000 to come from Primary Care services.

Interfaces:

External issues: There are elements of the strategy that need us to influence partner organisations, such as the Local Authority and Scottish Ambulance Service on transport (public transport, community transport solutions and emergency health service transport); and Scottish Government on national policy that will affect local services and delivery of the strategy. We need other services to understand the impact of any service changes that they plan or make, and to put in mitigations where there is adverse impact for health services or for the health of local communities.

Service models:

Integration within localities: We need to work as integrated services within localities and develop locality planning to help make the necessary changes in primary care both in the short term and to deliver the longer term vision.

Primary Care

We need to recognise and value the components of good quality primary care, which include continuity of care, knowing the practice population really well, knowing the locality, having continuity of staffing, and a good level of voluntary sector and community involvement.

We would go further and recommend the development of wider community health and social care teams within localities, of which primary care is at the core. This will include:

- The development of a locality primary care team to include GP roles as envisaged in the new GP contract, pharmacy, and health improvement practitioner time, working with community nursing, social care and other professionals such as OT to develop a

more integrated model of health and social care, as part of integrated locality working;

- This to include flexible use of community health, social care and supported accommodation and housing resources, and flexible bed availability within local care homes;
- Along with third sector partners, making best use of the voluntary sector in areas such as carers support;
- Locality working in health and social care that includes a culture of devolved responsibility to local teams, having permission to do things differently within local teams to meet local needs, developing third sector engagement and community involvement.

Recommended Actions

Workload: Prevention & anticipatory care

- Develop a more comprehensive anticipatory care programme with better case management to reduce the burden of disease, reduce the out of hours workload, prevent hospital admissions and reduce hospital bed usage with shorter lengths of stay and quicker discharges.
- Develop and implement a framework and programme for self management and self care, which should include a comprehensive website with links to self care advice for common conditions, and support for staff in helping patients develop their own capacity for self care.
- Increase understanding within communities, the workforce and in management of the importance of these approaches.
- Develop a Primary Care Workforce Plan that includes an understanding of core skills required to deliver services effectively including prevention and anticipatory care, and the amount of time required to do this well.
- Provide skills development and training as well as a structure which provides guidance on roles and responsibilities, including specifically 'end of life' conversations and the use of advanced directives, primary/ secondary prevention, supporting self-management with assets-based approaches, and an holistic approach to primary, community and social care.
- Focus in the short term on the areas where there will be the biggest gain in reducing demand and improving the quality of patient experience such as poly-pharmacy, anticipatory care and self-management.

Behaviours, communication and ways of working

- Recognise that positive behaviour, communication and mutual respect are crucial to a well functioning organisation. Management responses need to become supportive, facilitative, problem solving, honest, consistent, building confidence, enabling and action focussed.

- Tackle particular examples of behaviours in a more systematic way as a Board – so the rhetoric of partnership, collaboration and leadership become the reality of staff experience in primary care.
- Learn to be person centred about the staff delivering services as well as about patients, and give a different profile and value to the clinical voice in primary care.
- Understand how we can use existing communication structures and pathways more effectively, or reform them to meet the needs of Shetland; for example, consider how we use representation on professional consultative committees, how well they engage, or changing the way they work to make communication easier, quicker and more effective.
- Foster cooperative working across different elements of health and social care.
- Where things work well, get folk together to share experience, and fix the things that need improvement e.g. variable experience of consultants and GPs working well together; variable approaches to change and service redesign.

Workforce

Management:

- Build a Primary Care management team that can:
    - work strategically to inform and maintain best practice and plan ahead for change to build a sustainable primary care function;
    - deliver the operational change necessary to implement the strategy;
    - work directly with practices on quality improvement and to improve systems such as 'doing it once for everybody';
    - work with other Board services to better support primary care and improve the quality of service experience, including taking responsibility for helping to fix operational issues, with a work plan to deliver short term improvements;
    - pursue opportunities for additional funding into primary care in Shetland, from internal sources such as Endowment Funds to benefit non-core services, and external funding sources wherever possible;
    - take forward new policy and national change eg the new GP contract.
- Introduce a separate Practice Manager and clinical leadership for Lerwick Health Centre.
- Develop opportunities for collaborating in back room support functions, for example: use of Primary Care data for planning, management and clinical purposes; best practice policies such as lone working; payroll.
- Take forward clinical collaboration across/between practices.
- Develop a workforce plan and deliver changes in the primary care workforce including training and growing new staff.

GPs

- Actively support and encourage a range of measures to recruit more GPs into Shetland – an urgent priority in the short term, to fill current gaps and for future succession planning and to support retention including:

    - better, more imaginative advertising;
    - having a policy of new GP recruitment from outwith Shetland wherever the opportunity arises to bring local GP numbers upto establishment level;
    - actively pursuing schemes such as the Specialist Trainee training programme, Return to Work schemes, Remote & Rural Fellows NES scheme, the Scotland GP Enhanced Induction Programme;
    - develop a more consistent and imaginative approach to training, including increasing the number of training practices in Shetland, and attracting national funding for training such as NES schemes.
- Develop GP roles beyond core primary care:
    - More GP Special Interest roles as part of repatriation of services back to Shetland;
    - Linking special interest roles to other roles such as GP Fellows.

Nursing in the community

- Short term practical actions on community nursing to include:
    - Draw up a list of core duties that community nurses can deliver on and share with GPs;
    - Sort out practical issues that prevent practice and community nurses working together and sharing expertise and skills for the local patient population.
- Use the planned Review of Nursing in the Community to develop the nursing workforce so that there is an appropriate skill mix including healthcare assistants, nurses working at the top of their licence, including a range of specialist practitioners – specialist nurses, advanced nurse practitioners and nurse prescribers.
- Develop collaboration between practice and community nursing, recognising community nurses as part of the core primary care team, in the longer term even integration across the nursing workforce, to make best use of the range of skills available.
- Look at the potential for collaboration across nursing and social care in developing new roles.

Extending the role of the wider team

- Extend the use of pharmacists, health improvement practitioners and allied health professionals in primary care.

Small island staffing

- The Board should agree a population figure below which it is reasonable to review staffing in the remote isles.
- Review the nursing service provided to the non-doctored isles as part of the planned Review of Nursing in the Community, and take account of the views of the responsible GPs in doing that.
- Review the frequency and logistics of island visits by GPs to support the development of future models of service.

External Issues

- Lobby government on the new GP contract and on other streams of funding for primary care.
- Implement the national Out of Hours review locally in a way that will improve primary care delivery in Shetland, particularly in terms of access to services for unscheduled care, and GP recruitment and retention.
- Work with the Scottish Ambulance Service to understand the gaps in on-island transport and to better meet the needs of the most remote communities in Shetland (particularly the outer isles).
- Improve public and community transport to get better access to services specifically for those without access to a car.
- Lobby on telecommunications infrastructure & broadband width.

Structure and models of service

Integration within localities

- Develop active management support at locality level through identifying managers with a responsibility to develop individual localities and locality planning (part of the plan for Health and Social Care Integration) and locality budget setting.
- Develop the wider health and social care team in each locality, in which primary care plays a key part.
- Develop the role of the GP in professional leadership and coordination of services within each locality.
- Support clinical conversations, and a multi-professional approach in each locality.
- Work with the voluntary sector and local communities to build their contributions to future models of primary care at a local level.

The model of primary care

- In the short term, support a range of service models in Shetland to suit the local context. This should include small practices that work well in serving small and isolated populations, collaboration between practices in shared service or confederated models, ensuring that larger practices maintain or develop systems for continuity of care for patients and a close working relationship with their locality, ahead of a more integrated approach to locality teams when the new GP contract is introduced.
- Describe and develop collaboration and support that will make small practices more viable and resilient. Within this, we should spell out possible or preferred links between practices for collaboration and joint working.
- Review how primary care resources are distributed across Shetland – services and staffing, based on an understanding of workload and access for patients, as part of the development of wider locality health and social care teams, using the range of professional roles differently, and in preparation for the changes of the new GP contract and future commissioning of primary care by the IJB.

- Build in the capacity in primary care to do anticipatory care and prevention work.
- Develop a more ambitious programme in the use of IT to support single system working, for instance on IT-supported remote access, and on a single electronic record.
- Build relationships with other parts of the local NHS particularly secondary care, mental health and AHPs, with a longer term vision of developing a single local system of health and care, removing the boundaries between primary and secondary care.
- In the longer term develop the model of service to support the local vision for primary care:

Local populations will be served by a particular general medical practice as the local point of access for most care. GPs will work as the expert medical generalist providing complex care in the community, dealing with undifferentiated presentations and taking a lead for quality improvement. They will work within a wider multi-disciplinary team consisting of nursing, pharmacy, health improvement practitioners, social care and other relevant staff, working with the third sector and local communities to provide community based support for patients, building long-term relationships with their patients to allow for the delivery of more person-centred, holistic care across the full range of health problems. Each locality in Shetland should have a GP service working as part of a wider integrated health and social care team, staffed appropriately for their local population.

- Shetland needs to develop a local model of service for Out of Hours unscheduled care that will best meet local needs through multi-disciplinary staffing that is sustainable and resilient.

IMPLEMENTATION

The recommendations can be divided into actions that can be done straight away such as work on behaviours, developing the workforce plan, strengthening Primary Care Management and clinical behaviours, supporting collaboration and joint working, making sure that necessary savings are made in line with the direction of the strategy; and those that need further work or national policy such as working up service models and the local response to the new GP contract. This should be taken into account in implementation.

An implementation plan to deliver the strategy should be drawn up and owned by the Primary Care Management Team and the Health and Social Care Directorate.

Accountability for implementation should sit with the Integration Joint Board working with the professional bodies to engage clinical staff, particularly the GP sub-committee of the Local Medical Committee.

Primary Care Strategy – Action Plan

The Primary Care Strategy Executive Summary sets out a number of recommendations for consideration and an action plan has been developed based on these recommendations.

An initial draft of the action plan has been circulated to the Primary Care Strategy Steering Group and all Shetland General Practitioners; the plan will be updated on a six monthly basis to the Integrated Joint Board. It is proposed that the Steering Group continue, with a remit to support the implementation of the Action Plan.

Overall accountability for implementation of the Strategy will sit with the Integration Joint Board, working with professional bodies to engage staff; in particular the GP sub-committee of the Local Medical Committee and the new Cluster Quality Lead role being introduced as part of the 2016/17 transitional arrangements prior to a new GP contract.

It should be noted that whilst some recommendations can be implemented in a relatively short timescale, there are others which will require further work, such as working up proposed new service models and a local response to the new GP contract, once the detail for this is announced. In addition, the new GP contract may require amendment of the action plan, depending on the proposed models of care and/or ways in which services are to be delivered in future.

There are several projects underway in Shetland, (such as a review of the Community Nursing workforce and a local review of Out of Hours services), which link to the Primary Care Strategy and where there is cross over with existing work, this will be noted in the narrative.

Lisa Watt
Service Manager Primary Care

Version 1 – 04/04/16
LMC – Local Medical Committee; DCHSC – Director of Community Health & Social Care; IT – IT department

RECOMMENDATION	LEAD PERSON/DEPT	TIMESCALE	COMMENTS
Develop capacity to do prevention, early intervention, supported self-management and anticipatory care planning effectively	Primary Care Manager/LMC/Health Improvement	March 2017	There are several pieces of work underway looking at self management (including an existing self-management guide for Shetland residents) and anticipatory care planning is a major feature of the new GP cluster model which has been introduced in 2016/17.
Develop a comprehensive website with links to self care advice for common conditions	Health Improvement/LMC/IT	March 2017	Links with action above. The existing NHS website has links to NHS24 self care, the NHS Shetland self care leaflet, NHS Shetland Health Improvement and "Know who to turn to".
Recognise the value of and invest in good quality administration, management and clinical leadership in Primary Care	DCHSC/Medical Director/Primary Care Manager	Dec 2016	There is currently no Lead GP for Primary Care in Shetland, although there will shortly be a Cluster Quality Lead under the new transitional year arrangements. It is intended to roll out the SIRS programme to all practices (this is being led by public health), which will have an impact on administrative support within the primary care department
Increase the role and availability of Pharmacists in Primary Care	Director of Pharmacy	March 2017	Ongoing piece of work – external funding has been secured for a fixed period to provide additional pharmacy support to general practices
Improve the recruitment and retention of GPs in Shetland	Primary Care Manager/Medical Director/LMC	March 2017	Several bids have been made (with the support of the Shetland GPs) to the national GP Recruitment & Retention Fund announced in February. In addition, Shetland is part of a remote Scotland group bidding for monies for a National Remote & Rural Scottish website. This section will be updated once we the outcome of the bids
Review existing advertising routes for vacant GP posts	Human Resources/LMC/Primary Care Manager	June 2016	Currently advertising using ruralgp.com, Facebook, BMJ, SHOW and specific one off pieces of advertising (e.g. Guardian newspaper). External funding was sourced to enable vacancy promotion through Promote Shetland. NHS Orkney have advised they only use the BMJ
Exit interviews to be offered to all independent GPs (currently only	Human Resources	June 2016	Exit interviews are voluntary and GPs will not be expected to take part if they do not wish to

Version 1 – 04/04/16

LMC – Local Medical Committee; DCHSC – Director of Community Health & Social Care; IT – IT department

offered to directly employed staff)			
Influence partner organisations such as Scottish Ambulance Service, Shetland Islands Council with regard to transport issues and Scottish Government on national policy that will affect local services	Medical Director/Head of Planning & Modernisation	March 2017	Other services to understand the impact of any service changes that they plan or make, and to put in mitigations where there is adverse impact for health services or for the health of local communities
Actively pursue schemes such as Remote & Rural Fellows Scheme	Medical Director		Discussions are currently underway re a Remote & Rural Fellow placement in Shetland
Increase the number of training practices in Shetland	Medical Director/LMC	Dec 2016	There is currently one training practice in Shetland, the Deanery have indicated that they would be interested in seeing another practice undertaking training accreditation
To increase the focus of Primary Care on the Board of NHS Shetland, it is proposed to have a specified non-executive director with a remit for Primary Care issues	Medical Director/Chief Executive	Sept 2016	Proposal to be developed which sets an outcomes approach for the role.
The development of a locality primary care team to include GP roles as envisaged in the new GP contract, pharmacy, and health improvement practitioner time, working with community nursing, social care and other professionals such as OT to develop a more integrated model of health and social care, as part of integrated locality working	Community Health & Social Care operational team	Oct 2016	Discussions regarding locality service models underway; detail on the new GP contract is not yet known and will be incorporated into this action plan once this is available (possibly May/June 2016)
Develop a Primary Care Workforce Plan	Primary Care Manager/All GP Practices	Dec 2016	This should include an understanding of core skills required to deliver services effectively including prevention and anticipatory care, and the amount of time required to do this well
Provide skills development and training	Medical Director/LMC/Staff Development	Mar 2017	This should include a structure which provides guidance on roles and responsibilities, including specifically 'end of life' conversations and the use of advanced directives, primary/ secondary prevention, supporting self-management with

			assets-based approaches, and an holistic approach to primary, community and social care. This action has been given a timescale of March 2017, in recognition that the training schedule for 2016/17 will already be in place
Understand how we can use existing communication structures and pathways more effectively, or reform them to meet the needs of Shetland;.	Medical Director/LMC	Aug 2016	For example, consider how we use representation on professional consultative committees, how well they engage, or changing the way they work to make communication easier, quicker and more effective
Review capacity of existing Primary Care Management team (2 individuals)	DCHSC/Primary Care Manager	Aug 2016	Existing members of staff cover a variety of roles, including IT facilitation and will also be taking forward new GP contract and transitional year arrangements. In order to have capacity to do this and to support practices, a review of existing workload is required
Consider development of additional GP with Special Interest roles as part of repatriation of services back to Shetland	Medical Director	Dec 2016	Where it is possible to enhance GP roles by offering special interest roles this should be done, on the understanding that this can make existing GP roles more attractive but at the same time backfill will be required to free up GPs to do this work
Use the planned Review of Nursing in the Community to develop the nursing workforce so that there is an appropriate skill mix including healthcare assistants, nurses working at the top of their licence, including a range of specialist practitioners – specialist nurses, advanced nurse practitioners and nurse prescribers	Chief Nurse (Community)	Dec 2016	The Review of Nursing has already commenced and this action will be taken forward directly as part of that project.
Develop collaboration between practice and community nursing, recognising community nurses as part of the core primary care team, to make best use of the range of skills available.	Chief Nurse (Community)	Dec 2016	The Review of Nursing has already commenced and this action will be taken forward directly as part of that project
Review the nursing service provided to remote areas as part of the	Chief Nurse (Community)	Dec 2016	The Review of Nursing has already commenced and this action will be taken forward directly as part of that project

planned project for Review of Nursing in the Community, and take account the views of the responsible GPs in doing that			
The Board of NHS Shetland should agree a population figure below which it is reasonable to review staffing in remote areas.	DCHSC	Oct 2016	This action will include exploring the use of technology to facilitate the delivery of services.
Implement the national Out of Hours review locally in a way that will improve primary care delivery in Shetland, particularly in terms of access to services for unscheduled care, and GP recruitment and retention	Medical Director	Oct 2016	A local Out of Hours review is already underway and this action will be taken forward directly as part of that project. This action will also include the need to work with the Scottish Ambulance Service to understand the gaps in on-island transport
Develop service models for Shetland to suit the local context	LMC/Primary Care Manager/Medical Director	Dec 2016	This should include small practices that work well in serving small and isolated populations, collaboration between practices in shared service or confederated models, ensuring that larger practices maintain or develop systems for continuity of care for patients and a close working relationship with their locality, ahead of a more integrated approach to locality teams when the new GP contract is introduced. This will also include reviewing how primary care resources (both services and staffing) are distributed across Shetland
Develop an ambitious programme in the use of IT to support single system working, for instance one IT-supported remote access, and one single electronic record	IT/Medical Director/LMC	March 2017	Work is in hand looking at a single electronic record, primarily around the use of EMIS web. This will be a national framework model available in 2017

Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Shetland's Autism Spectrum Disorder Strategy 2016–2021
Reference Number:	CC-26-16 F
Author / Job Title:	Jordan Sutherland, Team Leader – Supported Living

Decisions / Action required:

The Integration Joint Board is asked to approve Shetland's draft Autism Spectrum Disorder (ASD) Strategy 2016–2021. An action plan is currently being developed to accompany the strategy, and will be presented to the IJB separately for consideration in 6 months time. Approving the draft strategy will allow us to submit a final version to the Scottish Government.

High Level Summary:

Shetland's ASD Strategy identifies priority areas for development and improvement to services for people with ASD in Shetland and will inform how local services will develop until 2021, which coincides with the life span of the Scottish Strategy for Autism.

There are six key goals identified in the local strategy, and these will inform workstreams in the action plan to address the needs of both children and adults with ASD, their families, and carers.

Corporate Priorities and Strategic Aims:

The strategy supports the delivery of the following outcomes in Shetland's Single Outcome Agreement, with a specific focus on people with ASD:

Shetland Single Outcome Agreement 2013:

- We have supported people to achieve their full potential at all life stages – from birth and early years through working lives to old age.

Community Health and Social Care Directorate Plan has the following relevant priorities:

- Developing person-centred services, with personalisation driving the shape of all public services and a strong focus on developing a person centred approach to care and care planning.
- Implementing changes to services and our workforce to support the delivery of safe, efficient, sustainable services.

Key Issues:
The strategy has been developed in response to the Scottish Strategy for Autism, which was published by the Scottish Government in November 2011. Scottish Government placed a requirement on local authority/health board areas to develop local strategies and action plans, to demonstrate how the high level outcomes of the national strategy will be realised at a local level. Shetland's ASD Strategy has been developed in consultation with *other stakeholders including the forums listed below.*, and has been amended in respect of feedback from these forums. The local strategy's lifespan is from 2016–2021, which coincides with the end of the Scottish Government's 10-year strategy. Work is well underway in Shetland, albeit to date, this has not been formalised in a local strategy document.

Implications :	
Service Users, Patients and Communities:	Shetland's ASD Strategy is intended to bring about improvement in the way services are provided for people with Autism Spectrum Disorder throughout the lifespan, ensuring that Shetland responds to the unique needs of these individuals.
Human Resources and Organisational Development:	There are no significant Human Resources implications however the strategy does address workforce development, with a view to consolidate and rationalise training we already provide to staff across health, social care and education, to ensure that the training we provide meets the needs of the respective staff groups.
Equality, Diversity and Human Rights:	The strategy is intended to improve equality of access to services and support for people with ASD, and as such there is no requirement for a further equality impact assessment.
Partnership Working	The strategy has been developed with a range of partners in integrated services, and will also require partnership working with Education and the third sector in delivering effective support to people with ASD and their families.
Legal:	No legal implications.
Finance:	There are no financial implications arising from the ongoing development of the ASD Strategy. Any costs will be met from within existing budgets or external funding will be sought. Shetland has been successful in bidding for external funding on three occasions from the Scottish Government's Autism Innovation and Development fund, and having a finalised local ASD strategy will strengthen our position, should we bid for external funding in the future.
Assets and Property:	There are no impacts for assets or property.
Environmental:	There is no environmental impact resulting from the ASD Strategy

Risk Management:	The risk of not delivering against the ASD strategy is that we will not achieve Scottish Government's aims of improving outcomes for people with ASD, their parents and carers, by 2021. Risk in relation to delivering the local strategy will be monitored and reported to the IJB against an action plan, which will accompany the strategy document, and is currently in development.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility for planning integrated services, and for operational oversight of a range of integrated services which support adults with ASD, their families and carers. The strategy will also be presented to the SIC Education and Families Committee for approval on 13th June 2016, as it encompasses the needs of children in receipt of education social care provided by the Children's Services directorate of the Council.	
Previously considered by:	NHS Executive Management Team Meeting PFPI Steering Group Shetland Mental Health Partnership Child Health Forum Integrated Children and Young People's Strategic Planning Group Carers Link Group NHS Strategy and Redesign Committee Community Health and Social Care Operational Meeting NHS Area Partnership Forum NHS Shetland Board Meeting Integrated Joint Board	02 March 2016 07 March 2016 07 March 2016 10 March 2016 11 March 2016 15 March 2016 15 March 2016 13 April 2016 13 April 2016 19 April 2016 27 April 2016
	In addition the strategy will be presented to Education and Families Committee for approval in relation to support services to children provided by the SIC Children's Services Directorate	13 June 2016

Agenda Item

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Shetland Islands Council

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Shetland's Autism Spectrum Disorder Strategy 2016–2021
Reference Number:	CC-26-16 F
Author / Job Title:	Jordan Sutherland, Team Leader – Supported Living

1. Introduction

1.1 This report presents Shetland's draft Autism Spectrum Disorder (ASD) Strategy 2016–2021, for approval by the Integration Joint Board. The draft ASD Strategy is attached as Appendix 1.

1.2 The IJB is asked to approve the Strategy and to agree to receive further updates on the Action Plan on a six monthly basis.

2. Background

2.1 The Scottish Strategy for Autism was published by the Scottish Government in November 2011, and identified autism as a national priority.

2.2 The Scottish Government's 10-year strategy identifies 26 recommendations for action at national and local levels, recognising that people with ASD have unique needs. Shetland's ASD Strategy has been developed in response to those recommendations, and in consultation with local service providers.

2.3 Autism Spectrum Disorder is a lifelong neurodevelopment condition, which affects how people communicate and interact with others. The local strategy encompasses the whole lifespan, complementing the Scottish Strategy for Autism, and acknowledging that ASD is a lifelong condition.

3. The Strategy

3.1 The strategy seeks to improve outcomes for people who have ASD, and support the delivery of the Scottish Government's vision for improving local services for people with ASD.

3.2 Data collection regarding the number of individuals with a diagnosis of ASD is an issue at a national level. Autism is now included in the Learning Disability Statistics Scotland (LDSS) report, compiled annually by the Scottish Consortium for Learning Disability, however this report does not include statistics for children, and reflects data for individuals who have had contact with the local authority in the last three years.

3.3 In 2005, a report for the Office of National Statistics estimated that ASD affects 1 in 100 people, which would translate into approximately 225 people in Shetland.

3.4 Diagnosis of ASD has not always been available in Shetland (particularly for adults), and it is likely that there are a number of adults with ASD who do not yet have a formal diagnosis. There is now an established diagnostic pathway for children, and work is underway to address diagnosis for adults.

3.5 Shetland's ASD Strategy identifies six local goals, which will inform the development and improvement of local services for people with ASD, as follows:

1. **Awareness Raising and Workforce Development**
   People employed across all sectors will recognise the unique needs of people with ASD. We will work to ensure that clear information is available to people with ASD, their families and carers, regarding local services available to them.

2. **Assessment and Diagnosis**
   There will be a clear pathway for the assessment and diagnosis of ASD, for both children and adults. This will include signposting to appropriate post diagnostic supports.

3. **Active Citizenship**
   People with ASD will have opportunities to engage in meaningful activity throughout the lifespan, enabling them to develop new skills and maximise their potential for independence.

4. **Transition**
   Transitions at key life stages will be planned and managed well for people with ASD, particularly for those moving between children and adult services.

5. **Support for Families and Carers**
   Carers will be recognised as equal partners in providing care and support for people with ASD.

6. **Employment**
   People with ASD should be supported to access employment where possible, and there must be a clear pathway for this.

3.6 These aspirations will be supported by an action plan which will coordinate activity required to deliver the strategy aims and achieve better outcomes for people with ASD.

4. Performance Monitoring

4.1 An Action Plan is being developed to accompany the strategy document, and a working group has been established including representation from all statutory services, a carer representative, and we also hope include people with ASD.

5. Conclusion

5.1 The IJB is asked to approve Shetland's Draft ASD Strategy 2016 – 2021 and note its content.

5.2 Approval will also be required from the SIC's Education and Families Committee and NHS Board, and if approved by all we will submit a final version of the strategy to the Scottish Government in June 2016.

Contact Details:
Jordan Sutherland, Team Leader – Supported Living
jordan.sutherland@shetland.gov.uk,
Tel: 01595 744306
4 April 2016

Appendices:
Appendix 1: Shetland's ASD Strategy 2016 – 2021

Background Documents:
The Scottish Strategy for Autism (2011 – 2021)
http://www.gov.scot/Resource/Doc/361926/0122373.pdf

Shetland Islands Council

NHS Shetland

Shetland's Autism Spectrum Disorder Strategy 2016 -2021

Date: 16th April 2016
Version: 7.2
Author: Jordan Sutherland / Clare Scott
Review Date: December 2016

Document Control

Title of Document	Shetland's Autism Spectrum Disorder Strategy 2016-2021
Committee Reference Number	CC-26-16
Author	Jordan Sutherland, Team Leader - Supported Living
Executive Manager	Clare Scott, Executive Manager Adult Services

Document Clearance	**Date**
Circulation to key stakeholders group across children and adults CH&SC	20-Jan-16
NHS-S EMT	02-Mar-16
Patient Focussed Public Involvement Steering Group	07-Mar -16
Shetland Mental Health Partnership	07-Mar -16
Child Health Forum	10-Mar-'16
Integrated Children and Young People's Strategic Planning Group	11-Mar-'16
Carers Link Group	15-Mar-'16
NHS Strategy & Redesign Committee	15-Mar -16
CH&SC Ops	13-Apr-16
NHS –S Area Partnership Forum	13-Apr '16
NHS –S Area Clinical Forum	14-Apr '16
NHS Shetland Board meeting	19-Apr '16
Integrated Joint Board	27-Apr-'16
Education and Families Committee	13-June 16

Date	**Version**	**Group**	**Reason**	**Outcome**
December 2015	V1	First draft		
5th April 2016	V1.1	Groups as above	Comments received during document clearance process	V2

DATE	**AMENDMENTS MADE TO DOCUMENT**
16.02.2016	Significant amendments to text
08.03.201616	P2. Document Clearance – Dates added
17.03.2016	Various minor amendments to text, following comments from various meetings, Allied Health Professions, and GIRFEC Programme Manager,
18.03.2016	Artwork added

Shetland Autism Spectrum Disorder Strategy 2015

Contents

Appendices

1. EXECTUIVE SUMMARY

Scottish Government published The Scottish Strategy for Autism in 2011, making Autism a national priority. The national strategy sets out the government's vision for improvements to services for people with autism spectrum disorder, their families and carers, over a 10 year period.

Shetland's Autism Spectrum Disorder Strategy 2016-2021 has been developed with a range of key stakeholders, and we have identified six local goals, which will inform the development and improvement of local services for people with Autism Spectrum Disorder (ASD) in Shetland.

Our Local Goals:

1. **Awareness Raising and Workforce Development**

   People employed across all sectors will recognise the unique needs of people with ASD. We will work to ensure that clear information is available to people with ASD, their families, and carers, regarding local services available to them.

2. **Assessment and Diagnosis**

   There will be a clear pathway for the assessment and diagnosis of ASD, for both children and adults. This will include signposting to appropriate post diagnostic supports.

3. **Active Citizenship**

   People with autism will have opportunities to engage in meaningful activity throughout the lifespan, enabling them to develop new skills and maximise their potential for independence.

4. **Transition**

   Transitions at key life stages will be planned and managed well for people with ASD, particularly for those moving between children and adult services.

5. **Support for Families and Carers**

   Carers will be recognised as equal partners in providing care and support to people with ASD.

6. **Employment**

   People with ASD should be supported to access employment, and there must be a clear pathway for this.

Simon Bokor-Ingram — Director of Community Health and Social Care

Helen Budge — Director of Children's Services

2. INTRODUCTION

The Scottish Government published the Scottish Strategy for Autism in 2011, setting out the governments vision that:

> *'Individuals on the autism spectrum are respected, accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives'*

The 10-year strategy identifies 26 recommendations for action at national and local levels, recognising that people with autism have unique needs. These recommendations are far reaching, and consider the needs of people with autism across the whole spectrum, and throughout the lifespan. In addition to the recommendations, the strategy identifies ten indicators of best practice in the provision of autism services (see table 1).

Shetland's Autism Strategy sets out the priorities and strategic direction for the development and improvement of local services for people with autism, their families and carers.

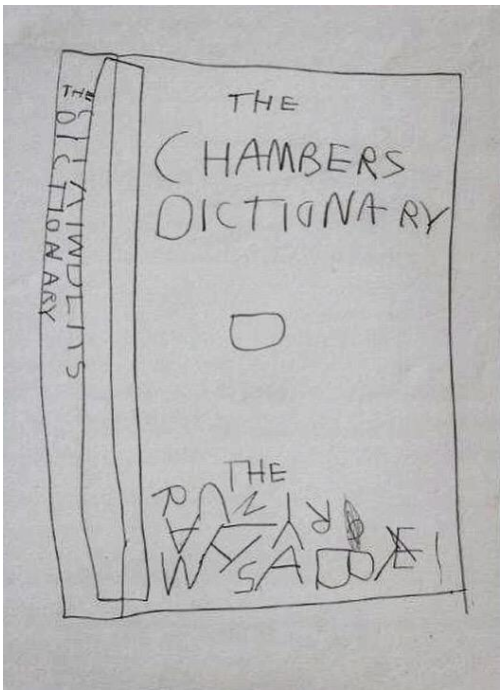
Terminology

Autism Spectrum Disorder is used throughout this document, and includes Asperger Syndrome and childhood autism. Some people prefer to use Autism, or the word 'condition' rather than 'disorder,' however for the purpose of this document, Autism Spectrum Disorder is used to fit with diagnostic terminology.

No.	Ten indicators for Best Practice (table 1)
1.	A local autism strategy developed in co-operation with people across the autism spectrum
2.	Access to training and development to inform and improve understanding of Autism Spectrum Disorder (ASD) amongst professionals
3.	A process for ensuring a means of easy access to useful and practical information about ASD
4.	An ASD training plan to improve the knowledge and skills of those who work with people who have ASD
5.	A process for data collection which improves the reporting of how many people with ASD are receiving services and informs the planning of these services
6.	A multiagency care pathway for assessment, diagnosis, intervention and support
7.	A process for stakeholder feedback to inform service improvement and encourage engagement
8.	Services that can demonstrate that service delivery is multi-agency and coordinated and targets the needs of people with autism
9.	Clear multi-agency procedures and plans to support individuals through major transitions at each important life stage
10.	A self-evaluation framework to ensure best practice implementation and monitoring

Table 1: 10 Indicators of Best Practice (Scottish Government 2011)

3. WHAT IS AUTISM SPECTRUM DISORDER (ASD)?



Autism is a lifelong neurodevelopmental disorder commonly referred to as autism spectrum disorder (ASD). ASD affects people differently with some individuals being able to live independently, while other will need a lifetime of specialist support.

ASD affects how people communicate with, and relate to, other people. It also affects how they make sense of the world around them.

"It makes me more of a loner. I am antisocial; I can't easily cope with too many human-to-human integrations. I find it difficult to process all that verbal and non-verbal information. It's a bit like a PC, you can run your OC under Windows and you select four applications to use. Then you spend ages waiting while your computer is trying to sort out which of these tasks it is going to work on and for how long. Then, it shares out the processor time on a basis that cannot prioritise. The upshot is that I can only cope with things on a one-to-one or small group basis, and I don't know how to evaluate and prioritise things"

David Nicholas Andrews - http://www.angelfire.com/in/AspergerArtforms/autism.html

Wing and Gould (1979) first described autism as a spectrum disorder. ASD affects each individual in a different way, although all people with ASD will experience difficulty in three areas of functioning. This is sometimes referred to as the triad of impairments and means people may experience problems with the following:

- Social communication – may include difficulty in processing verbal information, understanding and using language, and tone of voice, body language, facial expressions, gestures and articulating feelings.
- Social Interactions – may include difficulty understanding social behaviour and boundaries, personal space, making eye contact, expressing emotions, understanding others emotions, interpreting the actions of others, understanding humour, or showing interest in others views and affects the ability to interact with other people.
- Behaviour and Sensory processing (social imagination) – may include difficulty with sensory processing, may feel more comfortable in set routines and/or repetitive behaviours, develop special areas of interest, and have difficulty in unfamiliar situations, predicting what comes next, and understanding danger, thinking and behaving flexibly.

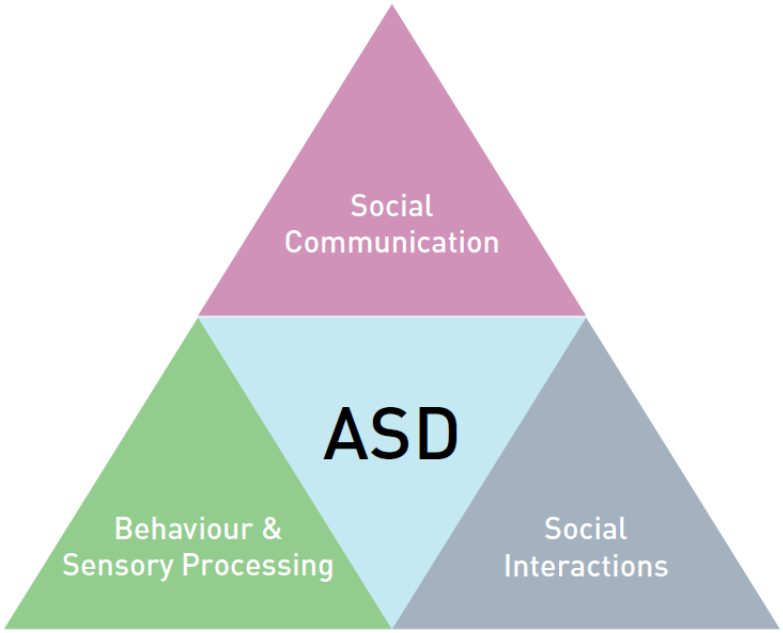


Figure 1: Autism Spectrum Disorder triad of impairments

The most significant area of difficulty for people with autism spectrum disorders is social interaction. This is particularly relevant for people who are diagnosed later in childhood or adult life, as many people learn to compensate for difficulties with social communication or imagination, but the social interaction impairment is still evident even though it may be shown in more subtle ways. Many people with Autism Spectrum Disorder have a co-existing (or comorbid) medical condition such as a learning disability, epilepsy, or other medical problem, which affects their quality of life.

The Scottish Strategy for Autism: Menu of Interventions (Scottish Government 2013) identifies 14 main challenges encountered by people with Autism Spectrum Disorder and their families (see figure 2).

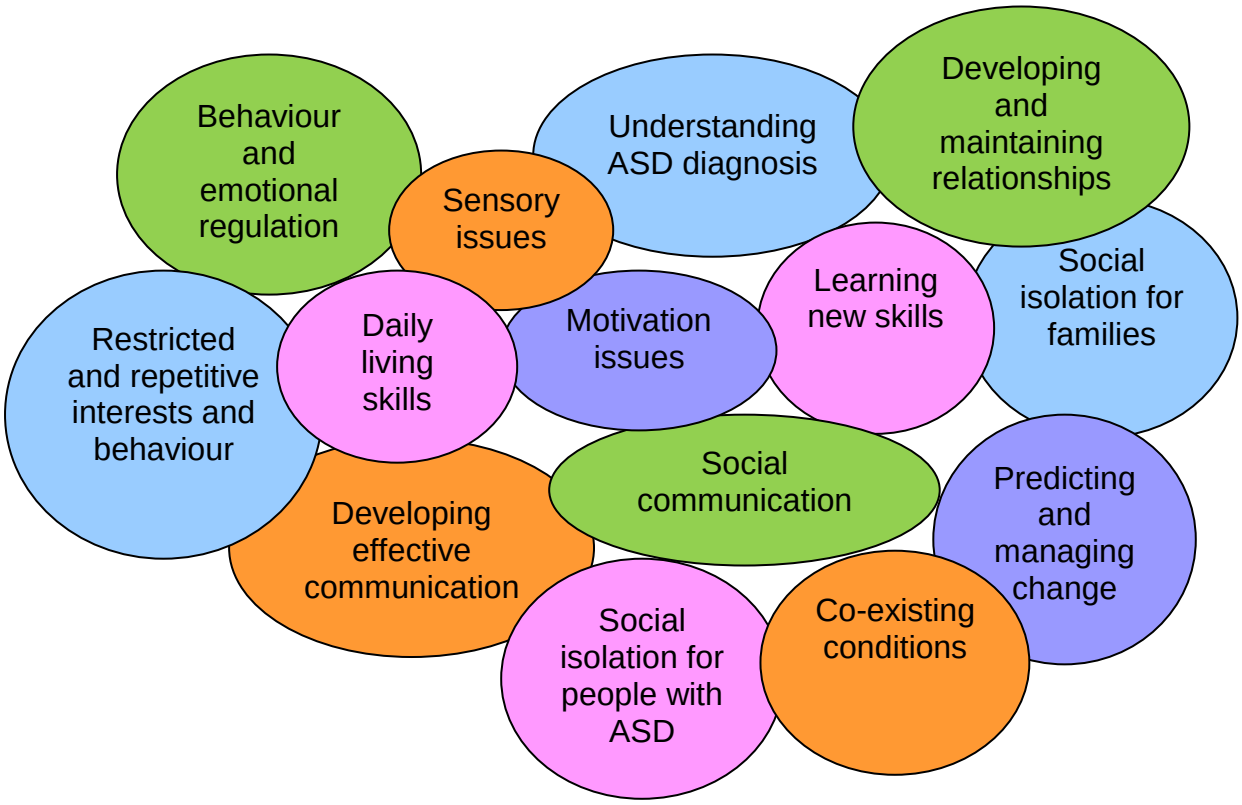


Figure 2: 14 Challenges that can impact on people with ASD and their families

4. PREVALENCE OF AUTISM SPECTRUM DISORDER IN SHETLAND

The national prevalence of autism in children is rising yearly. In 2003 it was reported to be 1 child in 163, 10 years later in 2013 it was reported to be 1 child in 67[1].

The National Autistic Society estimates that approximately 1.1% of the UK population or 700,000 people have autism. Based on 2011 census figures the prevalence in Scotland is as follows:

Population of Scotland: 5,295,400

Prevalence of Autism: 58,249

(National Autistic Society, 2013)

It was estimated that in 2012 there were approximately 202 people in Shetland with Autism, based on a population of 22,500 (National Autism Services Mapping Project: Shetland Council Service Map 2013). Local statistics showed a much lower proportion of people known to statutory services as having Autism Spectrum Disorder, which suggests that there may be people with ASD who do not have a diagnosis, and are not known to the local authority living in the community.

Data collection is an issue nationally as there are no reliable statistics specific to ASD for children and adults. Data is collected in schools regarding the numbers of pupils with additional support needs (ASN), which can include a wide variety of issues. The Scottish Consortium for Learning Disability (SCLD) publishes annual statistics regarding the numbers of adults with learning disabilities (LD), including those with ASD, who have been in contact with local authorities in the past three years, but there are no reliable national statistics regarding the total number of individuals with ASD.

Autism Spectrum diagnosis				No AS Diagnosis	Not known	AS diagnosis as % of all adults	All adults
Classical Autism	Asperger's Syndrome	Other AS diagnosis	Total with AS diagnosis				
28	13	0	41	33	80	26.6	154

Figure 3: Adults with Learning Disabilities or ASD known to Local Authority in last three years (SCLD 2015)

5. THE NATIONAL CONTEXT

The Scottish Government's policy direction is set out through three interlinked strands of Vision, Values and Goals.

Vision

"Our vision is that individuals on the autism spectrum are respected, accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives"

The Scottish Strategy for Autism Scottish Government 2011

[1] Data Source: www.scotland.gov.uk/Topics/Statistics/Browse/School-Education/dspupcensus18

Underpinning Values

• **Dignity**: people should be given the care and support they need in a way which promotes their independence and emotional well-being and respects their dignity

• **Privacy**: people should be supported to have choice and control over their lives so that they are able to have the same chosen level of privacy as other citizens

• **Choice***:* care and support should be personalised and based on the identified need and wishes of the individual

• **Safety:** people should be supported to feel safe and secure without being over- protected

• **Realising potential:** people should have the opportunity to achieve all they can

• **Equality and diversity:** people should have equal access to information assessment and services. Health and social care agencies should work to redress inequalities and challenge discrimination

(Scottish Government 2011)

People with ASD expect to have the support of professionals working together in their best interests to make these values a reality.

Goals

The Scottish Government has set out the following high-level goals in the Scottish Strategy for Autism, and a timeframe for achieving them, in order to benchmark progress towards delivering on the government's vision.

Foundations: by year 2:

1. Access to mainstream services where these are appropriate to meet individual needs
2. Access to services which understand and are able to meet the needs of people, specifically related to their autism
3. Removal of short term barriers such as unaddressed diagnosis and delayed intervention
4. Access to post-diagnostic support for families and individuals (particularly where there is a late diagnosis)
5. Implementation of existing commissioning guidelines by local authorities, NHS and other relevant service providers

Whole life journey: by 5 years

1. Access to integrated service provision across the lifespan to address the multi-dimensional aspects of autism
2. Access to appropriate transition planning across the lifespan
3. Consistent adoption of good practice guidance in key areas of education, health and social care across local authority areas
4. Capacity and awareness-building in mainstream services to ensure people are met with recognition and understanding of autism

Holistic personalised approaches: by 10 years

1. Meaningful partnership between central and local government and the independent sector.
2. Creative and collaborative use of service budgets to meet individual needs (irrespective of what the entry route to the system is)
3. Access to appropriate assessment of needs throughout life
4. Access to consistent levels of appropriate support across the lifespan including into older age

Links to other National and Local Drivers

The Keys to Life: Improving Quality of Life for People with Learning Disabilities, 2013

National Health and Wellbeing Outcomes 2015

Shetland Partnership: Our Community Plan, 2013-2020

Integrated Children and Young People's Services Plan 2014-17

A Guide to Getting It Right for Every Child, 2012

Commissioning Services for People on the Autism Spectrum: Policy and Practice Guidance 2008

The Autism Toolbox: An Autism Resource for Scottish Schools, 2009

Caring Together: The Carers Strategy for Scotland, 2010-2015

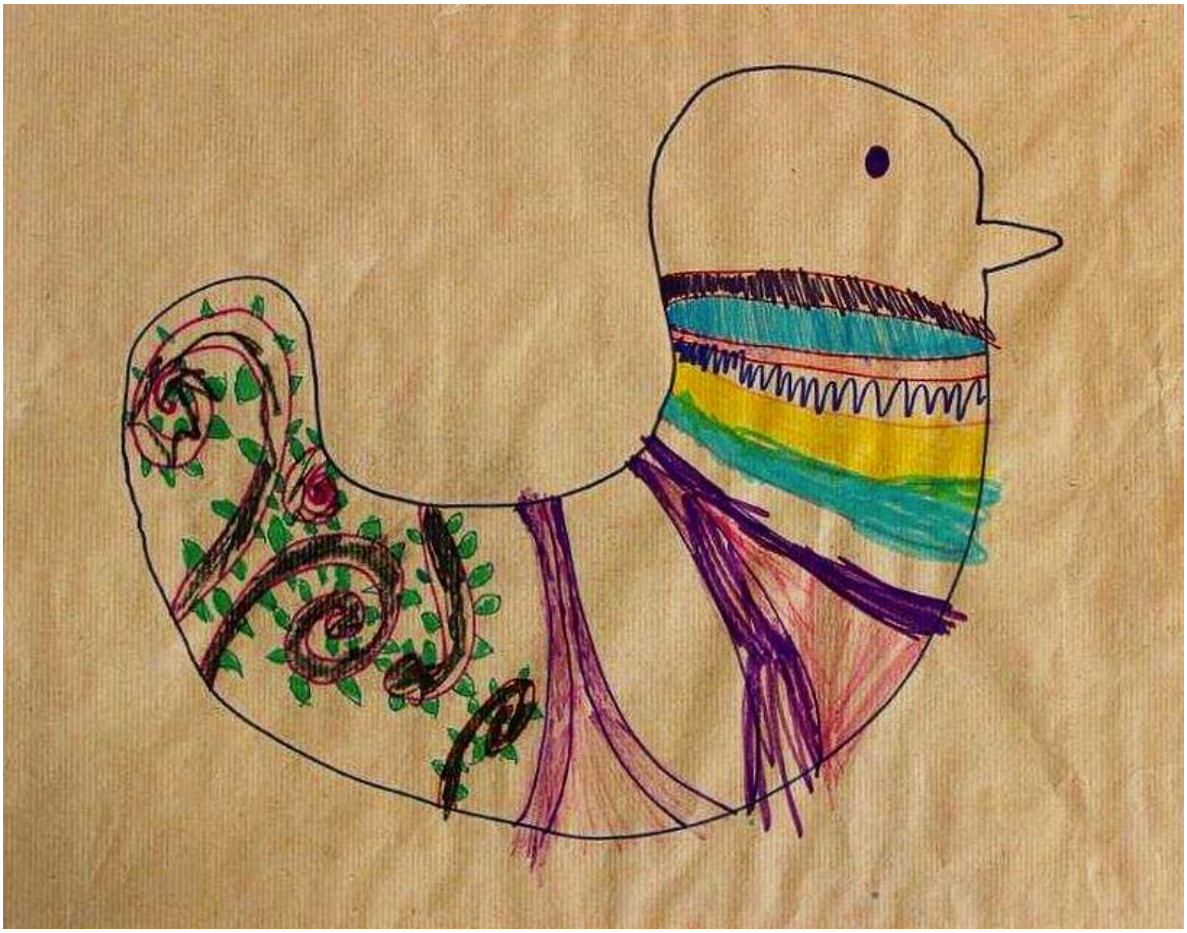
Self Directed Support: A National Strategy for Scotland 2010

6. LOCAL NEEDS ANALYSIS

Shetland is a rural island community in the north east of Scotland, comprising of a number of islands linked by overland crossings and interisland ferry services. Shetland Islands Council and NHS Shetland provide most statutory services in the islands. The Children's Services Directorate of the Council provides Education, Children and Families Social Work and Social Care services including respite and short breaks for children.

The integrated Community Health and Social Care Directorate of NHS Shetland and the Shetland Islands Council includes a range of services for adults and some for children. Due to the relatively small population, people with ASD tend to access services that also support people with a range of other needs, such as having a learning disability; there are limited specialist ASD services. The needs of the people of Shetland are met in their local communities wherever possible, and more specialist services are commissioned outwith Shetland as a last resort. This requires local services to work in a flexible and creative manner to respond to changing needs of the local population.

The model of assessment for both children and adults is strengths based, and outcome focussed in its approach. For Children, Getting it Right for Every Child (GIRFEC) Child's Plan is the multi-agency assessment, and the Barnardos Outcomes Framework is used to measure individual outcomes. For adults, Shetland's Single Shared Assessment process is known as With You For You, and the assessment tool is called 'Understanding You.' Assessments are conducted in a person centred manner, and focus on supporting people to achieve their personal goals.



6.1 Autism Mapping Results

A National Mapping Project was carried out across Scotland to gather information regarding services available for people with ASD at a local level, and to establish a national picture informing future developments, and investment of Scottish Government funding.

The 'National Autism Services Mapping Project: Shetland Islands Council Service Map' was produced in September 2013, and presents a snapshot of services for people with autism in Shetland. The project gathered data using a desk based research exercise (looking at policies and procedures), issued questionnaires to relevant stakeholders and ran a series of workshops conducted in Lerwick, Shetland:

- 25 people attended a multi agency meeting as part of the mapping project including representatives from health, education, social work, Disability Shetland, day services, family services, Supported Living and Housing services, library services, early years services and respite and short breaks.
- 5 carers attended a workshop for parent carers
- Workshops for people with autism were offered by videoconference, but no one signed up for these.

The results from the mapping project are limited in terms of being representative of the views of people with ASD, and their parents or carers. The results of the mapping project are attached as Appendix 2.

There are some areas of good practice locally in the provision of support for people with ASD. However, we recognise that there are some vulnerabilities and areas for improvement, including:

- Difficulty getting a diagnosis of ASD

- Difficulty getting the right support and/or a lack of clarity regarding how to access it
- Specialist knowledge tends to revolve around individuals who have a special interest rather than a designated role for people with ASD

7. LOCAL GOALS

Following a review of information available locally and an evaluation of the services currently provided, we have identified six goals for Shetland. These are summarised the table below, and there is more detailed information about each of them in the subsequent sections.

1. **Awareness Raising and Workforce Development**

   People employed across all sectors will recognise the unique needs of people with ASD. We will work to ensure that clear information is available to people with ASD, their families, and carers, regarding local services available to them.

2. **Assessment and Diagnosis**

   There will be a clear pathway for the assessment and diagnosis of ASD, for both children and adults. This will include signposting to appropriate post diagnostic supports.

3. **Active Citizenship**

   People with autism will have opportunities to engage in meaningful activity throughout the lifespan, enabling them to develop new skills and maximise their potential for independence.

4. **Transition**

   Transitions at key life stages will be planned and managed well for people with ASD, particularly for those moving between children and adult services.

5. **Support for Families and Carers**

   Carers will be recognised as equal partners in providing care and support to people with ASD.

6. **Employment**

   People with ASD should be supported to access employment, and there must be a clear pathway for this.

7.1 Awareness Raising and Workforce Development

The Council and NHS currently deliver a range of training to staff that support people with ASD, however the procurement of training lacks coordination. A number of frontline staff across services for children and adults received National Autistic Society accredited SPELL and TEACCH training. Education staff have also received introductory training in using the Autism Toolbox, facilitated by Autism Network Scotland. We need to review and evaluate the training we currently provide against the NHS Education Scotland 'Optimising Outcomes Framework,' and establish the knowledge and skills required at each level of the organisation, ensuring procurement of appropriate training to meet the training and development needs of staff in a sustainable and coordinated way.

The Optimising Outcomes Framework identifies four levels of knowledge and skills, as follows:

1. Autism Informed: Essential knowledge and skills required by all staff in health and social care
2. Autism Skilled: Staff with direct and/or frequent contact, or roles with high impact
3. Autism Enhanced: More regular of intense contact with individuals with ASD. Role focuses specifically on autism, provides specific interventions for autism or manages the care or service for individuals on the spectrum.
4. Expertise in Autism: Highly specialist knowledge and skills. Those with a specialist role in the care, management and support of people on the spectrum and their carers.

We will seek to establish a network of Autism Champions across services in both the statutory and voluntary sector, to act as a point of contact for enquiries relating to ASD, and to disseminate information to teams across organisations.

We will also engage with Shetland College UHI to offer accredited qualifications in ASD for staff working across Children and Adult Services.

7.2 Assessment and Diagnosis

The Scottish Intercollegiate Guidelines Network (SIGN) recommends a multi-disciplinary approach to assessment and diagnosis of autism spectrum disorder. The assessment should include of a detailed history of the individual's development, direct clinical observations, and take account of how the individual behaves in other situations. Some specific autism or language assessments may also be carried out, for example, ADOS 2 (Autism Diagnosis Observation Scale, 2nd edition).

The ASD Strategy seeks to ensure there are clear diagnostic pathways for both children and adults, and that post-diagnostic support is available for those who need it. We have subdivided this section to reflect the different routes for child and adult diagnosis and support.

Children's Diagnostic Pathway

Following the implementation of the Children and Young People (Scotland) Act 2014, all children and young people in Scotland have a Named Person, who will usually be a Health Visitor or a promoted teacher when the child starts education. The Named Person provides a consistent approach to supporting children and young people's wellbeing, giving access to advice and support for families.

We will ensure that Health Visitors receive training to recognise early signs and symptoms of ASD, and how to refer on for more specialised involvement, and that teaching staff have access to an appropriate level of training following a mapping exercise using the 'NES Optimising Outcomes Framework'

If it is felt that an ASD assessment is required, the local assessment team will carry out the assessment. The team consists of Speech and Language Therapy, Educational Psychology, GP with a Special Interest in Child Health, and a visiting Consultant Paediatrician. There may also be input from Education Outreach Group and the Child and Adolescent Mental Health Service.

The EarlyBird Plus Programme is run as a post diagnostic support group for parents of children aged 4-8 years, diagnosed with ASD. Due to small numbers of children diagnosed locally, the programme runs when there is a requirement. There is a range of other supports available locally for children and young people. Children and young people with ASD have their needs identified through the Getting It Right For Every Child (GIRFEC) process, and support is tailored to meet the needs of the child and their family.

Adult Diagnostic Pathway

We will seek to ensure that diagnosis is available for those who require it, in a timely manner and provided as close to home as is possible. Currently, adults who do not have a diagnosis of ASD may be referred on for assessment by their GP. This may involve the adult having to go off island for an assessment on mainland Scotland, as there are not sufficient services available locally.

Adults who may require community care services are entitled to have their needs assessed in accordance with section 12A of the Social Work Scotland Act 1968. The local authority has a duty to provide services to meet an adult's eligible care needs in accordance with local and National Eligibility Criteria. Carers of adults are also entitled to an assessment of their needs in relation their caring role. As such, the lack of a diagnosis should not be a barrier to people receiving the services they require. It is acknowledged however that diagnosis might inform a care plan and support strategies, which would benefit the adult. A formal diagnosis will also ensure individuals receive financial support they might be eligible for, and that appropriate supports or 'reasonable adjustments' are considered by employers, as ASD is recognised as a disability under the Equality Act 2010.

We will also seek to provide clarity regarding the post diagnostic support pathway for people diagnosed with ASD in adulthood, and their families, ensuring they are provided with information regarding services they may be eligible for (e.g. respite and short breaks etc.). We will also establish links with acute medical services (hospital) to ensure that the needs of people with ASD are considered when they are admitted to hospital.

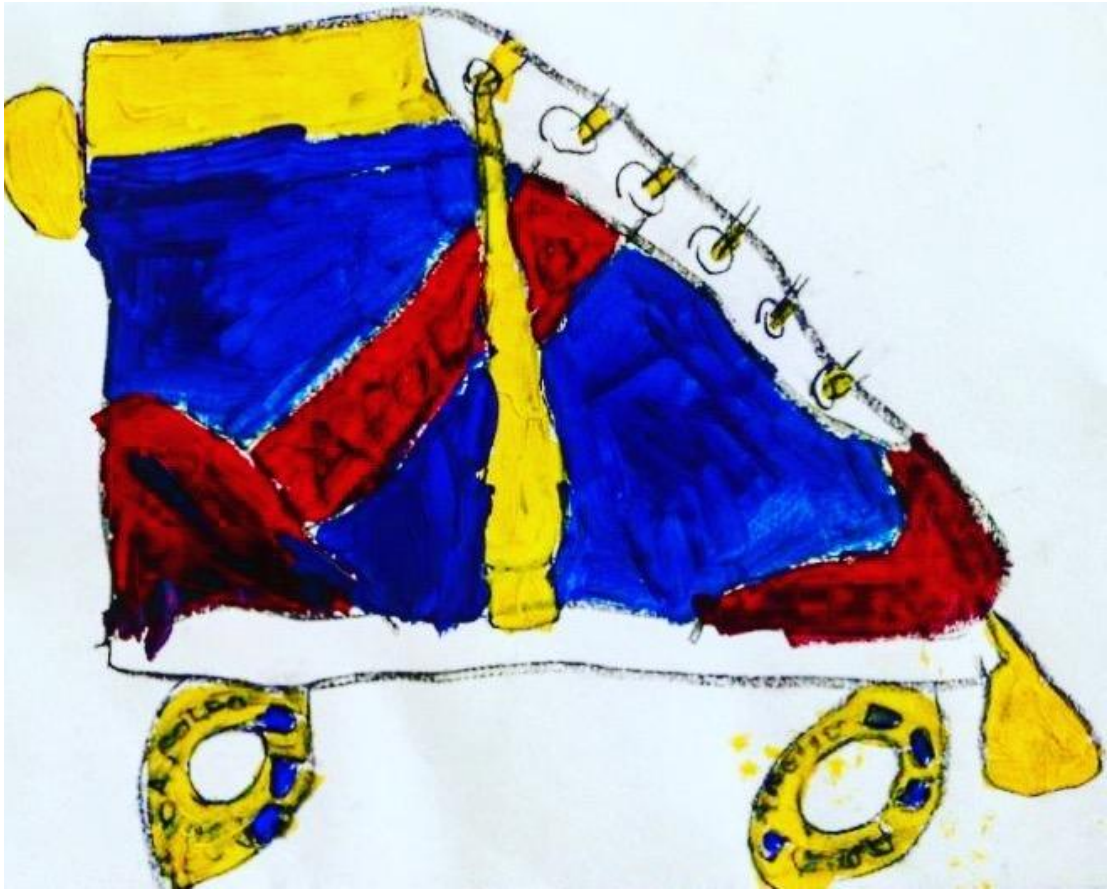
7.3 Active Citizenship

People with ASD can face a range of barriers to everyday activities, and it can therefore be difficult to access social opportunities and various other things other people take for granted. This strategy will aim to ensure that people with ASD receive support to engage in activities that are important to them.

The Council's Supported Living & Outreach and Housing Service provide supported accommodation, and outreach support for people with ASD. There are a number of other services that support people to develop independent living skills, and this support can begin at school, if appropriate. We will seek to ensure that we continue to support people with ASD to live as independently as possible in the community.

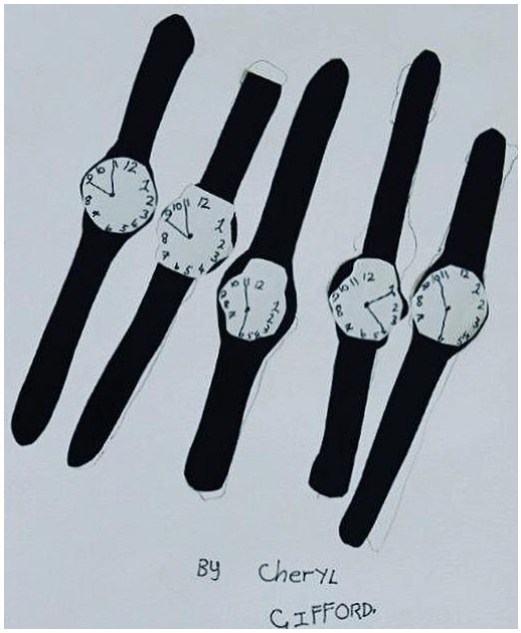
There are a number of local services which may be involved in supporting people with ASD to participate in meaningful activities, including Shetland Befriending Scheme, Shetland Community Bike Project, Bridges Project, Shetland College, Moving on Employment Project, and COPE Ltd etc. We will ensure that people with ASD continue to have opportunities to develop skills for independent living, and that the accommodation needs of people with ASD are considered by local housing providers.

Shetland Arts currently support ASN film screenings at the local cinema, and they also provide supported creative activities for people with additional support needs. We will ensure that we work with local partners to promote good practice that already exists in the local community, and raise the profile of inclusive practice to make mainstream services more accessible



7.4 Transitions

When considering 'transition,' the primary focus for practitioners, people with ASD, and their families, is often the point where children move into adulthood. It is important to ensure that this is planned and well managed to achieve the best outcomes for people with ASD. It is also necessary to recognise that there are a number of other important transitions throughout the lifespan.



The Scottish Transitions Forum has produced guidance, which identifies seven 'Principles of Good Transitions' (2013). We will ensure that these principles are embedded in practice locally (see below):

1. All plans and assessments should be made in a person-centred way
2. Support should be co-ordinated across all services
3. Planning should start early and continue up to age 25
4. Young people should get the support they needs
5. Young people, parents and carers must have access to the information they need
6. Families and carers need support
7. Legislation and policy should be co-ordinated and simplified

The Shetland Islands Council has an existing policy supporting transition between Children and Adult Services, which we will review to ensure that transitions are managed effectively and in a timely manner for people with ASD. We will also consider the other organisations involved in supporting people with ASD, and how we support transitions at other key life stages throughout the lifespan.

7.5 Support for Families and Carers

Shetland recognises the valuable contribution that carers make to the support of people in our communities, including those with ASD. A carer is someone who provides unpaid care for a friend or relative who needs his or her support due to an illness, disability, mental health problem or addiction (Scottish Government 2010). Shetland is developing a separate Carers Strategy to recognise the vital role carers have in supporting strong communities and this section will focus specifically on support for people with ASD.

The Education Outreach Group, including the Pre-School Home Visiting Services, have a key role in supporting families, particularly in the early years. Where a need is identified, the Council provides short breaks and respite services to support carers and families of children and adults who have learning disabilities or ASD at Short Breaks for Children or Newcraigielea Services.

Voluntary Action Shetland operate a Virtual Carers Centre, which provides a range of information and advice for carers in Shetland. The website signposts to a number of carers groups which provide a source of support to those with a caring role, as well as providing details of training, short breaks, and financial assistance which may be relevant. See www.shetlandcarers.org for further details.

We will seek to ensure that families and carers of those with ASD have timely access to the right information and advice regarding services and supports for people with ASD.

7.6 Employment

Shetland has established a 5-stage Employability Pathway, which sets out the various stages of support a person has to move through in order to gain sustainable employment. The process will support individuals who have two or more barriers to employment, and may include adults who have ASD.

There are a number of supported employment placements available locally, some of which are commissioned by the Shetland Islands Council. These placements enable people to develop skills, which may result in them, to move into sustainable employment at a later stage. There are also volunteering opportunities, and work experience placements supported by the voluntary sector.

We will ensure that the unique needs of people with ASD are recognised by staff working in agencies that provide assistance with employment to ensure that there are opportunities to move into sustainable employment where possible. We will also ensure that commissioned services meet, and continue to meet, the criteria for accreditation set out in the Scottish Government guidance, 'Commissioning Services for People on the Autism Spectrum' (2008).

8. THE VIEWS OF PEOPLE WITH ASD, THEIR FAMILIES AND CARERS

In September 2013, a national mapping exercise was conducted to review the services available for people with ASD, and this included consultation with people who have ASD, their families and carers. The number of people involved in the consultation process was low (see section 6.1); however the local results show that people feel services could be planned better at a strategic level, and that there are gaps in local delivery.

We will seek to establish a local autism network, including people with ASD, family members and carers, to contribute to the future development of support for people with ASD in Shetland. Due to the dispersed nature of the population in Shetland, it is important that we use a variety of methods to effectively engage with as many people as possible, and we will therefore seek to use a variety of communications, including social media, to ensure we reach a wide audience.

Shetland Islands Council reviewed the provision of day services for adults with learning disabilities in 2014, and a working group of parents, carers and people who access day services was established as part of the consultation. The group was successful, and we may seek to broaden the remit of this existing group, to act as a reference group for the provision of ASD and learning disability services.

9. MONITORING AND REPORTING

The Autism Spectrum Disorder Strategy will be accompanied by an action plan, which will be reported on a six monthly basis to the Integrated Joint Board and SIC Education and Families Committee.

The Community Health and Social Care Strategic Group will monitor the action plan on a quarterly basis, to ensure that work is progressing in accordance with the agreed timescales.

10. KEY ACHIEVEMENTS TO DATE

Shetland has made a number of achievements in the provision and delivery of services for people with ASD since the Scottish Strategy for Autism was first published. So far we have:

- Established an ASD Pathway Assessment Team for Children and Young People
- Trained staff in ADOS2 (Autism Diagnostic Observation Scale 2)
- Trained staff to deliver the EarlyBird post-diagnostic support program (for parents of children)
- Delivered training to Health Visitors in detecting early signs of ASD (March 2015)
- Autism Network Scotland delivered training to a number of staff from children and adult services in March 2015
- Produced a directory of local autism resources in conjunction with Autism Network Scotland as part of their Menu of interventions Roadshows: http://www.autismnetworkscotland.org.uk/shetland/
- Established a Working Group to develop an ASD Action Plan, which will accompany this strategy document, to drive forward improvements to local services.

APPENDIX 1

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Appendix 2

National Autism Services Mapping Project
Shetland Council Service Map
September 2013

National Autism Services Mapping Project

Shetland Council Service Map

September 2013

National Autism Services Mapping Project

Shetland Local Service Map

Contents

[1] Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people and the world around them.
It is a spectrum condition, which means that, while all people with autism share certain areas of difficulty, their condition will affect them in different ways. Aspergers syndrome is a form of autism

[2] Definition of a carer
Throughout this document we use the term "carer" to describe individuals who provides unpaid support to a relative family or friends who has autism. The majority of individuals are parent carers but the term carer also describes other family members such as siblings, grandparents or friends who provide substantial unpaid care.
We use the term support worker to describe individuals providing paid support to individuals with autism

1 Background to the National Mapping Project

The National Mapping Project has been a short term fact finding exercise and analysis of information relating to the delivery of services for individuals with autism in your area. It is designed to map out existing service provision across Scotland in order to build up a full picture of the national position which will help inform future local decisions on autism co-ordination on who will do what and where, and influence national decisions on the investment of Scottish Government funding for autism in the future.

The Service Map presented below is a snapshot of the situation in your area with regard to the delivery of services for people with autism. It is predicated on the information collected from the desk research into policies and practice, people we spoke to at the focus groups and the questionnaires completed by individuals in your area. In some areas there was not a full representation of all stakeholders. The corollary of which is that those who did respond will clearly have had an impact on the picture we have drawn.

The Service Map is not the complete story of the services you deliver in your area, those responsible for the delivery infrastructure already in place and service users will both have additional information not recorded here due to the short term nature of the work and reflective of the level of engagement with the Project.

However, together with the national findings and knowledge of your current delivery, it is hoped this service map will help inform the design and delivery of your Autism Action Plans as agreed under Autism Strategy funding to local authorities.

2 Methodology

The Mapping Project gathered information in three ways:

- Desktop research in relation to Data and Strategic Policy
- Online questionnaires for:
  - People living with Autism
  - Carers
  - Statutory providers
  - Service providers

- Workshops with:
  - People living with Autism
  - Parents and carers
  - Multi-agency groups

The Aims of the Workshops were to identify:

People living with autism:

I. To gather experience of people with autism about the places, people and activities that help them have a "meaningful life"
II. Gather information about how the core services contribute to having a meaningful life
III. Gather ideas of what might happen to improve things and what difference that would make

Carers and parents:

I. To have a better understanding of what carers want to see in their local areas
II. To have a better understanding of the local areas and what is making a difference for people living with autism and their families
III. To identify what would make a difference for them

Multi-agency groups:

I. To use the 10 indicators for developing best practice as a baseline for discussion
II. To gather information about how services work in partnership together
III. To explore the depth of partnership working
IV. To provide knowledge about the impact for people with autism, through identifying the challenges and gaps in services

3 How the service map is organised

From the information gathered throughout this exercise Mapping Coordinators identified a number of recurring themes. It also became apparent that the themes could be arranged under aspects of delivery that individuals talked about. These were: People, Processes, Services, Specialist Services and those issues which were specific to Parents and Carers.

People	Processes	Services	Specific Services	Parents and Carers
Autism Knowledge and Awareness	Carers/Family Support including groups/listening to carers/carers assessment/named person	Advocacy	Autism Specific Services for Children and Adults	Parents/Carers as equal partners
Community and Social Opportunities	Communication and Signposting	Criminal Justice including Police/Autism Alert Card		Carers/Family Support
Environment including sensory	Diagnosis - All aspects	Education/Further Educations – including pre-school/mainstream and autism specific		
Inclusion/ Acceptance of autism	Information/Data Sharing	Employment/Employ ability		
People/ Professionals who understand	Intervention (universal for all services	Housing		
Reasonable adjustments to accommodate autism	Multi-Agency/Partnership/ Pathway, Communication and Co-ordination of services	Respite		
Transport and Rural Issue	Prevention (early intervention) approach	Services - Access/Gaps/perfor mance		
	Autism Planning Structures	Service Responsibility including lack of service for people with Asperger's and high functioning autism		
	Quality of life/Wellbeing/Feeling	Transitions - all major life transitions		
	Training – all aspects For professionals – a framework for training			

For coherence with the Scottish Strategy for Autism the themes have been for the most part organised within the service map according to the Ten Indicators for best practice in the provision of effective services as laid out in the Scottish Strategy for Autism.

A particular focus has been offered on issues specific to Parent and Carers and to Quality of Life outcomes for individuals with autism.

Key to codes: the following codes indicate the source of the data ie if the information has been gathered from the questionnaires or the workshops and from which group.

Please note that where small numbers responded in any area and there was a possibility of identifying an individual, that information has not been directly quoted and has instead been used to ascertain a trend along with other quotes, information or data.

- M for multi agency workshop
- C for carers workshop
- I for individuals with autism who took part in a workshop or completed workshop tasks individually
- SAQ for Statutory Agencies Questionnaire
- SPQ for Service Providers Questionnaire
- CQ for Carers questionnaire
- IQ for Individuals questionnaire
- QQ for quantitative data across national responses to questionnaires
- Quotes from individuals are in quotation marks

4 Background for your area?

- Scottish Government Audit for People with Autistic Spectrum Disorders (2004) estimated that the prevalence figure for autism in Shetland based on 2003 numbers of people with a diagnosis was 31.2 per 10,000 for children and 5.4 per 10,000 of the adult population. In children this is just below the national rate of 35.3 per 10,000, but with adults it is more than twice the national average rate of 2.2 adults with a diagnosis per 10,000. Returns from Shetland to eSAY[3] Statistics 2011 indicates that information about whether or not an adult has a diagnosis of autism was available for 59 out of 136 people known to services. Of the 59 people for whom there was information, 26 had a diagnosis of autism. The Scottish Strategy for Autism (2011[4]) suggests an expected prevalence rate of 90 per 10000 which would suggest the actual prevalence figures for autism in Shetland, going by the 2012 population of 22,500, would be 202.
- Autistic Spectrum Disorder Policy for Children and Young People, Shetland Islands Council Children's Services (2011) sets out 12 Key Priorities to provide autism friendly provision both within and out-with education built on involvement of young people and their carers. Recognition is given to the need for information, guidance, respite and support groups for families, successful transitions in to adult services plus promotion of community awareness and understanding of autism.
- The Better Brighter Future 2011-2014 is Shetland's integrated children's service plan which plans to meet the additional support needs of children through the Getting it Right for Every Child approach.
- With You for You (2010) is the person-centered multi agency approach for the planning and delivery of adult care and support services.
- There is a multi agency autism strategy group with representation from both adult and children services.

[3] http://www.scld.org.uk/sites/default/files/booklet_1_-_learning_disability_and_asd_2.pdf

[4] http://www.scotland.gov.uk/Publications/2011/11/01120340/0

5 What we asked and who responded to us

- A desk-based research exercise was carried out into policy in Shetland including autism specific policy as well as wider additional support needs/disability policy across social services, education and housing.
- 25 people attended a multi agency meeting which included people from health, education, social work, Disability Shetland, day care services, family services, supported living and housing services, library services, early years services and respite services.
- 5 carers attended a workshop for parent carers
- There had been an arrangement to meet with a group of people with autism through Disability Shetland, but this was cancelled as Disability Shetland felt the ability range of participants was too wide for the workshop to be accessible. Two opportunities were offered for a workshop by video conference but no one with autism in Shetland signed up for this.
- 7 people from statutory agencies and 1 individual with autism completed online questionnaires from Shetland. No service providers or carers completed questionnaires online. The individual with autism did not include any qualitative data on his/her response.
- The short time scale of the mapping project meant that only one visit was possible and this severely limited opportunities for people to participate.
- The autism strategy group distributed the link to the online questionnaires widely. The low response rate may be for a number of reasons, but given that the 5 carers who took part rated services as good or excellent, it is possible that it is because people are generally satisfied with services that meant they did not feel the need to respond.
- Due to the amount of information from any group in Shetland, this service map provides only a partial picture of services in Shetland. Quantitative information from the online questionnaires across Scotland is included to provide some general information.

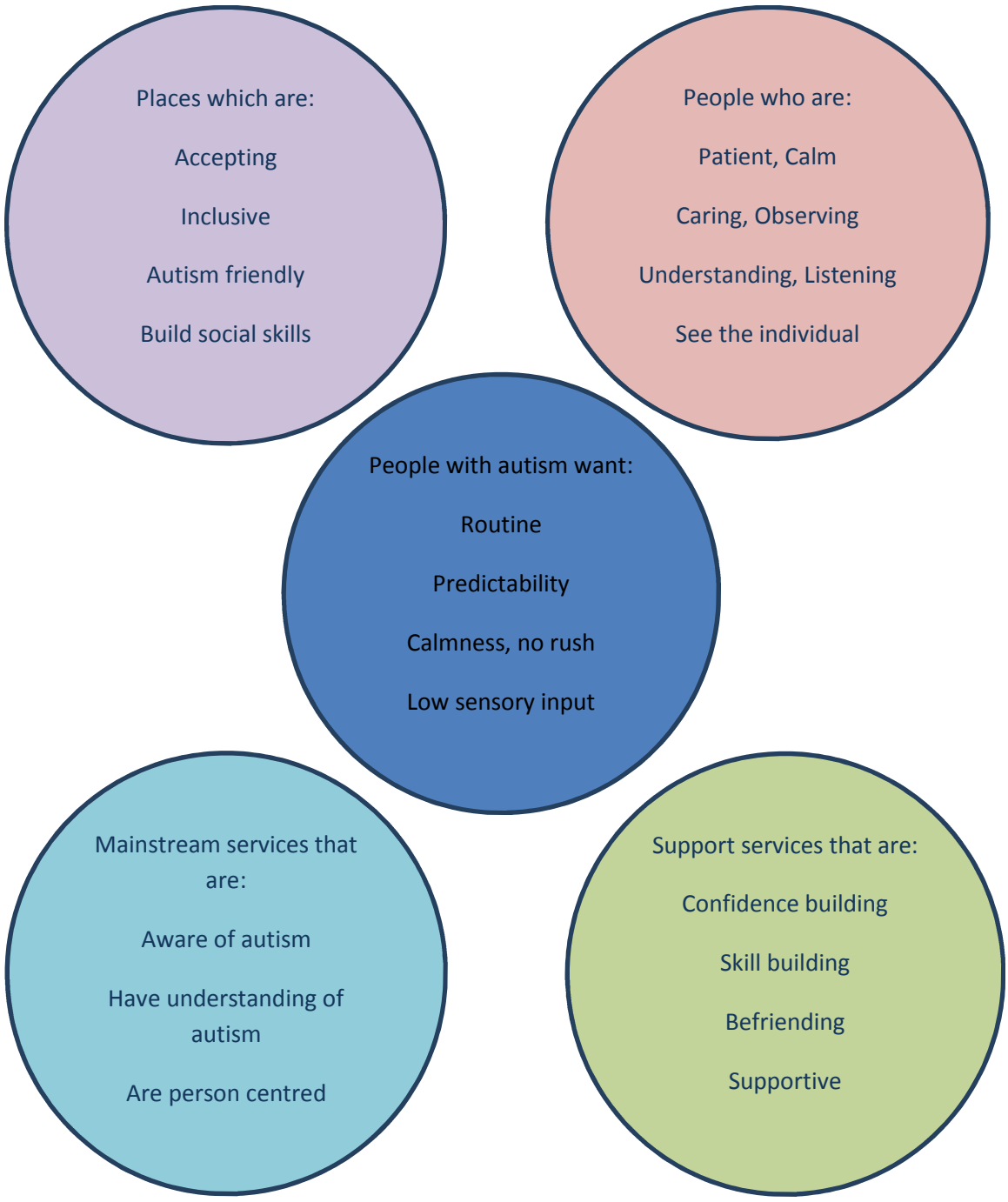
The numbers responding is represented in the table below

Focus Groups	Nos	Questionnaire responses	Nos
Multi-agency	18	Multi-agency	7
Service providers	7 *	Service providers	0
Parent/Carers	5	Parent/Carers	0
People with autism	0	People with autism	1

*As many support services are provided in-house it was not always clear whether people were service providers or statutory agency.

6 Carers told us people with autism want:

(No qualitative data available from individuals with autism)



7 What Parents and Carers told us

5 carers attended the workshop. All were parent carers of children/young people with autism, 7 in total, aged between 5 and 19 years of age. The word cloud below represents proportionately (the larger the word the more often it was said) things parent carers felt contributed to quality of life for their children/young people.

Carers were asked to score services between poor, satisfactory, good and excellent. The table below indicates the scores given. One parent scored his/her two children separately, so 6 score sheets were completed.

Parents and Carers scores for: 'How my area is doing'	
Care and Support response	1.5
Health response	3
Education and Further Education	3
Transitions	2.5
Employment	Not applicable
Housing and Community Support	2.5

Carers were asked to agree their top three actions points which they would like to see.

Top three action identified by Parents/Carers in (LA)
1 Place for information and carer support
2 More access to respite, including for siblings
3 More opportunities post-school

Specific information relating to Parent/Carers' Issues

	What's working well?	What's not working well?
Parents/Carers as equal partners	In respect of a young person's independence, parent/ carers only involved in planning with permission of young person (SAQ).	No comments were made
Carers/Family Support including groups/listening to carers/carers assessment/named person	The ASD policy (2011) mentions the importance of access to family support groups (P). Carers spoke of a coffee morning where children were catered for and safe, so parent carers were able to chat to one another (C).	No comments were made

The five parent carers were very positive about the services they received.

8 Comments about Community and Social Opportunities

	What's working well?	What's not working well?
Community and social opportunities	The leisure centre (C) library (SAQ) and adult learning (M) are mentioned as accessible community opportunities. A social group for teenagers with autism or ADHD was also mentioned (M). The National picture presented is that there is wide recognition (90% QQ) that social/community opportunities are important. The National picture presented is that support to access social activities is reflected in 90% of care plans (QQ) .	The national picture presented from carers completing these questions is90% thought children faced social challenges at school, only 50% thought the person they cared had friends in the community and only 34% thought the person was included in the community (QQ).

Issues for Consideration
It was said that people should be patient and understanding as this makes things easier for the carer

9 Statutory and Voluntary Services perspective

25 people attended the multi agency meeting, as indicated below. Most of the service providers listed below were involved in short breaks, respite or day care provision, one was from Disability Shetland.

Agencies attending Focus Groups	Nos
Health	1
Social Work	1
Education	7
Further Education	
Criminal Justice	
Police	
Employment/Employability	1
Housing/building standards/supported living	5
Service Providers	7
Other/environmental health/library/infrastructure	3

Rating where people feel they are with the LA Strategy for Autism where 1 is 'work has not yet begun', 2 is 'made a start', 3 is 'good progress' and 4 is 'completed'.

Good practice indicator	Mean score
A local autism strategy	2
Access to training and development	2
A process for ensuring a means of easy access to useful and practical info about ASD	2
An ASD training plan	2
A process for data collection	2
A multi-agency care pathway	2
A framework and process for seeking stakeholder feedback	2
Services that can demonstrate that service delivery is multi-agency in focus	3
Clear multi-agency procedures and plans	2
A self-evaluation framework	2

10 A Summary of Findings in relation to the 10 Indicators of Good Practice

The tables below set out the responses from the information gathered from individuals in your area. They are set out under themes or headings which were developed from the national data sets.

Please note:

The following Indicators have been grouped together. The information gathered did not distinguish between the two aspirations:

2. Access to training and development to inform staff and improve the understanding amongst professionals about autism.

4. An ASD Training Plan to improve the knowledge and skills of those who work with people who have autism, to ensure that people with autism are properly supported by trained staff.

Similarly the following Indicators have also been grouped together for the reasons outlined above:

7. A framework and process for seeking stakeholder feedback to inform service improvement and encourage engagement.

10. A self-evaluation framework to ensure best practice implementation and monitoring.

1.

A local Autism Strategy developed in co-operation with people across the autism spectrum, carers and professionals, ensuring that the needs of people with ASD and carers are reflected and incorporated within local policies and plans.

	What's working well?	What's not working well?
ASD Planning structures	There is a clear autism Policy and action plan for children's services (P&M). There is a multi agency group which meets regularly to take the strategy forward (P) and there is a link to adult services (M) from his group. The National picture presented is that 78% of NHS staff and 92% of other statutory agency staff sought service user feedback in development of services(QQ)	No lead was identified (SAQ)

Issues for Consideration
Better links between children and adult services (M)

2.

Access to training and development to inform staff and improve the understanding amongst professionals about autism.

4.

An ASD Training Plan to improve the knowledge and skills of those who work with people who have autism, to ensure that people with autism are properly supported by trained staff.

	What's working well?	What's not working well?
Training –all aspects. For professionals – a framework for training	There is evidence of awareness raising across the sector, specific service training and NHS /Education had training plans (M&SAQ).	There may be a gap in getting training to the frontline in services outside of health or education (M). Although people receive awareness training they recognise the need for further training (SAQ) and training which is not just for support staff but for all staff (SAQ).
People/professionals who understand	People who are patient and understanding of autism, who observe and listen to understand the uniqueness of the individual; who are calm and able to sort out challenging behaviour from autism, people who genuinely care; these are the people who are able to make a difference (C).	

Issues for Consideration
• A coordinated approach to autism training across the area (M&SAQ) • Better links to training opportunities (M&SAQ)

3.

A process for ensuring a means of easy access to useful and practical information about autism, and local action, for stakeholders to improve communication.

	What's working well?	What's not working well?
Autism knowledge and awareness	There is Early Bird and general awareness training in children's services (M) and Adult Learning do awareness raising about Aspergers across the public sector (SAQ). The ASD policy (2011) promotes community wide awareness raising (P). The National picture presented is that appoximately half of service providers thought they had a role in raising awareness (QQ).	There are still some agencies who have a limited awareness of the impact of autism on the individual's life (SAQ).
Communication & signposting	ASD policy (2011) aims to provide the right information and guidance to families (P) and a range of examples of available information was provided (SAQ). Psychology are good at ensuring communication needs are met (M) and other services take a person-centred	Adults would benefit from post diagnostic information (M).

	approach to communication (SAQ).	
Inclusion/Acceptance of autism	There are inclusive evening classes (M).	

Issues for Consideration
o A co-ordinated approach to raising awareness and providing information about local and national support would be helpful (SAQ). o Improved information is an action in the service plan (M); carers raised their need for more information (C).

5.

A process for data collection which improves the reporting of how many people with autism are receiving services and informs the planning of these services.

	What's working well?	What's not working well?
Information/Data sharing	Social Work collect data; there is data collection within education but there are data sharing issues re sharing with other agencies (M). The national picture presented is that 90% of NHS staff, 94% of other statutory agencies and 87% of service providers said they recorded if service users had autism (QQ).	There may be a lack of consistency in data sharing approaches (M). A concern was raised about the secure GSX email (M).

Issues for Consideration
o The consistency of approach to collection of data o An approach to resolving information sharing issues

6.

A multi-agency care pathway for assessment, diagnosis and intervention to improve the support for people with autism and remove barriers.

	What's working well?	What's not working well?
Diagnosis – all aspects	Carers reported good pre and post diagnostic support (C). NHS and Learning Disability link around adult assessment (M)	However, there is recognition that there is a gap in securing an adult diagnosis if it is not picked up in school. Adult diagnosis is off-island (M&SAQ).
Interventions (universal) for all services	Various different interventions were mentioned, Moving On, Direction Team and Shetland Befrienders (M).	
Prevention (early intervention) approach	Bruce Family Centre and Disability Shetland listen and respond to need preventing a crisis being reached (C).	
Multi-Agency/Partnership/ Pathway, Communication and Co-ordination of services	Better Brighter Future children's service plan uses the Getting it right approach to additional support services. With You For You is the person-centred approach to providing services for adults (P). Lots of examples of good multiagency working were provided in both children and adult services, between statutory agencies and service providers (M&SAQ).	The multiagency approach works well around individuals but is not planned strategically (SAQ). There were examples given of some agencies which do not seem to engage as well (M). Some families will opt not to have involvement of social work, preferring to seek information and advice only (SAQ).

Issues for Consideration
• Improved information as part of post diagnostic support including information about local services (C).

8.

Services that can demonstrate that service delivery is multi-agency in focus and coordinated effectively to target meeting the needs of people with autism.

	What's working well?	What's not working well?
Environment including sensory	Psychological service input to schools about the sensory needs of autism (M).	In the national data 74% (QQ) individuals with autism completing the questionnaire reported experiencing sensory difficulties at school; 66% (QQ) of these did not receive any help with that.
Reasonable adjustments to accommodate autism	Autism friendly cinema screenings is an example of reasonable adjustment (C).	
Services - Access/Gaps/ performance	In terms of services meeting the need of people with autism, the National picture presented is that 26% carers said that needs were fully met, 60% partially met and 14% not met (QQ).	Access to a GP can sometimes be difficult (M).
Service Responsibility including lack of service for people with Asperger and high functioning autism		The multi agency group suggested that services for adults with autismcould be improved and that the services for individuals who are high-functioning but still have complex needs are not consistent.

Criminal Justice including Police/ Autism Alert Card	The national picture presented is that only 28% of people with autism had Autism Alert Cards and only 6% of those had used it (QQ).	
Education/Further Educations – including pre-school/mainstream and autism specific	Several mainstream schools were cited by carers as being good (C). A person centred approach is taken to meeting the needs of students in college (SAQ).	There was a suggestion from a Statutory Agency that the information from schools to colleges could be passed on earlier so that individuals could be supported.
Employment/ Employability	Employment services work to support individuals to acquire the skills needed to gain employment or access training. The support offered is person centred and for as long as needed. Potential employers are provided awareness raising (SAQ). Nationally 33% people with autism is said they were in work, of whom 47% had support and 56% enjoyed their work. (QQ)	It was suggested that there is a lack of employment opportunities available particularly outside of Lerwick (M).
Housing	Housing as an organisation has a good understanding of autism (C).	Housing services would like to improve housing for people with autism Shetland wide (M).
Respite	The ASD policy 2011 recognises the importance of respite to families (P). The Laburnum Centre works well providing both respite and life skills development (C).	

Transport and Rural Issues	" I do feel however that the discreet geography and small population of Shetland means that there are opportunities to work productively & imaginatively with other agencies in meeting support needs." (SAQ).	Rurality presents a challenge to delivering the strategy in current economic restrictions (SAQ).
Autism Specific Services for Children and Adults	Spectrum group, Disability Shetland, Bruce Family Centre; Laburnum Centre were all listed as valueable services (M&C). One of the benefits is that these services offers routine and predictability (C). Nationally 66% of service providers were providing a targetted service for people with ASD (QQ).	

7.

A framework and process for seeking stakeholder feedback to inform service improvement and encourage engagement.

10.

A self-evaluation framework to ensure best practice implementation and monitoring.

Autistic Spectrum Disorder Policy for Children and Young People, Shetland Islands Council Children's Services (2011) recognises the importance of involving people with autism and their carers.

9.

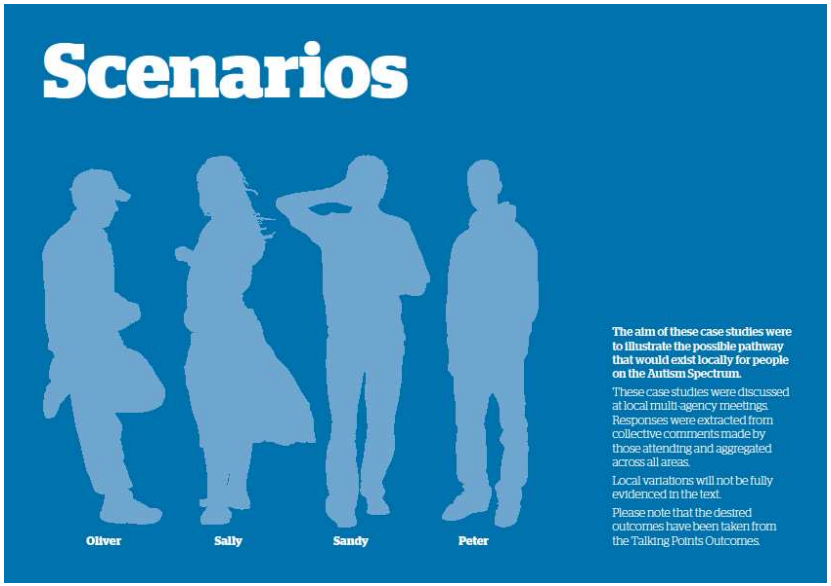
Clear multi-agency procedures and plans which are in place to support individuals through major transitions at each important life-stage.

	What's working well?	What's not working well?
Transitions – all major life transitions	The ASD policy (2011) promotes successful transition in to suitable adult service provision (P). The links between school and adult services are robust (M) and liaison with further education good (M&MQ).	Lack of data sharing can make transitions difficult (MQ).

11 Scenarios

During the course of the project the Mapping Coordinators employed a number of case studies to help agencies determine how they worked together with individuals. Of all the case studies offered four were used more often than others. Below you will find an illustration of one of those case studies with the information extrapolated from across Scotland to give a picture of what is likely to happen. This will be useful in measuring what's happening locally against the information drawn nationally.

To access the results of the case studies double click on the image below and then click on each named case study to review the results. If you are unable to access the PDF through the image please double click on the icon below.



NAS Scenariosfinal.pdf

11 Moving Forward

The information presented above, as stated in the introduction, offers a snapshot of the situation in your area with regard to the delivery of services for people with Autism and their families. The Service Map is not the complete story of the services you deliver in your area, However, together with the National findings and knowledge of your current delivery, it is hoped this service map will help inform the design and delivery of your Autism Action Plans as agreed under Autism Strategy funding to local authorities.

The information from the entire National Autism Services Mapping Project, across all local authorities in Scotland, will be gathered together and a full report published. The Scottish Strategy for Autism web site has up to date information on the implementation of the strategy for your information http://www.autismstrategyscotland.org.uk/

Agenda Item

6

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2015
Report Title:	Supporting Delivery of Services in Localities
Reference Number:	CC-22-16-F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

The purpose of this report is to inform the Integration Joint Board of the intention by the Chief Officer to refocus management resources to better support locality working.

That the IJB considers the report, and RESOLVES to support the strategic direction, and to receive further updates on progress at future meetings.

High Level Summary:

Our delivery of services needs to adapt and respond to the changes going on around us. Traditional delivery will produce more of the same, and will not deal with the challenges already described in a way that creates sustainability and a different level of resilience.

In Shetland, with our small health and social care economy, we have some unique opportunities for partnership working, but also some particular challenges, which include diseconomies of scale.

Locality based teams can provide the wrap around care so vitally needed to achieve our ambitions in Shetland for care in the right place, at the right time, and provided by the right people. Health and social care professionals who know and understand their localities; have access to the wider community asset base; and know their vulnerable client caseload have the most opportunity for meeting our aspirations to reduce emergency admissions; maintain people in their own homes and communities; and improving quality for health and care.

Corporate Priorities and Joint Working:

The outcome of the project will be an operational management and professional structure that supports an improved way of delivering services to our communities. This will support the requirement to develop localities as specified within the Public Bodies (Joint Working) (Scotland) Act 2014.

Key Issues:

Community and staff engagement has been undertaken as part of the project. Most recently staff engaged in a series of meetings held in each locality to better understand the challenges and how those challenges might best be met to deliver improvements for

integrated working.

Implications :	
Service Users, Patients and Communities:	Improved delivery structures will better support communities and individuals in communities, with an emphasis on enabling people to remain in their communities through older age and infirmity.
Human Resources and Organisational Development:	There will be a full staff engagement process in both NHS Shetland and the Shetland Islands Council with any proposed staff restructure. A further detailed report containing proposals for change will be subject to both organisations formal employee consultation mechanisms. The Council and NHS have a range of policies that will apply to any staff affected by an organisational change. There is also regular consultation with Trade Unions and Staff Side through the consultative mechanisms in place in both organisations and through the Joint Staff Forum.
Equality, Diversity and Human Rights:	Shetland's Joint Strategic (Commissioning) Plan supports and promotes equalities, health and human rights.
Legal:	Any changes to the terms and conditions of individuals will potentially require legal advice to support the HR process.
Finance:	There will be a continued drive to reduce management costs wherever practicable to do so. There are no foreseen increases in costs for the project to improve delivery structures in localities.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The main risk is that of not developing and establishing new service provision models. We must continue to promote new ways of working and provide flexible, responsive health and care services in the community. We must work in collaboration with Acute Services, with Third Sector partners and communities to promote prevention, early intervention and develop health improvement programmes.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions.

	This particular report is presented to the IJB in terms of its responsibility for operational oversight of integrated services. The Chief Officer is responsible for the operational management of integrated services
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

6

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Supporting Delivery of Services in Localities
Reference Number:	CC-22-16-F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The purpose of this report is to inform the Integration Joint Board of the intention by the Chief Officer to refocus management resources to better support locality working.

2. Background

2.1 Planning and delivering services in localities is one of the requirements set out in the Public Bodies (Joint Working) (Scotland) Act 2014, which states that partnerships must:

a) Divide the area of the local authority into two or more localities; and
b) Set out separately the arrangements for the carrying out of the integration functions in relation to each such locality.

2.2 Shetland has a long history of partnership working, and we should rightly be proud of that. Health and social care services have more recently been the subject of intense scrutiny at a national level, with legislation in place that directs Health Boards and Local Authorities to join up how they deliver these services. In Shetland, an Integration Joint Board has existed since late 2015, with that Board directing the strategic planning of these services, and directing service delivery to ensure that the strategic aims are met.

2.3 There are many challenges facing public sector services and these challenges apply to Shetland. An ageing population; government cuts to budgets; and difficulties in recruitment are common to many parts of Scotland, and are challenges faced in Shetland. Health and Social Care Integration is a solution that we must capitalise on, and realise the full potential of in order to cope with our local challenges.

2.4 Whilst Shetland performs well on many indicators for health and social care, there are a number of areas that require a particular focus if we are to meet the challenges of demographic change (an ageing population and increase in

the number of people with long term conditions and disability) and the diminishing amount of resources at our disposal. While the actual numbers of delayed discharges from hospital are low, relative to the size of our population, the rates are high. For people aged over 75 who are admitted as an emergency to hospital, again while the actual numbers appear small, the rates are high.

2.5 Comparing Shetland to the rest of Scotland gives us a much better indication of how well we are delivering the right services at the right time. Our balance of care - between helping people to remain in their own homes versus the number of people in residential care - is good, in that we are supporting a number of people to remain in their own homes. In future years, as the population continues to age, we will have to be better than we are now in supporting more people to remain in their own homes, recognising that we have a finite number of care centre places. The funding we receive from the Shetland Charitable Trust for supporting the rural care model is being decreased by the Trust each year, and so maintaining services at their current levels going forward will not be possible.

2.6 Our delivery of services needs to adapt and respond to the changes going on around us. Traditional delivery will produce more of the same, and will not deal with the challenges already described in a way that creates sustainability and a different level of resilience. A significant number of health and care economies across the UK have been forging ahead with changing how they deliver services in order to keep pace with the pressures of ageing populations and falling budgets. In Shetland, with our small health and social care economy, we have some unique opportunities for partnership working, but also some particular challenges, which include diseconomies of scale.

2.7 Service delivery in Shetland by health and social care has followed traditional models, where uni-disciplinary teams have been created, who cooperate and will work together when required to do so. Information sharing is hampered by the plethora of different systems that are used, and compounded by teams being located in different offices/bases where there are no day to day connections between staff. Small steps of change have been tested, with recent success of an intermediate care team that is multi-disciplinary, co-located and have a single management structure.

2.8 Shetland is made up of many small communities, with different needs, and access to different resources. There are seven planning localities in Shetland and the health and social care resources that include physical assets largely fit into this locality model. Feedback from communities, both through public engagement processes and through complaints, suggests that organisations are not always working together in a sufficiently coordinated way. Feedback from staff suggests that they are often unaware, despite the small size of the community they are serving, of who they should be contacting in other disciplines for advice or input to particular client cases.

2.9 Multi-disciplinary teams are not a new concept. Traditionally, multi-disciplinary teams in health and care terminology would include health professionals and social care practitioners. Multi-disciplinary teams can be much wider than this, and can include other statutory agency staff (police, fire, ambulance for example), the Third Sector, Independent Sector, and

Community Groups. Multi-disciplinary teams for health and social care need leadership, and leaders who will direct and coordinate, and oversee the activity in a locality to ensure that it meets the strategic aims of the Health and Social Care Partnership.

2.10 Working in multi-disciplinary teams provides joined up and seamless care, particularly for those with long term conditions and disabilities. Appendix 1 shows how a locality based model might look. We need to try and prevent people experiencing a crisis, but if that does occur, we need to respond swiftly with the right kind of support. If a hospital admission is unavoidable, then we need to expedite a hospital discharge as soon as possible, and support a recovery at home or in a community facility. To achieve this, there needs to be a single point of contact for access to health and social care, 24 hours a day, 7 days a week. Better ways of sharing information between professionals about people who need their support need to be found. We need to identify vulnerable people and those with complex care needs, and ensure that services are coordinated to support them in the community. Better support networks are needed in the community to help people returning home from hospital. Community teams need to be inclusive not just of professionals from health and social care, but volunteers and other agencies to meet the local community's needs for health, wellbeing and social care.

2.11 Locality based teams (supported by specialist in-reach services) can provide the wrap around care so vitally needed to achieve our ambitions in Shetland for care in the right place, at the right time, and provided by the right people. Health and social care professionals who know and understand their localities; have access to the wider community asset base; and know their vulnerable client caseload have the most opportunity for meeting our aspirations to reduce emergency admissions; maintain people in their own homes and communities; and improving quality for health and care.

2.12 Staff need to be supported to work in a different way. Some of our staff already work in small or isolated teams, particularly in the more remote areas of Shetland. Often it is in these communities that we see the most success where there is a multi-disciplinary approach, with GPs, Community Nurses and Social Care Workers co-operating for an agreed objective. Professionals need to work with the right team members to achieve the outcomes required for individuals, and as professionals should be practising with a level of autonomy as part of a multi-disciplinary team.

2.13 Operational line management and professional supervision and accountability will be clearly defined for each professional group, to ensure that individuals are properly supported to deliver effectively and efficiently. This may mean that for some staff there are two separate individuals who provide the operational and the professional supervision (where your line manager is not from your profession). This model is used extensively in many other areas, and is well tried and tested in Shetland, both in health and social care. Professionals will come together on a regular basis, as a uni-professional discipline, as happens already in a number of professions who meet to discuss governance issues and to develop as individuals through contact with peers.

2.14 The Chief Officer will work with the HR Lead for the Shetland Islands Council and NHS Shetland to ensure that due process is followed. Staff engagement will be initiated through the Joint Staff Forum.

3. Recommendations

It is recommended that the IJB considers the report, and RESOLVES to support the strategic direction and to receive further updates on progress at future meetings.

4. Conclusions

4.1 The outcomes for individual clients/patients and for communities with locality based multi-disciplinary teams will be measurable and we will be able to articulate success to our communities. The measures we will use include the national health and wellbeing outcomes. We will measure the reductions in emergency admissions to hospital; the reduced lengths of stay in hospital; and the improvements in individuals' accounts of their health and wellbeing. Staff will gain better satisfaction from their work, with a reduction in duplication; better communication; and the support from working in a larger multi-disciplinary team.

4.2 Shetland has health and social care staff who are highly motivated, dedicated and who are willing to adapt to new circumstances. The ability to adapt is often forgotten when staff are questioning a new initiative, but recent history demonstrates how flexible our staff are willing to be. Staff are our greatest asset, and need to be informed, involved and supported as we make this next step towards a truly integrated service delivery model.

Contact Details:
For further information please contact:
Simon Bokor-Ingram
Director of Community Health and Social Care
E-mail: simon.bokor-ingram@nhs.net or *simon.bokor-ingram@shetland.gov.uk*
Telephone: 01595 743087

3 April 2016

Background documents
Shetland's Draft Joint Strategic (Commissioning) Plan 2016/17-2019
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/FinalJointStrategicCommissioningPlan2016-19.pdf

Shetland Islands Council

APPENDIX 1

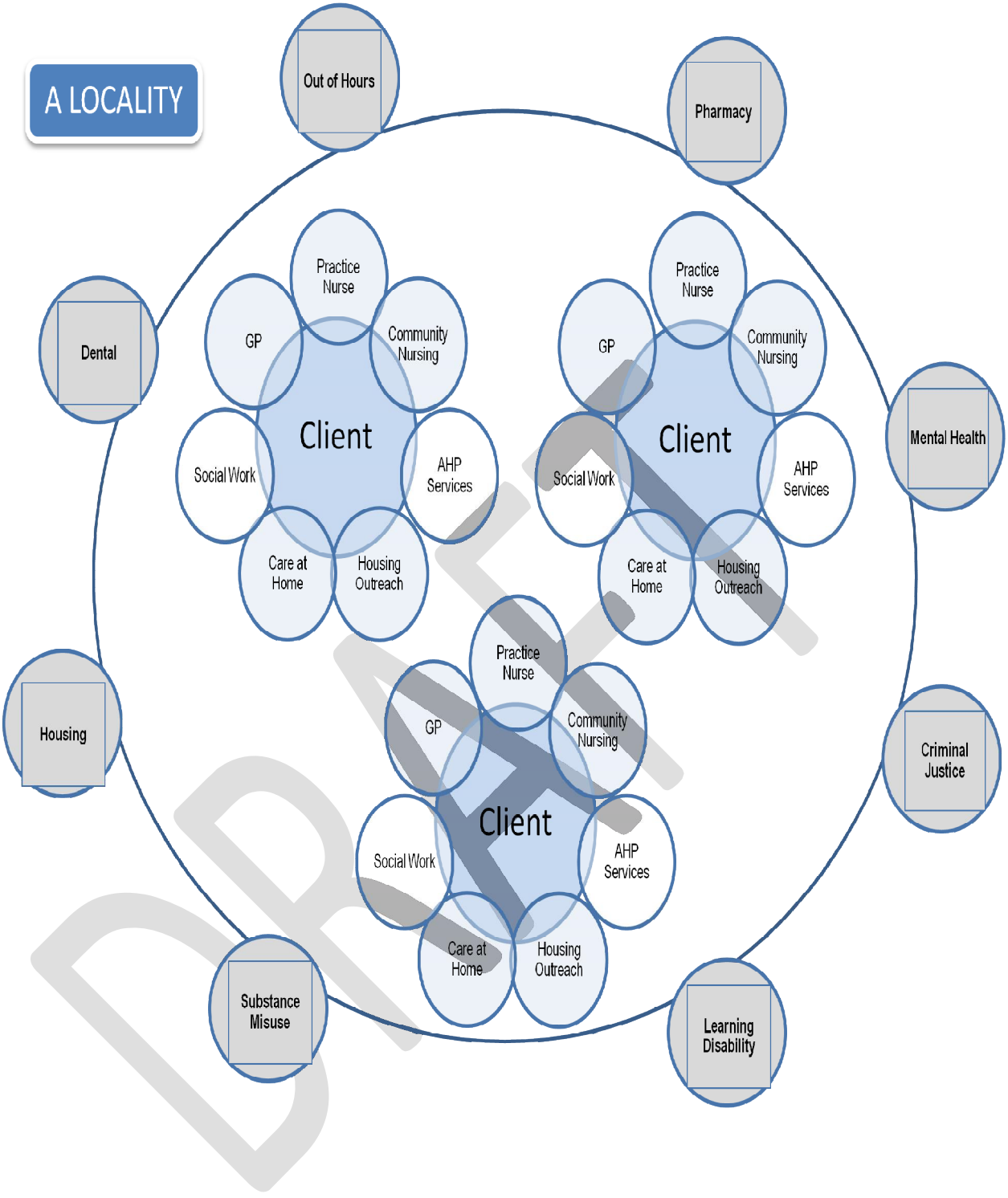
Groups of one or more localities will be supported by an Area Manager, who will have a responsibility for leading service delivery and strategic planning for that area. The areas will consist of the following localities:

Area 1	Area 2	Area 3
South Mainland-Levenwick (including Fair Isle)	Lerwick and Bressay	North Mainland – Brae / Hillswick
Central – Scalloway / Burra		Whalsay and Skerries
West Mainland – Bixter / Walls (including Foula)		North Isles- Yell / Unst / Fetlar

This arrangement also gives the most even spread of resident numbers for each Area, and creates a manageable portfolio for each Area Manger, who will be responsible for the operational delivery as well as strategic planning at locality level.

An Area Manager will have responsibility for managing services within one or more localities and working collaboratively with independent practices, third sector organisations and community groups. Three areas are proposed, which creates a more balanced portfolio than the current arrangements, where for instance Community Care Resources has a distinctly higher number of staff than any other service.

Area management will focus initially on the services being delivered within localities, with more specialist services “in reaching” into localities. Over time, the aim would be to move more services into the locality model. The model initially is illustrated with services that are to be included within localities (direct management and liaison) centring on the individual, with a number of other services in reaching into localities (the services around the edge of the outer circle).



Within each locality the core services depicted delivering at an individual level will also draw on the services that in-reach, which are shown on the outer ring. Services that are to be in the area management accountability are still being determined via consultation and engagement with the Operational Management Team.

Agenda Item

7

Shetland Islands Council

NHS Shetland

Meeting:	Integrated Joint Board
Date:	27 April 2016
Report Title:	Care and Support Charge Policy 2016-19
Reference Number:	CC-23-16 D1
Author / Job Title:	Jo Robinson/ Executive Manager Allied Health Professionals

Decisions / Action required:

NOTE the information presented in this report and its appendices;

NOTE the work undertaken to ensure the Policy supports the principles of co-production, anti-poverty measures and waiving the charges to carers

NOTE the areas in which the Policy exceeds the minimum standards set by COSLA

NOTE the Policy and the work to be undertaken by the service to develop the Policy further over the next year.

High Level Summary:

This report presents the report and policy that was considered by the Policy & Resources Committee on 18 April (Appendix 1).

Included in the report is the Draft Care and Support Charging Policy 2016/19. It outlines the changes made to the 2015/16 Policy in response to updated Convention of Scottish Local Authorities (COSLA) guidance and feedback from stakeholders.

The report highlights the areas where the Draft Care and Support Charging Policy exceeds the standards in the Minimum Standard Financial assessment template devised by COSLA.

The report identifies the contribution that the Policy expects to make towards meeting the Council's Medium Term Financial Plan in 2016/17.

Corporate Priorities and Strategic Aims:

The adoption of the Policy contributes to the Integrated Joint Board's objectives of using resources effectively and efficiently in the provision of health and social care services. The implementation of the Policy will assist to achieve a balanced budget which will support the Council's aim of supporting older people across Shetland and people who are living with disabilities (including learning disabilities) or long-term conditions so they can get the services they need to help them live as independently as possible.

Key Issues:
The COSLA Guidance on which the Policy is based on is only approved in February of each financial year. The Policy has previously been devised for the single financial year, starting in April. This has meant that there has been very little time to ascertain the effect of any changes in the guidance and to draft the local Policy and submit it to committee for approval before the beginning of the financial year to which the Policy pertains. It is considered that in practice this also gives those in receipt of charges inadequate time to come to an informed view about whether or not they want to draw upon a chargeable service. For this reason, this Policy has been drafted to cover the period 2016-19 with the undertaking that it will be brought back to Council if there are significant differences in Charging guidance or legislation in future years. In January 2015 COSLA Leaders requested work to be undertaken on anti-poverty measures, with a view to lifting greater numbers of people out of charging. One measure that has now been adopted in the 2016/17 COSLA guidance was to raise the buffer (which is used to establish the minimum charging threshold) from 16% to 25%. In 2015/16 the COSLA guidance introduced a Minimum Standard Financial Assessment Template. The COSLA Guidance was clear at that time that the minimum standard did not prevent Councils from adopting a more generous treatment of a supported person's circumstance than laid out in their paper. In recognition of this, and in response to local feedback received, Shetland Islands Council adopted a more generous Policy in 2015/16, and the 2016-19 draft Policy again recommends this approach. A further issue that requires consideration is that of the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014. The Regulations state that a local authority must waive charges where services are provided to carers who are in need. The Regulations also have the effect that local authorities cannot means test or require a contribution from a carer where the support is being delivered by way of a direct payment. The 2016-19 draft Policy therefore includes a section outlining the process by which a carer's needs will be assessed and a decision made on whether the provision or securing the provision of support to the carer will help the carer to provide, or continue to provide, care for the cared-for person. Where support is provided in this manner, it should not be charged for.

Implications :	
Service Users, Patients and Communities:	Feedback from stakeholders has been collated by staff since the inception of the Care and Support Charging Policy. Revised COSLA guidance continues to address concerns from the community nationally. Consultation has taken place through 2015/16 with Carer's representatives, Citizen's Advice Bureau, Advocacy Shetland, and other third sector partners. The charging policies have been adapted locally to address concerns previously expressed. Consultation, monitoring and review will continue to take place during the course of 2016 and future years. The Policy will assist in maintaining the services delivered to people who currently use Community Health and Social Care services provided by the Council.
Human Resources and Organisational	The Policy will provide guidance to staff working within the Community Health and Social Care Service.

Development:	
Equality, Diversity and Human Rights:	All of the Human Rights protected by the European Convention on Human Rights (ECHR), in the Human Rights Act and in subsequent ratified conventions have been adhered to in the development and implementation of the Policy. The Equality Act 2010 places duties on Local Authorities which has relevance to such a Policy. Due consideration has been made to the impact on this Policy particularly with reference to disregards based on age. An Equalities Impact Assessment has been completed.
Partnership Working	There is ongoing discussion nationally about charging for services and the different approaches between NHS Services (free at the point of contact), and local authority. Guidance in this area will continue to be monitored.
Legal:	The legislative framework that supports the Care and Support Charging Policy includes services provided under the Social Work (Scotland) Act 1968. This legislation sets out services that customers can be expected to contribute towards and those that they cannot be expected to contribute towards. Failure to implement measures arising from Carers (Waiving of Charges for Support) (Scotland) Regulations 2014 will leave the Council in breach of this guidance.
Finance:	Continued implementation of this Policy plays a significant part in the Community Health and Social Care Directorate meeting its obligations under the Council's Medium Term Financial Plan 2016-2020. Not meeting these obligations would put further pressure on reserves and/or other Directorate budgets. The income expected in the 2016/17 budget from the Care and Support Charging Policy is £308,812. It is estimated that implementation of the higher buffer of 25% will result in a loss of income of £16,783.00 based on current customer's financial assessments. In practice, the amount might vary from this according to individual customer's circumstances. The Local Government Finance settlement 2016-2017 included "Integration Funding" of £250M, and specified that this should be used to cover any costs accrued by moving to the new charging threshold. Introduction of the repair/maintenance allowance of £59.54 per week for customers who own their own homes and have savings under £10,000 reduced their potential maximum charge per year by an average of £1491, and is likely to result in a similar reduction in 2016/17. The exact amount will vary according to individual customer's circumstances.
Assets and Property:	No implications
Environmental:	No implications

Risk Management:	Financial risk Failure to reduce the net ongoing running costs of the Council carries a significant risk of the Council's financial policies not being adhered to and will require a further draw from reserves which is not sustainable. Social risk There is a risk that people will refuse services to meet their assessed need and in doing so may increase their vulnerability. Such cases have been monitored since implementation and will continue to be monitored closely. The Policy sets out the procedure for reviewing, waiving or abating charges where necessary.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility for operational oversight of a range of integrated services which support adults requiring an assessed level of care and support.	
Previously considered by:	Policy and Resources Committee	18 April 2016

Agenda Item

7

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	Care and Support Charging Policy 2016-19
Reference Number:	CC-23-16-D1
Author / Job Title:	Jo Robinson / Executive Manager Allied Health Professionals

1. Introduction

1.1 This report presents the Draft Care and Support Charging Policy 2016-19 presented to Policy & Resources Committee on 18 April 2016 for approval (see Appendix 1). It outlines the changes made to the 2015/16 Policy in response to updated Coalition of Scottish Local Authorities (COSLA) guidance and feedback from stakeholders.

1.2 The report highlights the areas where the Draft Care and Support Charging Policy exceeds the standards in the Minimum Standard Financial assessment template devised by COSLA.

1.3 The report identifies the contribution that the Policy expects to make towards meeting the Council's Medium Term Financial Plan in 2016/17.

2. Background

2.1 Appendix 1 gives the full background information to this draft Policy. All relevant considerations are included in this appendix.

3. Conclusions

3.1 The Integration Joint Board are asked to:

NOTE the information presented in this report and its appendices;

NOTE the work undertaken to ensure the Policy supports the principles of co-production, anti-poverty measures and waiving the charges to carers

NOTE the areas in which the Policy exceeds the minimum standards set by COSLA

NOTE the Policy and the work to be undertaken by the service to develop the Policy further over the next year.

Contact Details:
For further information please contact:
Jo Robinson
Executive Manager Allied Health Professionals
E-mail: jo.robinson@shetland.gov.uk
Telephone: 01595 744343

Appendices

Appendix 1 – Report to Policy & Resources Committee

Additional reading

Scottish Health and Care Experience Survey 2013-14, Volume 1, National Results, A National Statistics Publication for Scotland published by the Scottish Government.
http://www.scotland.gov.uk/Resource/0045/00451272.pdf

Statutory guidance to accompany section 3 of the Social Care (Self-directed Support) (Scotland) Act 2013 and the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014
http://www.gov.scot/Resource/0044/00447402.pdf

Agenda Item

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Shetland Islands Council

Policy and Resources Committee **18 April 2016**

Care and Support Charging Policy 2016-2019	
CC-23-16- F	
Report by Executive Manager Allied Health Professionals	

1. Summary

1.1 This report presents the Draft Care and Support Charging Policy 2016-19 (Appendix 1). It outlines the changes made to the 2015/16 policy in response to updated Convention of Scottish Local Authorities (COSLA) guidance and feedback from stakeholders.

1.2 The report highlights the areas where the Draft Care and Support Charging Policy exceeds the standards in the Minimum Standard Financial assessment template devised by COSLA.

1.3 The report identifies the contribution that the Policy expects to make towards meeting the Council's Medium Term Financial Plan in 2016/17.

2. Decision Required

That the Policy and Resources Committee RESOLVES to:

2.1 adopt the Care and Support Charging Policy 2016-19; and

2.2 delegate authority to the Executive Manager – Allied Health Professionals to update the Policy from time to time in accordance with guidelines or changes in legislation, provided that any significant changes be reported to the Policy and Resources Committee for approval [as per paragraph 3.3].

3. Detail

3.1 The Community Health and Social Care Directorate (previously Community Care Directorate) implemented a Policy of charging for selected community care services in September 2013, based on

guidance issued by COSLA. The Policy has been revised in each subsequent year based on updated guidance from COSLA and feedback from stakeholders.

3.2 The 2016/17 COSLA Guidance was released in February 2016. This guidance was written in consultation with a range of representative organisations including Scottish Government, the Association of Directors of Social Work, Age Scotland, Coalition of Carers, Independent Living in Scotland, the Scottish Consortium for Learning Disability, Alzheimer's Scotland, and Capability Scotland. It has been endorsed by the political leadership of COSLA. The guidance can be found at Appendix 2.

3.3 In the years 2013-16, the COSLA guidance has only been signed off by COSLA members in February each year. This has meant that there has been very little time to ascertain the effect of any changes and to draft the local Policy and submit it to Committee for approval before the beginning of the financial year to which the Policy pertains. It is considered that in practice this also gives those in receipt of charges inadequate time to come to an informed view about whether or not they want to draw upon a chargeable service. For this reason, this Policy has been drafted to cover the period 2016-19 with the undertaking that it will be brought back to Committee if there are significant differences in Charging guidance or legislation in future years. It is proposed that minor updates be made from time to time, and that these will be communicated to Members through briefing notes.

3.4 Whilst the COSLA guidance emphasises that the contribution to sustainable community care services from charging should not be underestimated, it also emphasises that any policies on charging should be "co-produced" with the people who are affected by the Policy. Formal and informal feedback received by the Community Health and Social Care Directorate continues to be taken account of and is incorporated in the 2016-19 draft Policy.

3.5 In January 2015 COSLA Leaders requested work to be undertaken on anti-poverty measures, with a view to lifting greater numbers of people out of charging. One measure that has now been adopted in the 2016/17 COSLA guidance was to raise the buffer (which is used to establish the minimum charging threshold) from 16% to 25%. This has therefore been included in the local 2016-19 draft Policy. It is estimated that this will result in a loss of income of £16,783.00 based on current customers' financial assessments. In practice, the amount might vary from this according to individual customer's circumstances.

3.6 In 2015/16 the COSLA guidance also introduced a Minimum Standard Financial Assessment Template (Appendix 3). The COSLA Guidance was clear at that time that the minimum standard did not prevent Councils from adopting a more generous treatment of a supported person's circumstance than laid out in their paper. In recognition of this, and in response to local feedback received, Shetland Islands Council adopted a more generous policy in 2015/16, and the 2016-19 draft Policy again recommends this approach. The differences between the minimum standard and the proposed standard locally are shown below:

Minimum standard template (COSLA)	Proposed standard for Council 2016-19 Policy
People *under* pension age should be charged £1/ 250 on all capital above £6,000 People *over* pension age should be charged £1/500 on all capital above £10,000	People of *all* ages will continue to be charged at the more generous rate of £1/ 500 on all capital above £10,000. This proposal was approved by Council in the 2014/15 Policy in response to concerns from people under pension age that if they had ongoing needs over many years, their savings would decrease rapidly. The higher level afforded them more protection against dwindling savings.
Capital Upper Limit of £16,000 over which customers are charged the full cost of services	No proposal to introduce a Capital Upper Limit until the impact on customers can be fully assessed. It is estimated that this change would affect approximately 40 customers negatively. Work is ongoing to allow better predictions of the impact of this proposed change to be undertaken.
No property repair/ maintenance allowance specified.	Introduction of a repair/maintenance allowance of £59.54 per week for customers who own their own homes and have savings under £10,000. This was in response to feedback received regarding the ability of customers in this situation to maintain their homes adequately. In 2015/16, this change affected 20 customers positively, reducing their potential maximum charge per year by an average of £1,491.

3.7 A further issue that requires consideration is that of the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014. The Regulations state that a local authority must waive charges where services are provided to carers who are in need. The Regulations also have the effect that local authorities cannot means test or require a contribution from a carer where the support is being delivered by way of a direct payment. The 2016-19 draft Policy therefore includes a section outlining the process by which a carer's needs will be assessed and a decision made on whether the provision or securing the provision of support to the carer will help the carer to provide, or continue to provide, care for the cared-for person. Where support is provided in this manner, it should not be charged for.

4.0 Implications

Strategic

4.1 Delivery On Corporate Priorities

Implementing the Care and Support Charging Policy will generate income that will help the Community Health and Social Care Directorate to meet its obligations in relation to the Medium Term Financial Plan.

4.2 Community /Stakeholder Issues

Feedback from stakeholders has been collated by staff since the inception of the Care and Support Charging policy. Revised COSLA guidance continues to address concerns from the community nationally. Consultation has taken place through 2015/16 with Carer's representatives, Citizen's Advice Bureau, Advocacy Shetland, and other third sector partners. The charging policies have been adapted locally to address concerns previously expressed. Consultation, monitoring and review will continue to take place during the course of 2016 and future years.

The Policy will assist in maintaining the services delivered to people who currently use Community Health and Social Care services provided by the Council.

4.3 Policy And/Or Delegated Authority

As this Policy relates to the procedures regarding charging, it is a matter for decision by the Policy and Resources Committee which has delegated authority for the co-ordination, control and proper management of the financial affairs of the Council.

Any matters relating to the delivery or provision of the functional services concerned are delegated to the Integration Joint Board.

4.4 Risk Management

Financial risk

Failure to reduce the net ongoing running costs of the Council carries a significant risk of the Council's financial policies not being adhered to and will require a further draw from reserves which is not sustainable.

Social risk

There is a risk that people will refuse services to meet their assessed need and in doing so may increase their vulnerability. Such cases have been monitored since implementation and will continue to be monitored closely. The Policy sets out the procedure for reviewing, waiving or abating charges where necessary.

Legal risk

Failure to implement measures arising from Carers (Waiving of Charges for Support) (Scotland) Regulations 2014 will leave the Council in breach of this guidance.

4.5 Equalities, Health And Human Rights

All of the Human Rights protected by the European Convention on Human Rights (ECHR), in the Human Rights Act and in subsequent ratified conventions have been adhered to in the development and implementation of the Policy. The Equality Act 2010 places duties on Local Authorities which has relevance to such a policy. Due consideration has been made to the impact on this policy particularly with reference to disregards based on age.

An Equality Impact Assessment has been completed and can be found at Appendix 4.

4.6 Environmental

There are no environmental issues associated with this Policy.

4.7 Financial

Continued implementation of this policy plays a significant part in the Community Health and Social Care Directorate meeting its obligations under the Council's Medium Term Financial Plan. Not meeting these obligations would put further pressure on reserves and/or other Directorate budgets.

The income expected in the 2016/17 budget from the Care and Support Charging Policy is £308,812. It is estimated that implementation of the higher buffer of 25% will result in a loss of income of £16,783.00 based on current customer's financial assessments. In practice, the amount might vary from this according to individual customer's circumstances. The Local Government Finance settlement 2016-2017 included "Integration Funding" of £250M, and specified that this should be used to cover any costs accrued by moving to the new charging threshold.

Introduction of the repair/maintenance allowance of £59.54 per week for customers who own their own homes and have savings under £10,000 reduced their potential maximum charge per year by an average of £1,491, and is likely to result in a similar reduction in 2016/17. The exact amount will vary according to individual customer's circumstances.

4.8 Legal

The legislative framework that supports the Care and Support Charging policy includes services provided under the Social Work (Scotland) Act 1968. This legislation sets out services that customers can be expected to contribute towards and those that they cannot be expected to contribute towards.

4.9 Human Resources

The ongoing workload has and will continue to be absorbed within existing administrative staffing levels. The Policy will provide guidance to staff working within the Community Health and Social Care Service.

4.10 Assets And Property

None

5.0 Conclusions

5.1 Continuing with this Policy will make a significant contribution to the Community Health and Social Care Directorate's ability to operate successfully within its set budget. Not successfully operating within agreed budgets puts pressure on further draw on reserves, other Directorates and current service provision.

5.2 The 2016/17 COSLA guidance has been updated to include anti-poverty measures. This has been incorporated in the draft local Policy which also takes account of many of the concerns expressed locally by stakeholders. The draft Policy also ensures that the issue of waiving the charges for carers is addressed.

For further information please contact:

Simon Bokor-Ingram - Director of Community Health and Social Care

Simon.Bokor-Ingram@shetland.gov.uk

01595 743697

Appendices

Appendix 1 - Draft Care and Support Charging Policy
Appendix 2 – COSLA National Strategy and Guidance – Charges applying to Non-residential Social Care Services
Appendix 3 – COSLA Financial Assessment Template – Minimum Standard
Appendix 4 – Equality Impact Assessment

Additional reading

Scottish Health and Care Experience Survey 2013-14, Volume 1, National Results, A National Statistics Publication for Scotland published by the Scottish Government.
http://www.scotland.gov.uk/Resource/0045/00451272.pdf

Statutory guidance to accompany section 3 of the Social Care (Self-directed Support) (Scotland) Act 2013 and the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014
http://www.gov.scot/Resource/0044/00447402.pdf

Shetland Islands Council

Community Health and Social Care

Care and Support Charging Policy

2016-19

DRAFT

Approved by Shetland Islands Council date…

1. Policy Statement

This Care and Support Charging Policy, which was agreed by Shetland Islands Council on (date), explains how we will work out how much customers should be charged towards the cost of the services they receive. The policy covers non-residential services for all people using social care services.

The policy is intended to help staff working for the Council, service providers, customers and other interested groups to understand how we will calculate charges.

Shetland Islands Council will charge for services where there is a statutory power do to so. We will not charge for 'personal care' services for people 65 years and over, as defined by the Community Care and Health (Scotland) Act 2002.

2. Principles on which the Care and Support Charging policy is based

Ability to Pay – all customers will contribute towards the cost of services they use, on the basis of their available income and cash assets.

Maximum charge – we will not charge more than the cost of providing the service

Equity – all service users will be treated equally

Transparency – service users will know how and why they are being charged for a particular service

Compliance with national guidance – the charging policy complies with COSLA's Guidance on charging policies for non-residential services that enable people to remain in their own home – 2016-2017, the National Assistance Act 1948 and the National Assistance (Assessment of Resources) Regulations 1991.

3. Aims of the Care and Support Charging Policy

The policy explains:

- What income, savings and capital we take into account when working out how much someone has to pay towards the cost of the service they receive. This is called the financial assessment.
- How we treat that income, savings and capital.
- What allowances are made for an individual's circumstances.
- What happens if a customer can't pay or won't pay.

4. Charges for Community Care Services

4.1 Services for which we may ask the customer to contribute

We will ask customers to meet the costs of the provision of the following services which have a set charge and are excluded from customer financial assessments.

- Community Alarm provision
- Cost of meals provided at Day Care
- Meals on Wheels

We may ask customers to contribute to the cost of the provision of the following services.

- Attending Day Services
- Care at Home
- Domestic Support
- Supported Living and Outreach Services
- Mental Health services

  The charges that will be applied are shown in Appendix 1 Section 1.

4.2 Services that are provided free of charge

- Service for people with a mental illness who are subject to a Compulsory Treatment Order.
- Services provided by the Criminal Justice Service.
- New or additional services for people age 65 and over who are being discharged from hospital. In this circumstance they will not be expected to contribute to their support for a period of 42 days.
- Re-ablement services. In this circumstance they will not be expected to contribute to their support for a period of 42 days.
- People who are terminally ill.
- Personal care tasks as defined by the Community Care and Health (Scotland) Act 2002 for people 65 years of age and over.

Free Personal Care: Preparation of Food

Charges will not be applied to the preparation of, or the provision of any assistance with the preparation of, a person's food including:

- defrosting, washing, peeling, cutting, chopping, pureeing, mixing or combining, cooking, heating or re-heating, or otherwise preparing food or ingredients;
- cooking, heating or re-heating pre-prepared fresh or frozen food;
- portioning or serving food;
- cutting up, pureeing or otherwise processing food to assist with eating it; and
- assisting in the fulfilment of special dietary needs, but not the supply of food (whether in the form of a pre-prepared meal or ingredients for a meal) to, or the obtaining of food for, the person, or the preparation of food prior to the point of supply to the person.

4.3 Charging for services provided to carers

In some circumstances we will not charge for support provided to carers to enable them to provide replacement care to a cared-for person. In these circumstances, the following must apply:

- the carer must have been in receipt of a carer's assessment;
- the assessment must have been considered and a decision reached about whether the carer has needs in relation to the caring responsibilities;

- the assessor should consider whether the needs can be met in whole or in part by the provision of support;
- if so, the assessor should decide whether to provide or secure the provision of support to the carer which will help the carer to provide, or continue to provide, care for the cared-for person.

Once it has been decided to provide support to the carer, the support cannot be charged for. This includes replacement care. For residential respite care which is to support the carer a maximum of eight weeks will be provided in a calendar year

4.4 Charging threshold

The charging threshold for the current year is shown in Appendix 1 Section 2. 2016/17 figures are shown in the examples below.

The charging threshold is the set level of personal income below which a person can receive community care service(s) without needing to pay a contribution or charge towards the cost of the service(s) they receive. The amounts set are linked to the rates set by the UK Government Department of Work and Pensions. These are rates of benefit which provide a top up of weekly income to a guaranteed minimum amount. We will not ask you to pay a charge for services where your income falls below the charging threshold.

Income Support - Personal Allowance	**2016/2017 (weekly)**
Single Person	**73.10**
Couple	**114.85**

Disability Premium	**2016/2017 (weekly)**
Single Person	**32.25**
Couple	**45.95**

Pension Credit - Guarantee Credit	**2016/2017 (weekly)**
Single Person	**155.60**
Couple	**237.55**

In order to provide more help to those on low income and to recognise that not all of a user's income above these rates should be taken in charges, we add a buffer to the income levels above. This buffer is currently set at 25%.

The **charging threshold** is worked out by adding the buffer (25%) to the appropriate DWP rate(s) for groups of people. Note: all thresholds are rounded up.

For people below state pension qualifying age the **Income Support Personal Allowance and** the **Disability Premium** are added together with the buffer added to the sum of these two rates.

	Income Support - Personal Allowance	Disability Premium	Buffer 25%	Charging Threshold (weekly)
Single Person	73.10	32.25	26.34	**£132**
Couple	114.85	45.95	40.20	**£201**

For people of state pension qualifying age or above the **Pension Credit Guarantee** is used as the basis for the charging threshold calculation with the buffer added.

	Pension Credit - Guarantee Credit	Buffer 25%	Charging Threshold (weekly)
Single Person	155.60	38.90	**£195**
Couple	237.55	59.39	**£297**

4.5 Financial assessment and household income

Customers will be asked to complete a financial assessment form.

If a customer does not want to provide financial information for the assessment we will charge the full cost of providing the service. This may mean that we may charge more than we would have done had we carried out a financial assessment.

Customers will be financially re-assessed on an annual basis unless their total package is covered by Free Personal Care, or the services they receive are not subject to a financial assessment. If a customer's circumstances changes in the mean time they can request a new financial assessment.

We will consider income from all sources and will take account of net earnings and all social security benefits with the exception of:

- **Mobility component of the Disability Living Allowance/Personal Independence Payment.**
- **All benefits paid for or on behalf of dependent children e.g. Child benefit**
- **Tax Credit**
- **Disability payment in respect of child**
- **War widows supplementary pension**

4.6 Earnings

Where a supported person or their partner is in receipt of earned income, when assessing income, we will only take account of net earnings. In addition, we will apply a minimum earnings disregard of the amount shown in Appendix 1 Section 3.

4.7 Compensation payments

Where a person is in receipt of a compensation award, we will establish the breakdown of any payments and consider whether some elements should be included when assessing a supported person's ability to pay a charge.

4.8 Mortgage payments and housing costs

We will deduct all rent payments made after application of housing benefit by people living in rented accommodation when calculating their available income.

We will deduct all capital and interest payments made by owner-occupiers towards mortgages on their primary residence (usual residence where a person owns more than one property) when calculating their available income.

We will deduct the agreed lodging allowance for people who reside at home with their parent/s. The agreed lodging allowance set for the purposes of this policy is shown in Appendix 1 Section 4.

We will deduct an agreed amount for homeowners with savings under £10,000 to enable them to maintain their property. The agreed maintenance allowance set for the purposes of this policy is shown in Appendix 1 Section 5.

We will deduct payments made by owner occupiers and tenants for council tax, water, sewerage and household insurance for building costs when calculating their available income.

4.9 Partners

The customer and their partner's income and capital will be taken into account for the provision of services which benefit both, i.e. domestic care tasks.

Where services are only provided to one member of the household, the following will apply:

Ownership of income/capital	Treatment of Income/capital
Solely owned by Individual	We will take this into account subject to normal disregards
Solely owned by Partner	We will not routinely take this into account as part of financial assessment.
Jointly owned	We will normally consider the individual to be in possession of an equal share of any joint financial resources.
Social security benefits paid to one member of a couple at couple's rates, (for example, pension credit, income support etc.)	We will consider what proportion of such income is "reasonable" to consider as part of the individual's means. It is for the local authority to decide what a reasonable proportion is.

4.10 Disability related expenditure

Disability related expenditure is the additional daily living costs of living with an illness or disability. Information relating to disability related expenditure will be included in the customer's assessment of need and subject to approval by the appropriate Executive Manager.

Additional costs may relate to, but will not be restricted to:

- additional heating requirements
- purchase, maintenance and repair of disability related equipment
- specialist dietary requirement
- specialist clothing
- help with cleaning and other domestic tasks

4.11 Income maximisation and benefit take-up

We will advise and draw customer's attention to sources of advice and help concerning their entitlement to receive state and other benefits.

4.12 Capital and tariff income

There are no upper capital limits at which someone is refused a service.We will take into account available capital such as savings held in a bank, building society, post office or other savings account, bonds, stocks and shares, value of PEPs , ISAs, etc.

The value of a supported person's home is not taken into account for the purposes of this policy. Neither are any business assets or money held in trust but any weekly income received from them is counted. For example, if part of a person's home is rented out some of the rent received as weekly income is counted.We will disregard capital below the amount shown in Appendix 1 Section 6. £1 per £500 of capital above this amount will be counted as a source of income for the purposes of this policy.

Where a person has capital in excess of the disregarded capital amount and is in receipt of income support, we will not treat the excess as a source of income as this exercise will have been carried out by the Department of Work and Pensions with an appropriate adjustment to the amount of Income Support paid to the supported person.

Capital income tariff does not take into account the interest received on cash held in saving accounts. The savings themselves and any interest received are included in the overall total of capital assets held at the time that the financial assessment is carried out. Capital tariff rates seek to take all this into consideration by establishing a weekly income.

4.13 Tapering arrangements

A taper is a method for dealing with income available to the service user that is over the threshold figure. We will disregard a percentage of the income above the threshold amount. Charges will be based on the remainder. The income percentage to be disregarded is shown in Appendix 1 Section 7.

4.14 Discharge from hospital

We will not charge people 65 years of age and over on the day of discharge from hospital for 42 days from the date of discharge for any new, intermediate or additional services if they have been in NHS in-patient care for more than one day (24 hours) for treatment, assessment or rehabilitation, or had surgery as an NHS day case.

This does not apply in cases where admission to hospital is on a regular basis or a frequent basis as part of regular treatment or ongoing care arrangements. Only new, intermediate or additional services provided after a person comes out of hospital will be free for a limited period. Services that were in place pre-admission and continue after discharge will continue to be chargeable.

4.15 Temporary or emergency admission to hospital or care home

If a customer was receiving community based services before a temporary admission to hospital or care home, we will not charge for services while they are away from home. The exception to this is the Community Alarm charge, where the service will continue to be charged for until the unit has been returned to the service provider.

The customer would be required to meet any cost for residential services if they are admitted to residential care.

There may be times when increased care has to be provided at short notice and thus the financial assessment is not updated at the same time. Under these circumstances payments will begin from the date of the service increase.

4.16 Cases of hardship and non payment of charges

Where a supported person has difficulty in meeting the approved cost of the service due to their financial circumstances, we will consider abating or waiving the charge. If there are other reasons of hardship, that are not financial, charges may also be abated or waived. A decision to abate or waive the charge will be made by the Director of Community Health and Social Care, following consideration by the Executive Manager of Social Work at a case review. Any decision to waive all or part of the weekly charge must be reviewed annually at the time of financial re-assessment.

Shetland Islands Council will pursue all assessed charges not paid by people assessed as being able to pay, through the Corporate Council Debt Recovery procedure.

The Director of Community Health and Social Care can recommend a debt for write-off once all normal Council Debt Recovery procedures have been followed. Write-off of debt for non-residential services can only be considered on the following grounds:

- Financial reasons – the customer has died and has left no estate or has absconded
- Social grounds – to pursue the debt would be at the detriment of the customer's well-being

Where an individual in receipt of traditional community care services disputes the level of charges, and does not pay whilst the dispute is being settled, we will not withdraw or reduce the service.

4.17 Incorrect Financial Assessment

Where we have been given the correct financial information by the customer, or his/her representative, and have calculated the charge wrongly, we will reimburse the full amount of any over-charge. We will seek to recover any amount by which they have been under-charged.

If any under-charge results from the customer, or their representative, providing us with incorrect financial information, we will seek to recover any amount by which they have been under-charged. If a customer, or their representative, provides us with incorrect financial information and this results in their being over-charged, we will refund the amount by which they have been over-charged.

4.18 Direct payments

Where a person is eligible for a charge towards their support the direct payment can be made on a "net" or a "gross" basis, i.e. the charge can be removed prior to the provision of the monthly direct payment or following the provision of the monthly payment.

4.19 Information for customers on Care and Support Charges

Customers will be given information about contributions at the time of assessment and charges will be applied from the first date the service is received, unless the customer is the age of 65 years and over and are being discharged from hospital. They will then have a period of 42 days where they will not be expected to contribute.

4.20 Changes to charge rates

All charges will be reviewed regularly. Details of any changes to expected contributions will be published.

4.21 Care and Support Charge appeals and reviews

Customers not satisfied with the calculation or outcome of their financial assessment will be encouraged to discuss their concern with staff involved in the assessment process or the member of care staff working with them. This would normally be their key worker.

Customers who remain dissatisfied will be entitled to pursue their complaint through the Department's complaint procedure.

http://www.shetland.gov.uk/community_care/documents/SC02rev-ComplaintsLeaflet-Jul12.pdf

This policy as outlined above will remain extant until updated as required.

Appendix 1

Details of values to be used in conjunction with the Care and Support Charging Policy for 2016-19

Section 1: Table of Charges

Community Care Services	
SUPPORTED LIVING CHARGE (From April 2016) **Charge per week (i)**	56.00
PERSONAL CARE CHARGE (Under 65s) (From April 2016) **Charge per hour (i)**	17.53
DOMESTIC HOME CARE CHARGE (From April 2016) **Charge per hour (i)**	12.33
DAY CARE (From April 2016) **Attendance Charge per day (i)**	5.00
Meal Charge per meal	6.00
MEALS ON WHEELS (From April 2015) **Charge per meal**	6.00
COMMUNITY ALARM RESPONSE SERVICE (From April 2016) **Charge per week**	1.15

(i)These services are means tested - taper levels and discretions are set out in the Care and Support Charging Policy. Charge is based on estimated increase to Disability Living Allowance Mid Rate Care Component and Standard Rate Personal Independence Payment (PIP).

Section 2: Charging threshold

We will not ask you to pay a charge for services where your income falls below the charging threshold shown below.

For people below state pension qualifying age:	**Charging Threshold (weekly)**
Single Person	**£132**
Couple	**£201**

For people of state pension qualifying age or above:	**Charging Threshold (weekly)**
Single Person	**£195**
Couple	**£297**

How this is calculated:

The charging threshold is the set level of personal income below which a person can receive community care service(s) without needing to pay a contribution or charge towards the cost of the service(s) they receive. The amounts set are linked to the rates set by the UK Government Department of Work and Pensions, shown below. These are rates of benefit which provide a top up of weekly income to a guaranteed minimum amount.

Income Support - Personal Allowance	**2016/2017 (weekly)**
Single Person	**73.10**
Couple	**114.85**

Disability Premium	**2016/2017 (weekly)**
Single Person	**32.25**
Couple	**45.95**

Pension Credit - Guarantee Credit	**2016/2017 (weekly)**
Single Person	**155.60**
Couple	**237.55**

In order to provide more help to those on low income and to recognise that not all of a user's income above these rates should be taken in charges, we add a buffer to the income levels above. This buffer is currently set at 25%.

The **charging threshold** is worked out by adding the buffer (25%) to the appropriate DWP rate(s) for groups of people as set out in the following tables (*all thresholds are rounded up).

For people below state pension qualifying age the **Income Support Personal Allowance and** the **Disability Premium** are added together with the buffer added to the sum of these two rates as shown below.

	Income Support - Personal Allowance	Disability Premium	Buffer 25%	Charging Threshold (weekly)
Single Person	73.10	32.25	26.34	**£132**
Couple	114.85	45.95	40.20	**£201**

For people of state pension qualifying age or above the **Pension Credit Guarantee** is used as the basis for the charging threshold calculation with the buffer added as shown below.

	Pension Credit - Guarantee Credit	Buffer 25%	Charging Threshold (weekly)
Single Person	155.60	38.90	**£195**
Couple	237.55	59.39	**£297**

Section 3
The Minimum Earnings disregard is £20

Section 4
The agreed Lodgings allowance is £59.54

Section 5
The agreed property maintenance allowance is £59.54

Section 6
Capital rules
Capital below £10,000 will be disregarded. £1 per £500 of capital above £10,000 will be counted as a source of income for the purposes of this policy.

Where a person has capital in excess of this amount £10,000 and is in receipt of income support, the excess will not be treated as a source of income as this exercise will have been carried out by the Department of Work and Pensions with an appropriate adjustment to the amount of Income Support paid to the supported person.

Section 7
Tapering arrangements are as follows:
30% of the income above the threshold amount will be disregarded. Charges will be based on the remaining 70%.

These figures will be updated on a yearly basis and/or where new guidance is provided by the Coalition of Scottish Local Authorities (COSLA).

National Strategy & Guidance

Charges Applying to Non-residential Social Care Services

2016/17

COSLA

Contents

COSLA CHARGING GUIDANCE - 2016/17

Executive Summary

This Guidance covers charging for non-residential social care services that enable people to remain in their own homes. It updates the document originally issued by COSLA in 2002, subsequently amended then substantially revised in 2012 and each subsequent year. It does not require councils to charge, nor does it prevent them from adopting a more generous treatment of the supported person's circumstances than is set out in this paper. It provides a framework that aims to maintain local accountability and discretion while encouraging councils to demonstrate that in developing their charging policies they have followed best practice. It aims to create an enabling environment for local authorities to work together to achieve greater consistency across Scotland in terms of the charges levied on people who use services.

Within this context, Council Leaders have collectively agreed that, where councils decide to apply charges for community care services:-

- These policies, at both a national and local level should be accessible, transparent, fair and equitable, and developed from a human rights perspective;
- They should be co-produced with the people who might be affected by a charging regime;
- Councils should balance the utility of additional charging income to improve the quality or scope of social care services against the impact on the quality of life for those who are charged;
- Measures should be taken to ensure that people who use services understand the reasons for charging and its contribution to supporting social care services and that the charges for particular services are clear;
- There should be transparency over what services are chargeable, and at what levels, and use should be made of the local charges information template attached at Annex A;
- Every council should publish its charging policy, a copy of which will be held on the COSLA website;
- Any individual user of services who is looking to move between local authority areas should be entitled to a description of any charges which would apply to them *as an individual* in advance of the move (the current and receiving local authority should work together to facilitate this);
- Charging policies should define the financial decision making processes that ensure the personal, social and economic circumstances of individuals are given due regard in determining whether charges should apply;
- Every council should nominate an officer to participate in a community of practitioners whose responsibility is to ensure that effective benchmarking is undertaken and consistency delivered.

Revisions 2016/17

This version of the COSLA Guidance represents ongoing progress toward reaching the outcomes identified as part of our continuing review and revision of the Charging Guidance for Non-residential Social Care Services in Scotland. This year a number of further revisions have been made to the guidance including clearer guidance on capital tariff income and enhanced guidance on practice in regard to the collection of payments for third party providers. In addition routine update has been made to reflect the annual uprating of the DWP benefits used to set the charging thresholds and example tables of tapers have been amended accordingly; these changes to the Substantive Guidance can be found in Section 7.

Minimum Charging Threshold (Buffer)

Significant among the revisions to the substantive guidance is the increase from 16.5% to 25% of the buffer which is used to establish the minimum charging threshold. Work on this was requested by COSLA Leaders in January 2015 with the intention of enhancing the anti-poverty measures set out in the guidance and lift greater numbers of people out of charging. Leaders agreed this on the proviso that this change would be fully funded by the Scottish Government. The effect of this revision is set out on page 27 of this guidance.

Future Work

Further policy development work remains to be undertaken in respect of a number of areas. These include the use of tapers and thresholds, appropriate alignment with new DWP benefits - once the old ones are deleted - and the potential impact of alternative charging regimes on councils' finances to name just a few. The on-going work required to complete improvements identified by the review of the charging guidance is being informed by the following set of agreed outcomes each of which require the application of resources from the stakeholders involved in the Charing Guidance Working Group.

Good progress has been made toward a number of elements of this work but further challenges remain to be tackled. Work will continue to be progressed against each of these outcomes over the coming months with ongoing improvements made on an annual basis; further details can be found at the point in the guidance referenced under the Progress column.

Outcome	Output	Progress
1. Partners' Income A fair and consistent approach is used in the treatment of partners' income and assets in establishing a service user's means to pay a charge for the community care service they use.	The treatment of partners' income better defined with national guidance.	7.17 – 7.21
2. Understanding Information People who use community care services understand the charges they pay and the cost to the council of providing each of the services they receive.	All councils' community care charging policies and tariffs are published and copies are accessible on the COSLA website via updated links. Comparative analysis of councils' charges is published on COSLA website	4.11 Revised 11/2015
3. Facilitating Movement People who use community care services are able to make fully informed decisions about the costs and care options available to them before moving from one local authority area to another.	A national protocol is developed which enables officers to provide, on request, clear information to people who use community care services and are considering a move to another local authority area. A tool to estimate potential charges is publically available.	5.11
4. Benchmarking Councils are able to benchmark their cost bases, service charges, rates charged per service, and use of income buffers and tapers.	Officers have access to the information they need to fully consider the wider charging context within which they are developing their local community care charging policies.	5.06 – 5.07 5.12 – 5.13

5. Financial Assessment To create an enabling environment for local authorities to work together to generate greater consistency across Scotland in the charges levied on people who use services.	A policy position on a CRAG style (regulation based) guidance is developed. Revised description of Capital & Tariff Income.	Self-regulation Pg. 30
6. Anti-poverty Measures Policies should define the financial decision making processes that ensure the personal, social and economic circumstances of individuals are given due regard in determining whether charges should apply.	An agreed approach to the consideration of disability related expenditure (DRE). A standard needs assessment & financial assessment template is produced. Buffer increased to 25%.	7.34 – 7.38 Pg. 3 Pg. 28
7. Personalisation Individuals are able to consider charges for services or support within the context of a personal budget or direct payment.	A policy position on the application of charges within an SDS context is developed.	Section 6
8. Local Priorities Councils balance the utility of additional charging income to improve the quality or scope of social care services against the impact on the quality of life for those who are charged.	A set of policy options with outline impact assessment.	

Standard Financial Assessment Template

In addition to the developments outlined above COSLA Leaders have agreed further action to implement a financial assessment template as a minimum standard across all member councils. The timing of this decision meant that it was unrealistic for councils to introduce this alignment for 2015/16. Instead the ambition is that councils would work towards full alignment with the template by April of the financial year 2016/17. The template, set out at Annex D, comprises a set of core rates and allowances drawn primarily from this charging guidance which are used as part of an individual's financial assessment – the process which determines the charge or level of contribution a person who uses non-residential social care services should contribute toward the cost of the care they receive.

The financial assessment process comprises a key element of the engagement between people who use non-residential social care services and the local authority. As such setting a minimum standard demonstrates a significant step toward greater consistency of councils' charging policies from the service user perspective. Whilst there will continue to be legitimate variation in the cost of providing services across different local authority areas a standard approach to the rates used in the financial assessment demonstrates a fair and proportionate approach.

Section 1 – High Level Principles

1.1 This Guidance defines the set of principles that should underpin councils' charging policies for non-residential care services. It has been written in consultation with representatives of a range of organisations including Scottish Government, the Association of Directors of Social Work, Age Scotland, Coalition of Carers, Independent Living in Scotland, the Scottish Consortium for Learning Disability, Alzheimer's Scotland and Capability Scotland and it has been endorsed by the political leadership of COSLA.

1.2 The National Guidance is intended to assist councils in determining whether to charge for non-residential social care services, taking into consideration the full range of legal, financial and policy drivers. Where councils decide to charge, the guidance also sets out the parameters of the charging regime that should apply. Charging policies at both a national and local level should be accessible, transparent, fair and equitable, and developed from a human rights perspective. To that extent, the Guidance describes a number of best practice steps that councils should cover in developing a charging policy.

1.3 Starting from the legal position that although there is no 'duty' placed upon councils to charge for community care services, they are currently empowered by the statute to make decisions about whether or not to charge for community care services, and, if they choose to, to develop and administer local charging policies. This Guidance has six over-arching objectives:

- To assist councils in determining whether to charge for community care services, taking into consideration the full range of legal, financial and policy drivers;
- To assist local authorities in developing a framework of charges for non-residential social care services that is fair, equitable, accessible and transparent;
- To create an enabling environment for local authorities to work together to generate greater consistency across Scotland in the charges levied on people who use services;
- To define financial decision making processes that ensure the personal, social and economic circumstances of individuals are given due regard in determining whether charges should apply;
- To ensure that people who use services understand the reason for charging, its contribution to supporting social care services and are able to contribute to the development of charging policies at a national and local level; and
- To ensure that councils have considered the contribution of community care to the human rights of supported people and the financial implications of charging on the supported person's quality of life, in terms of both their standard of living and their social and economic participation within the community.

1.4 At the heart of this Guidance lies a recognition that the role of the local authority is to create an enabling environment to support people who use care services – and their carers - building on their right to participate in society and supporting them to live independently, with control, freedom, choice, and dignity.

1.5 In developing this guidance, we promote a human rights based approach, drawing on the PANEL[1] approach, to generate the following principles:

- **Participation** in the development of charging policies, drawing on the principles of co-production in order to develop an honest dialogue about the rationale for charging and the nature of its implementation. It also recognises that the provision of community care advice, services and support can be a pre-requisite for participation in civic life.
- **Accountability** for the charging regime – including decisions around whether or not to charge – in terms of its public reporting, its transparency, its contribution to the range and quality of social care and support available to the local population and the financial impact this may have on existing users. Accountability also includes access to complaints mechanisms and remedies so that individuals can challenge the application of charging policies which they believe contravene their human rights. Furthermore, charging policies should demonstrate that they have taken account of the specific circumstances of the people who are subject to it, including for example, their economic and social status. There is a duty to assess the impact of policies to ensure they are compatible with human rights.
- **Non-discrimination and equality** in the way that charges are applied, and in terms of the impact of charging on the equality of opportunity of those who are charged, ensuring that charging policies have been subject to an Equality Impact Assessment. Local Authorities should seek to meet their obligations by assessing the impact their policies have on equality of opportunity between the general population and people who are charged for community care services.
- **Empowerment** of individuals to ensure that they are able to engage with the LA and the local community in terms of decisions on charging. It is also about ensuring individuals are fully aware of, and understand the rationale for, charges being applied and that they are empowered to effectively contribute to decisions on this. Councils should work with citizens to ensure that charges do not contribute to unacceptable levels of poverty, or act as a barrier to accessing the full range of human rights or adversely impact on the availability of support, and are generally consistent with preventive approaches to social care and anti poverty strategies. This will require welfare rights advice and other services to be in place to ensure that personal income is maximised and a full range of services and support can be accessed, including support to access the labour market.
- **Legality** in all decisions made, honouring the rights and entitlements of individuals within the context of the Human Rights Act and statute more generally. Individuals have the right to accessible information about charging policies, how charges are calculated and, where the person disagrees with the decision, the right to seek remedy through an effective compliant and appeal procedures.

1.6 Councils must not act in ways which are incompatible with the European Convention on Human Rights (ECHR) under section 6 of the Human Rights Act 1998. Many of the Articles of the ECHR are relevant to this Guidance but in particular Article 8 (right to private and family life, including autonomy in decision making, the right to work and the right to live with dignity) and Article 14 (non-discrimination on a number of grounds, including "any other status"). These articles speak directly to the issues that connect to local charging policies for non-residential social care, including portability of care, equality within and across

[1] UN endorsed approach to human rights

jurisdictions, and issues around income maximisation. Human rights compatible outcomes should therefore underpin the development of charging policies.

1.7 This Guidance also draws on the principles of the European Charter of Local Self-Government, which was adopted under the auspices of the Congress of the Council of Europe. The Charter provides that local authorities, acting within the limits of the law, should be able to regulate and manage a substantial share of public affairs under their own responsibility in the interests of the local population. It considers that public responsibilities should be exercised by the authorities closest to the citizens.

1.8 The Charter is an important foundation in the development of local charging arrangements because it recognises the principle that councils should be empowered to raise income in order to ensure that the provision of local services are optimised and maximally responsive to the needs of residents in a way which accords with human rights compatible outcomes. It holds that democratic accountability at a local level embeds a system of governance that holds the public bodies levying those charges to account.

1.9 It is recognised that there are tensions between a pure interpretation of the local autonomy of councils and a pure interpretation of equity across jurisdictions. Nonetheless, if a human rights based approach informs the development of policy at a local and national level, allied to a framework of cooperation between local authorities, then we believe that those tensions can be largely resolved. There will, ultimately, be a need for balance in the way that local authorities administer charges for care services: to ensure that the range and quality of local services are optimised on the one hand, and yet on the other, prevent people who are charged for services from falling into poverty.

Section 2 – Financial and Policy Context

Financial Context

2.1 Councils decide whether to use their legal powers to charge for non-residential social care services within an overall context of financial and demographic pressures. Since 2009-10, public expenditure has faced a long period of restraint, with revenue funding for Scottish local government falling in real terms.

2.2 At the same time demand for social work services is continuing to grow, largely as a result of demographic change. In particular, councils and their partners will have to support significantly increased numbers of older people who are frail, increasing numbers of disabled people of all ages , and – as a result of economic recession – increasing numbers of people with mental health issues, and alcohol and drug misuse.

Social Work Spend and Income from Charging

2.3 Local authority financial returns to the Scottish Government published for 2013/14[2] show income from service user charges for non-residential social care at **£54.2 million** – 2.4% of total gross expenditure on these services. However, due to a different interpretation of the CIPFA accounting rules, Glasgow included data on Independent Living Fund payments[3] to service users of nearly £8.5m in 2013/14 which needs to be deducted from this total to achieve consistency with the returns from other councils. Nevertheless, an amended income figure of £44.2 million would *under-state* the income collected from non-residential charges for other reasons:

1) **Non-inclusion of charging income** where service users are paid direct payments net of assessed of client contributions, or third parties are paid net[4]. For **Direct Payments (SDS option 1)** 26 councils (excluding Glasgow) recorded gross expenditure totalling £57m but not any notional charging income from the assessed client contribution. Another category is **Managed Personalised Budgets (SDS Option 2**), accounting for gross expenditure of £3.5m in 2013/14 (again excluding Glasgow), but with no council recording any assessed client contributions or charging income. For both SDS categories, Social Work Scotland has provided COSLA with revised estimates based on the percentage of income recorded for other non-residential services in each council's LFR3 return. However, it is likely that there are other payments made to care providers which are paid net of the client contribution, where this missing income is also not recorded on the LFR3 return.

2) **Non-inclusion of some "housing support" services** on the Social Work LFR3 financial return, which were formerly funded by "Supporting People" ring-fenced grants. For example, in 2013/14 the City of Edinburgh Council recorded community alarm service charging income of over £1 million on the Housing LFR return, rather than on the LFR3[5].

[2] Available at: http://www.gov.scot/Publications/2015/02/3131/downloads.
[3] This issue was first identified by Learning Disability Alliance Scotland.
[4] Where payments are made net of client contributions, the CIPFA accounting rules ask councils to add the missing income to the final accounts; LGF3 reporting guidance also expects this missing income to be included.
[5] Edinburgh transferred alarms services in April 2014 from Services for Communities (which included housing) to Health and Social Care and the community alarm spend and income is now included on the Social Work LFR3 return for 2014/15.

It remains unclear[6] whether all councils now include social care related housing support on the Social Work LFR3 return rather than counting some on the Housing LFR.

3) Finally, the 2013/14 Social Work LFR3 return for Highland Council records no non-residential charging income against their payment of £87.552m to NHS Highland for adult social care under Highland's lead agency model of Health and Social Care Integration. NHS Highland has made this information available separately to the Scottish Government and it includes £2.2 million of income from non-residential charges.

2.4 The best estimate[7] is that these three causes of under-counting of income amounted to over £5m in 2013/14. However, this is an under-estimate because we do not know the full scale of the under-recording of income mentioned in (1) and (2) for all local authorities.

2.5 The revised estimates for 2013/14 non-residential care income are shown below at **nearly £51 million for Scotland**:

Council charging income from people who use non-residential social work services, 2013/14 (Scottish Government statistics, amended by Social Work Scotland)

Scotland	**Children and Families**	**Older Persons**	**Adults aged 18-64**	Adults with physical dis-abilities	Adults with learning dis-abilities	Adults with mental health problems	Adults with other needs	**TOTAL ADULT SOCIAL CARE**	**TOTAL SOCIAL WORK (ex CJSW, Service Strategy)**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Direct Payments (SDS Option 1)	27	670	5,783	1,600	3,660	523	0	6,453	6,480
Managed Personal Budgets (SDS Option 2)	0	34	739	713	25	2	0	774	774
Home Care	19	17,557	8,364	1,895	5,056	1,229	184	25,921	25,940
Day Care	1,695	2,752	1,693	166	1,470	55	2	4,445	6,140
Equipment & adaptations	2	3,090	300	275	16	9	0	3,390	3,392
Other non-residential services	749	4,169	3,282	931	1,720	333	298	7,451	8,200
TOTAL NON-RESIDENTIAL CHARGING INCOME	**2,492**	**28,272**	**20,162**	**5,580**	**11,947**	**2,151**	**484**	**48,434**	**50,926**
Charging income as % of Gross Expenditure	0.4%	3.3%	2.3%	3.1%	2.4%	1.8%	0.8%	2.8%	2.2%
Total Gross Non-Residential Expenditure	**616,554**	**853,476**	**859,833**	**182,563**	**495,409**	**121,733**	**60,128**	**1,713,308**	**2,329,862**

2.6 The financial returns for the previous year, 2012/13, are likely to be affected by some or all of the issues discussed above, except for those relating to Health and Social care integration in Highland, but we do not have the information necessary to revise the published figures. Comparing the *published* non-residential income figures for 2012/13 (£52.702m) and 2013/14 (£54.200m) shows an increase of 2.8% -- a lower increase than in the previous year (10.4%).

Policy Context

Report on the Future Delivery of Public Services

2.7 In 2010, the Scottish Government established a Commission on the Future Delivery of Public Services to examine how Scotland's public services can secure improved outcomes for

[6] Part of the unclarity arises from the fact the "housing support" is defined in housing, not social work legislation, yet many of the actual functions and tasks overlap with social care because they concern various forms of help to enable disabled or vulnerable people maintain their housing tenancies.

[7] We thank Social Work Scotland for sharing this work

communities across the country. The Commission reported its recommendations in June 2011.

2.8 Among the priorities the Commission identified for public services to consider, the following are particularly relevant to our approach in charging for non-residential social care:

- Recognising that effective services must be designed with and for people and communities - not delivered 'top down' for administrative convenience
- Maximising scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities
- Working closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance, and build resilience
- Prioritising preventative measures to reduce demand and lessen inequalities
- Identifying and targeting the underlying causes of inter-generational deprivation and low aspiration
- Tightening oversight and accountability of public services, introducing consistent data-gathering and performance comparators, to improve services

Independent Living

2.9 Independent living has implications for policy and service delivery across and beyond local government. COSLA has signed up to and is committed to a vision for independent living in Scotland, alongside the Scottish Government, the NHS in Scotland and the disabled people's independent living movement. The Vision is available here http://www.scotland.gov.uk/Resource/0041/00418828.pdf.

2.10 COSLA has adopted the interpretation of independent living as set out in the vision and believes it should apply to any disabled person, any person who has long-term condition or any person who has developed a frailty. We are committed to making sure that everyone can take part in the community and live an ordinary life. This approach is supported by a range of initiatives already in place around the self-directed support agenda, and in the work across local government to promote coproduction in policy making and service planning. This encompasses health and social care, and other key policy areas such as housing, transport, education and employment.

2.11 Independent living is based on the core principles of choice, control, freedom and dignity, whereby supported people have equality of opportunity at home and work, in education and in the social and civic life of the community.

2.12 It is with reference to these concepts that councils should determine whether they want to charge for non-residential social care services and if so, the manner in which charging policies should be developed. These themes are expanded in Section 3.

Carers Strategy

2.13 The National Carers Strategy for Scotland recognises that carers, whatever their circumstances, should be able to enjoy the same opportunities in life as other people without caring responsibilities and be able to achieve their full potential as citizens.

2.14 Carers should be considered as equal partners in care, where they are supported to manage their caring responsibilities with confidence and in good health and to have a life of their

own outside of caring. Carers should be fully engaged in the planning and development of their own support and of the services for the people they care for. Carers should not be disadvantaged, or discriminated against, by virtue of their caring role.

2.15 All of these principles should be considered in the production and implementation of charging policies.

Anti-poverty Measures

2.16 Although income generated from charging for 'non-residential services' amounts to only 3% of the £3.6b gross expenditure on social care in Scotland, it is important to understand this from the point of view of the supported person. For the supported person, community care charges can amount to 100% of their available weekly income.

Welfare Reform

2.17 Welfare Reform is used as a shorthand for a complex package of major reforms as well as detailed changes to existing benefits. The Welfare Reform Act 2012 contains provisions for the introduction of Universal Credit to replace existing benefits and tax credits. It is intended to incentivise work and simplify the benefits system. It also replaces Disability Living Allowance (DLA) with a new benefit 'Personal Independence Payment (PIP).'

2.18 The introduction of the Universal Credit and PIP will impact upon a range of services currently delivered by Scottish councils and on the lives of disabled people. Personal Independence Payments will provide 2 levels of support rather than 3 under the DLA care component. Since the UK Government is already seeking to reduce the overall cost by 20% the impact of new assessment criteria is expected to particularly affect those with lower levels of disability.

2.19 All of this suggests that Welfare Reform will change the financial context for charging: reductions in the income of people who use services may well take more individuals below charging thresholds and consequently place additional demands on stretched social work resources.

2.20 Consideration is currently being given by the Scottish Government to mitigating the impact the changes will have on benefits and services received through pass-ported assessment processes.

Health and Social Care Integration

2.21 Effective partnership working between the NHS and local authorities is widely recognised as a prerequisite for achieving good health and social care outcomes. For the last decade in Scotland the focus has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways.

2.22 COSLA is working with the Scottish Government to develop integrated health and social care arrangements. Within this context, there will be a significant challenge in respect of working out how charging for social care services interfaces with healthcare which is free at the point of use.

Section 3 – Legal Issues

Human Rights

3.1 Community care is one essential tool among others, which ensures that people in need of support can live their life in the way they choose, at home, at work and in the community. Without it, many people cannot enjoy the human rights they are entitled to or live a productive life.

3.2 The UN Convention on the Rights of Persons with Disabilities (UNCRPD) strengthens and contextualises these rights and recognises the role of community care in doing so. Article 19 of the UNCRPD indicates that to ensure disabled people equally enjoy the rights laid out in the ECHR states must ensure that "disabled people have a right to live in the community, with the support they need and can make choices like other people do".

3.3 All of the human rights protected by the European Convention on Human Rights (ECHR), in the Human Rights Act and in subsequent ratified Conventions should be considered in decisions on whether or not to charge and, if charges are to be applied, in the development of charging policies.

3.4 Councils must not act in ways which are incompatible with the European Convention on Human Rights (ECHR) under section 6 of the Human Rights Act 1998. Many of the Articles of the ECHR are relevant to this Guidance but in particular Article 8 (right to private and family life, including autonomy in decision making, the right to work and the right to live with dignity) and Article 14 (non-discrimination on a number of grounds, including "any other status"). These articles speak directly to the issues that connect to local charging policies for non-residential social care, including portability of care, equality within and across jurisdictions, and issues around income maximisation. Human rights compatible outcomes should therefore underpin the development of charging policies.

Equality Act 2010

3.5 The Equality Act 2010 places both a general duty and a specific duty on local authorities, both of which are relevant to the development of charging policies. The general duty requires local authorities have due regard to the need to:

- eliminate discrimination, harassment and victimisation,
- advance equality of opportunity,
- promote good relations between persons who share a relevant protected characteristic and persons who do not share it.

3.6 This duty relates to disability, age, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

3.7 As a result of the general duty local authorities must consider how to promote equality and ensure that no group are put at a disadvantage by their charging policy. This should involve taking steps to ensure policies minimise any disadvantage experienced by any people of a protected characteristic, ensuring their specific needs are met, rights upheld and encouraging participation in the development of relevant policies.

3.8 The Equality Act 2010 also gives Ministers in Scotland the power to impose specific duties on local authorities. It is good practice for local authorities to carry out Equality Impact Assessments on their non-residential care charging policy in order to identify whether there is a disproportionate impact on people of a protected characteristic.

3.9 Equality Impact Assessments (EIA) can help local authorities to identify whether there is a disproportionate impact of a policy on people of a protected characteristic/group compared to those out with that group. Councils should undertake an Equality Impact Assessment of their Non-Residential Charging Policy.

Legislation

3.10 The current legislative framework for charging includes services provided under the **Social Work (Scotland) Act 1968 Section 87**.

3.11 In terms of the guidance on charging set out in the Scottish Office Circular SWSG1/1997 and with regard to subsequent development of this COSLA guidance, councils have the power to charge for a range of adult non-residential social care services, including:

- care at home
- day care
- lunch clubs
- meals on wheels
- domiciliary services
- wardens in sheltered housing
- community alarms and telecare
- laundry services
- aids and adaptations
- care and support services for those who have or have had a mental illness
- transport

3.12 The Circular also sets out what services cannot be charged for and these include:-

- Services for people who are subject to Compulsion Orders under the Criminal Procedure (Scotland) Act 2003
- Nursing Care and Personal Care for people aged over 65

3.13 Previous versions of the guidance have indicated that people who were subject to Community Care Orders should not be charged for the care they receive. Community Care Orders are no longer in use but a similar mechanism called Compulsory Treatment Orders introduced under the Mental Health (Care and Treatment) (Scotland) Act 2003 are in use. This means that in this regard the legislation referenced in Circular SWSG1/1997 has been superseded. Evidently the majority of councils do not charge people in these circumstances and it is recommended that councils should not charge people who are subject to Compulsory Treatment Orders.

Free Personal Care: Preparation of Food

3.14 Charges may not be applied to the preparation of, or the provision of any assistance with the preparation of, a person's food including (without prejudice to that generality)-

- defrosting, washing, peeling, cutting, chopping, pureeing, mixing or combining, cooking, heating or re-heating, or otherwise preparing food or ingredients;
- cooking, heating or re-heating pre-prepared fresh or frozen food;
- portioning or serving food;
- cutting up, pureeing or otherwise processing food to assist with eating it; and
- assisting in the fulfilment of special dietary needs, but not the supply of food (whether in the form of a pre-prepared meal or ingredients for a meal) to, or the obtaining of food for, the person, or the preparation of food prior to the point of supply to the person.

3.15 A statutory instrument was passed by Parliament to these effects and came into force on April 1st 2009. Councils should have regard to this in designing their charging policy.

Financial Assessment – Couples

3.16 Where one member of a couple is in receipt of non-residential services most Scottish Local Authorities take account of their joint income and capital in the financial assessment.

3.17 While paragraph 28 of the Scottish Office Circular SWSG1/97 states that "*under section 87(1A) of the 1968 Act authorities may charge only the person receiving the service and should have regard only to that individual's means in assessing his or her ability to* pay", it goes on to state in paragraph 29 that "*Local authorities may, in individual cases, wish to consider whether a client has sufficient reliable access to resources, other than his or her own resources, for them also to constitute his or her means for the purposes of Section 87(1A). The most likely instances of this kind will arise in relation to married or unmarried couples. It will be for the authority to consider each case in the light of their own legal advice"*.

3.18 It is recognised that this is an ambiguous area of law. To that end, COSLA has undertaken further work with its partners on establishing clarification of the policy in this area further details are set out in Section 7 of this guidance.

Section 4 – Developing Local Policies

4.1 The decision about whether to charge – and what to charge for – is a matter to be decided by the local authority. It is important that if a council chooses to develop a local charging policy that it adheres to the following principles.

- Policies should be co-produced with the people who might be affected by a charging regime and reference should be made to the PANEL approach set out at the beginning of this document;
- Councils should balance the utility of additional charging income to improve the quality or scope of social care services against the impact on the quality of life for those who are charged;
- Councils should ensure that people who use services understand the reasons for charging and its contribution to supporting social care services;
- There should be transparency over what services are chargeable, and at what levels, and use should be made of the standard template attached at Annex A;
- Policies should define the financial decision making processes that ensure the personal, social and economic circumstances of individuals are given due regard in determining whether charges should apply;

Co-production

4.2 The involvement of people in the planning of the services they use is a core principle in promoting equality and is at the heart of co-production. Being involved is not the same as being asked or consulted. It means people who use services and policy makers working in partnership right from the start. It allows for the trading of skills, information and expertise and assists in achieving mutual objectives.

4.3 Co-production engages people who use services as equal citizens: to help create or improve systems and structures, to better inform planning and decision making processes, and to deliver better outcomes. In recognition of their role as 'equal and expert partners' local charging policies should be developed in co-production with unpaid carers and their representative organisations. Scotland has a well established network of local carer organisations and local carer forums who can help to facilitate carer involvement. In addition, efforts should be made to engage the representatives of different population groups and their representative groups.

4.4 It is recognised that the co-production of charging policies could be perceived to be problematic given that the natural position of people who use services might be to resist charging, either out of principle or from a position of self interest (both are legitimate positions to hold). Recognising this, it may be that local groups or people who use services can help to both; work with LA's at the point at which they are considering applying charges in order to support them to consider the human rights impacts and the other potential options available; and, where a LA still wishes to apply charges, to develop policies that are as fair as possible within the context of the overall quantum of resource councils propose to raise through charging for non-residential care. It will also be important to balance the input of those who are affected by charges with those who stand to gain from the enhanced quality or scope of social care services that accrues from raising additional income.

4.5 It is also recognised that decisions on charges will be reviewed on an annual basis by councils as part of their budget setting processes. While it is important not to lose the principles of co-production within this context, councils should assess the requisite level of engagement with people who use services, carers and groups relative to the extent of the changes to policy being suggested. It is also recognised that in deciding to charge, councils will have to take account of a broader range of pressures and other levers to raise income including other service charges (such as car parking) and council tax.

Balancing Income against Impact

4.6 In coming to a view about the quantum of resource to be raised through charges, it is important to have a sense of the opportunity cost associated with different policy options. For example, a decision to completely eliminate charges would deliver maximum relief to those who would otherwise have been charged but will restrict the quality or range of services that might have been provided by a council to the general population. On the other hand, a charging regime that focuses solely on raising additional income could place at risk the overall well-being of those who pay the charges.

4.7 In making these relative judgements, it will be important to give consideration to the work of other councils. COSLA has established a community of practitioners to ensure that best practice is shared across Scotland. This matter is further explored in the next section.

Communicating the Purpose of Service Charges

4.8 It is important that the people who are charged for a service understand the purpose of a charging regime. To that end, it is recommended that councils should produce public information that describes:

- What services are charged for and what each charged for service provides in practice;
- The total resource raised through charging for non-residential social care services;
- The percentage of non-residential care expenditure made up from charging income;
- The delivery cost of each chargeable service (allowing the supported person to gauge what proportion of that service is supported by their contribution);
- An assessment of the added value of charging income in terms of the quality or scope of care and support available to the general population;

4.9 Councils should use a variety of media to promote this information, including the council website.

Delivering Transparency

4.10 It is important that people are given good and clear information about the services that are available and the charges that might apply to the services they use. This will ensure that customers/consumers are able to come to an informed view about whether or not they want to draw upon a chargeable service. It will also help individuals to come to a view about the types of charges that might apply should they move between local authority areas.

4.11 In order to deliver transparency and facilitate comparability across councils, it is recommended that all councils should use the template attached at **Annex A** to record charging information, which should then be published on the council website.

4.12 Where the supported person has difficulty in meeting the approved charge for the service due to their financial circumstances, it is recommended that Councils use their powers to abate or waive charges on a case by case basis. It is important within this context that councils take a holistic approach, and consider the full impact of all prospective combined charges on the well-being and independence of the supported person. Care should be taken to ensure that those who use more than one type of service are not unduly disadvantaged.

4.13 Allied to this, it is recommended that all Local Authorities should be proactive in promoting benefit take up for people who use services. Doing this would not only be beneficial to the individual but could contribute to the revenue of councils and to their local economy. Where possible, Local Authorities should ensure that there are dedicated staff to promote and assist with Income Maximisation processes for people who use services. The benefits entitlement of supported people should be reviewed on a regular basis.

4.14 Employability and supported employment services are also capable of tackling poverty by assisting people into work. Local authorities should continue to develop local services in line with the national guidance and local service priorities. [8]

[8] http://www.scotland.gov.uk/Publications/2010/02/23094107/0

Section 5 – Achieving Greater Consistency

5.1 As indicated in the first section of this document, this Guidance draws on the principles of the European Charter of Local Self-Government, which was adopted under the auspices of the Congress of the Council of Europe. The Charter provides that local authorities, acting within the limits of the law, should be able to regulate and manage a substantial share of public affairs under their own responsibility in the interests of the local population. It considers that public responsibilities should be exercised by the authorities closest to the citizens.

5.2 The Charter is an important foundation in the development of local charging arrangements because it recognises the principle that councils should be empowered to raise income in order to ensure that the provision of local services are optimised and maximally responsive to the needs of residents in a way which accords with human rights compatible outcomes. It holds that democratic accountability at a local level embeds a system of governance that holds the public bodies levying those charges to account.

5.3 It is recognised that there are tensions between a pure interpretation of the local autonomy of councils and a pure interpretation of equity across jurisdictions. On the one hand, councils have a legitimate capacity to raise income in response to local need or policy goals. On the other hand, local government in Scotland wants to create a level playing field, facilitating portability of care, respecting human rights and delivering equity for people who use services.

5.4 It is inevitable since councils are empowered to charge differentially that some variation will emerge in terms of the amount charged for across different services across different local authorities. Councils should seek to ground accountability for their charging policy in local democratic decision making **and** in taking a human rights based approach, recognising that tensions will have to be managed within this context.

5.5 In order to manage these tensions, this guidance recommends:

- That every council should nominate an officer to participate in a community of practitioners whose responsibility is to ensure that effective benchmarking is undertaken and consistency delivered;
- The benchmarking community should collectively work to identify levels of tolerance for the variable elements of charging defined in this guidance, ensuring a robust approach to self-regulation.

Benchmarking

5.6 The core purpose of a benchmarking approach is to encourage councils to review their own performance and to better understand how other comparable authorities achieve their results.

5.7 The outputs of the benchmarking exercise should be publicly reported to enhance accountability.

5.8 In pursuit of this ambition, in early 2010 COSLA launched a Community of Practice web based resource to provide a secure environment for local authority officers involved in the development and application of local charging policies to compare and contrast their approaches. Each Scottish council currently has one or more officers registered on the community of practice and the site has proved useful in sharing ideas and information about local charging policies.

5.9 Council officers involved in the development, revision and implementation of community care charging policies are encouraged to register and make use of the information and discussion forum available on the Charging for Non-Residential Social Care Services – Scotland Knowledge Hub website.[9]

Portability of Care

5.10 Portability of care is a principle that has been strongly advocated by a number of stakeholders, including Independent Living in Scotland. A human rights based approach requires that local authorities engage with this matter and this guidance therefore recommends that any individual user of services who is looking to move between local authority areas should be entitled to a description of any charges which would apply to them *as an individual* in advance of the move and any material differences in the nature of the service provided by the relevant authorities. The current and receiving local authority should work together to facilitate this.

5.11 Recent work has resulted in the development of a prototype online cost of care calculator which will allow people who use services to retrieve information about prospective charges should they move to another local authority area. Further work is ongoing to explore the most appropriate way of ensuring that the information delivered is helpful and avoids confusion.

COSLA Charging Guidance Surveys

5.12 COSLA also runs an annual survey of councils, which collects information on charging for non-residential care. These returns provide a valuable source of information which is shared across local authorities in an effort to engender greater consistency across Scotland.

5.13 Whilst COSLA will manage the surveys and data in such a way as to limit the reporting burden on councils we would urge that councils continue to maintain this helpful practice by continuing to make returns in response to these surveys (returns will often require updating a few elements of data).

Local Financial Returns (LFR) 3

5.14 The other key source of information on community care charging is the Scottish Government Local Financial Returns (LFR). The LFR information is used to monitor local authority expenditure for policy purposes and of specific interest is LFR3 which deals with Social Work expenditure.

[9] https://khub.net/web/chargingfornonresidentialsocialcareservicesscotland

5.15 There have been a range of data quality issues in respect of the LFR3 returns. It is recommended that in the interest of consistency councils adhere to the guidance issued on the completion of LFR3 [10]

[10] http://www.scotland.gov.uk/Resource/Doc/933/0084212.doc

Section 6 – Self-Directed Support

6.1 Self-Directed Support (SDS) is the term used to describe how people can exercise choice and control over the support or services that allow them to live independently. To achieve this SDS helps people to exercise control over the use of resources identified to meet agreed outcomes. This requires the person to be aware of the financial value attributed to meeting their needs – known as an individual budget – to allow them to make an informed choice about how it is used to meet their needs.

6.2 The Social Care (Self-directed Support) (Scotland) Act 2013 requires local authorities to provide a range of options, with varying levels of choice and control, to people with eligible support needs. The provisions of the Act came in to force on 1st April 2014, and apply to all new social care clients from that date, and to existing clients at the point of their next review. Self-directed Support processes present a variety of challenges for how authorities calculate and impose charges, and so it is important to consider fair and effective charging policies in the context of SDS.

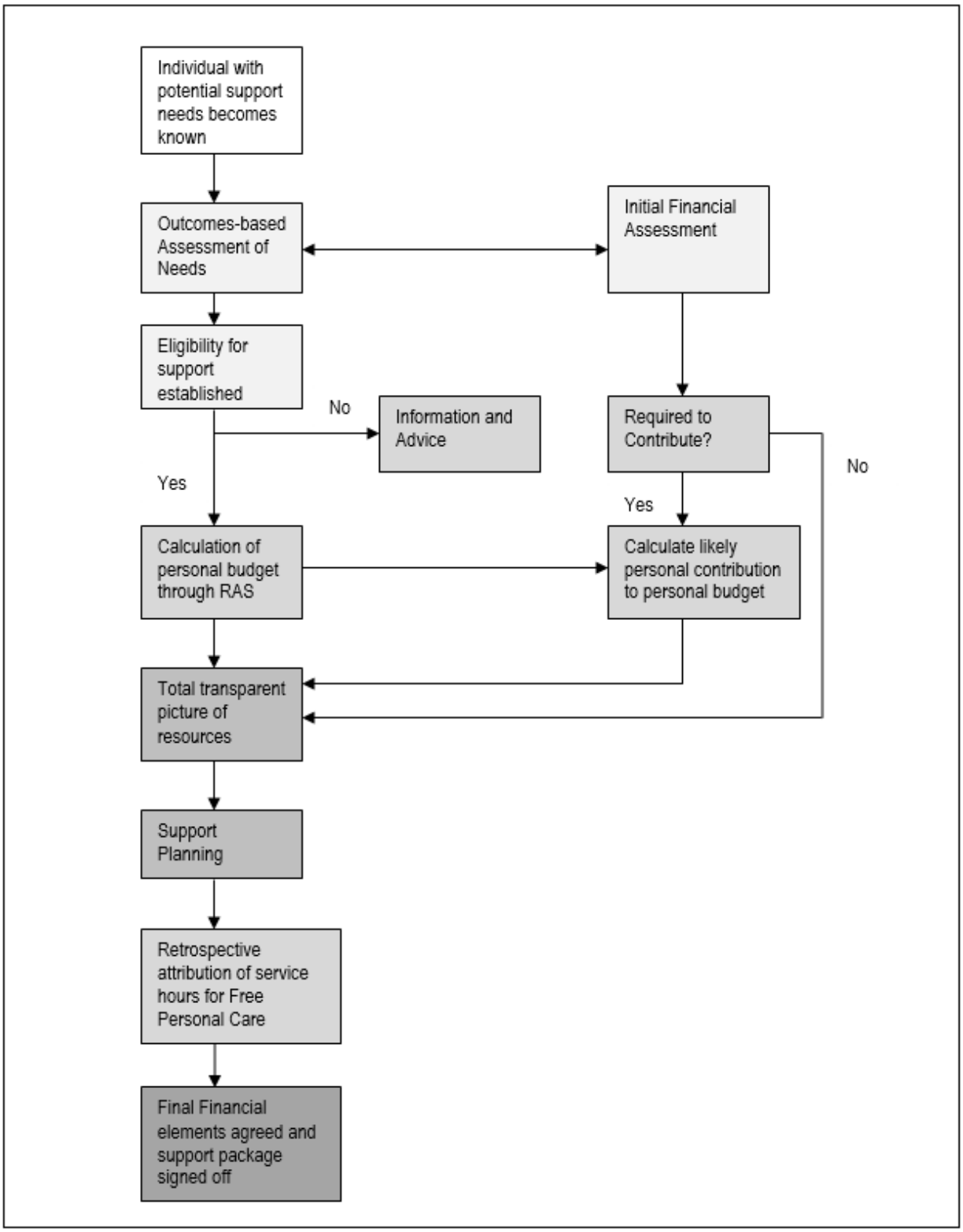
6.3 Good practice in self-directed support relies on outcome-based assessment and review. Instead of developing a menu of service types which will have fairly set charges, the typical self-directed approach involves the development of plans based on outcomes and the selection of support within an identified budget. The underlying structure of the traditional system of charging is linked to services. However, in a personalised or self-directed system of support, the focus shifts to enabling people to control and adjust their support at the point of delivery in order to meet their needs and achieve their outcomes. As such, the connection between 'the service' and 'the charge' becomes less well defined – and in some cases will disappear altogether. In view of this, a conceptual shift will have to be made in respect of how councils charge for services

6.4 This guidance recognises that councils will have been undergoing transition to these new arrangements during 2014/15, and that resulting service re-design and staff development requirements will be ongoing. Some local authorities have changed their approach to a system predicated on a general 'care and support charge'. Under these arrangements, subsequent to a financial assessment, those individuals with the ability to pay may be required to fund a proportion of their overall budget, which has been calculated as appropriate to meet their needs and achieve their outcomes. This 'care and support charge' may be linked to their personal budget and their ability to pay rather than the services that they ultimately utilise to meet their needs.

6.5 Several local authorities have chosen to refer to this as a 'contribution' based charging arrangement but for the purpose of this guidance we have chosen to describe this as the 'care and support charge.' A number of third sector organisations have raised concerns around the term 'contribution' as they feel it implies a voluntarism or a willingness to pay however the contribution is towards the care package.' With that observation, councils should give careful consideration to how any new arrangements are described.

Making Sense of Charging for SDS

6.6 Notwithstanding the different approaches that are developing in each local authority area, it is possible to illustrate – at a high level of generalisation - the various components of charging within an SDS context through a systems map. This is set out below.



Collecting the Care and Support Charge

6.7 The current position set out in the *Statutory Guidance to Accompany the Social Care (Self-directed Support) (Scotland) Act 2013*[11] states that the authority can arrange for the direct payment to be paid in instalments or in a lump sum payment. Where a person is eligible for a charge towards their support the direct payment can be made on a "net" or a "gross" basis, i.e. the charge can be removed prior to the provision of the monthly direct payment or following the provision of the monthly payment. The supported person may request the payment be made gross. In this circumstance, the local authority should give this request full consideration, taking into account the direct payment user's reasons and circumstances behind this request prior to a decision being made. If the authority decides to pay the direct payment gross it will pay the relevant amount to the direct payment user and the direct payment user will pay the local authority any contribution required. If the authority refuses to pay direct payments on a gross basis they should inform the supported person as to the reasons why.

6.8 Councils report a cost saving in identifying a net personal budget (where the overall quantum of public funding is reduced by the value of the care and support charge levied on an individual) inasmuch as it eliminates retrieval costs.

6.9 There may be circumstances where an individual is in the process of disputing the level of charges he/she has been asked to pay. Where an individual in receipt of traditional community care services disputes the level of charges, and does not pay whilst the dispute is being settled, the local authority cannot withdraw or reduce the service.

6.10 The Chartered Institute of Public Finance & Accountancy (CIPFA) have produced new guidance[12] intended for use by any staff with responsibility for the financial management of SDS. The guidance relates principally to councils objectives and seeks to support and inform staff undertaking financial management duties so that SDS outcomes, both at a personal and a local population level, are achieved. Ensuring that the financial management arrangements support and reflect the SDS person centred approach is therefore central to this guidance.

Treatment of Free Personal Care and other Non-Chargeable Services

6.11 By framing the discussion around a general care and support charge levied on the individual, the concept of free or subsidised services can be difficult to sustain. When people are required to fund a proportion of their personal budget, they are not paying towards the cost of specific services.

6.12 From a council's point of view, therefore, managing a system that includes free services creates additional complexity in the administration of SDS. If the Council simply chose to reduce the care and support charge for those people entitled to an element of free services, this might be deemed to be unfair to other supported people and hence may be open to legal challenge.

6.13 The main issue for councils in Scotland arises in respect of Free Personal Care. While there may be a number of ways to ensure compliance with the legislation, SDS may require some

[11] http://www.scotland.gov.uk/Resource/0044/00446933.pdf)
[12] http://www.cipfa.org/members/regions/scotland/news/guidance-notes-on-self-directed-support

retrospective attribution of 'service hours' to an individual's support package. The collection of the care and support charge can therefore only be finalised once the details of the support plan have been taken into consideration.

Transition to SDS-compatible arrangements

6.14 In making the transition to a charging policy that is compatible with SDS, it is important to consider the impact on people who are being supported. The following checklist was included in previous charging guidance to ensure any transition is fair and transparent. It is recognised that many of these processes will be cyclical in nature and Councils may wish to re-visit this checklist as part of ongoing review and improvement activity:

- Councils should carry out a desktop analysis to determine the impact of changes to the policy on both individuals and income to the authority as a whole;
- Councils should ensure that any new policy is co-produced with citizens and communities of interest;
- An equality impact assessment should be undertaken;
- Councils should consider what (if any) transitional arrangements may be needed where the amount an individual is charged changes significantly. Any transitional protection should compare the amount that an individual paid under the previous charging regime against the amount he or she is required to pay under the new arrangements. Transitional protection should have a clear timeframe which should apply equally to all, be transparent and recorded in a policy.

6.15 Consultation with stakeholders on any policy charges is essential. Any consultation document would need to help people to understand why these changes are being introduced and how it will affect the way people engage with councils and partner organisations.

Requirement to waive charges to carers under SDS regulations

6.16 Section 3 of the Self-directed Support (Scotland) Act 2013 gave local authorities the power to provide **carers** with support to help them continue in their caring role and, where the authority has decided to provide support, confers a duty on the local authority to offer the self-directed support options.

6.17 Section 16 of the Act establishes a general power for local authorities to charge for support provided to carers under Section 3. However, Scottish Ministers subsequently introduced Regulations which in fact prevent councils from imposing any such charges. Extracts from the current statutory guidance[13] are set out below.

4.1 The Regulations state that a local authority must waive charges where services are provided to adult carers under section 3(4) of the 2013 and where services are provided to children who are in need under section 22 of the 1995 Act because they are young carers.

4.2 The Regulations also have the effect that local authorities cannot means test or require a contribution from a carer or young carer where the support is being delivered by way of a direct payment.

4.3 Charges will not be made for support provided to carers either directly by local authorities or commissioned by the local authority through other statutory, independent and third sector

[13] http://www.scotland.gov.uk/Resource/0044/00447402.pdf

bodies. However, if a carer wishes to supplement and pay for support above the agreed level they will receive through self-directed support, then this is a matter entirely for the individual carer.

. . .

8.8 Local authorities might decide to arrange replacement care for a cared-for person as part of the support which they provide to a carer under section 3 of the 2013 Act in order to give a break from caring. Where replacement care is provided as support under section 3 in order to meet the carer's needs, the local authority must waive charges for the cost of the replacement care.

Section 7 – Substantive Guidance

7.1 This section comprises the detailed material guidance to which local authority officers should refer when developing or revising local charging policies. This will also be of significant interest to a wider audience of stakeholder organisations and the general public.

7.2 The following paragraphs comprise the practical elements councils need to accommodate within their charging policies. It includes recommended approaches to the treatment of income in terms of minimum income, charging thresholds and maximum contributions or charges required from a supported person.

7.3 Welfare Reform will result in wide ranging changes to both universal and disability benefits over the next few years. During the period of transition the out-going benefits system will run in parallel with the new system. Whilst the introduction of Universal Credit will eventually replace Income Support and Disability Premiums, these benefits along with Pension Credit will continue to be awarded and will continue, this year, as the agreed basis for calculating the **charging threshold** referred to below.

7.4 In terms of the potential disregards which are set out in figure 7.1 and at annex C it is suggested that councils treat the mobility component of PIP in the same way as the mobility component of DLA.

Charging Thresholds

7.5 A charging threshold is the set level of personal income below which a person can receive community care service(s) without needing to pay a contribution or charge toward the cost of the service(s) they receive.

People whose income falls below the charging threshold do not need to pay a contribution or charge toward the community care services they are assessed as needing.

DWP Rates

7.6 At the moment and in the absence of any other suitable national index the **charging threshold** is linked to rates set by the UK Government Department for Work & Pensions. These are rates of benefit which provide a top up of weekly income to a **guaranteed minimum amount** and are set out below.

Income Support - Personal Allowance	**2016/2017 (weekly)**
Single Person	**73.10**
Couple	**114.85**

Disability Premium	**2016/2017 (weekly)**
Single Person	**32.25**
Couple	**45.95**

Pension Credit - Guarantee Credit	2016/2017 (weekly)
Single Person	**155.60**
Couple	**237.55**

Figures from DWP Schedule of benefit rates from April 2015 (Income Support and Disability Premium frozen for 2016).

Buffer

7.7 In order to provide more help to those on low income and to recognise that not all of a user's income above these rates should be taken in charges, a **buffer** is added to the income levels above. This buffer is now set at **25%** (see fig 7.2. for an illustration of how the maximum charge is reached).

7.8 The **charging threshold** is worked out by adding the buffer (25%) to the appropriate DWP rate(s) for groups of people as set out in the following tables (*all thresholds are rounded up).

7.9 For people below state pension qualifying age the **Income Support Personal Allowance** and the **Disability Premium** are added together with the buffer added to the sum of these two rates as shown below.

	Income Support - Personal Allowance	Disability Premium	Buffer 25%	Charging Threshold* (weekly)
Single Person	73.1	32.25	26.34	**£132**
Couple	114.85	45.95	40.20	**£201**

7.10 For people of state pension qualifying age or above the **Pension Credit Guarantee** is used as the basis for the charging threshold calculation with the buffer added as shown below (whilst at this time there is no change to the charging guidance on these age thresholds councils may wish to be aware of the information on the DWP alignment of pension ages set out at Annex B).

	Pension Credit - Guarantee Credit	Buffer 25%	Charging Threshold* (weekly)
Single Person	~~151.20~~ 155.60	38.90	**£195**
Couple	~~230.85~~ 237.55	59.39	**£297**

7.11 It is recommended that the charge thresholds be uprated on an annual basis, using the approach outlined in the above paragraphs. The benefit uprating figures are normally announced in November each year allowing Local Authorities to make any necessary adjustments in their charge arrangements to take effect at the beginning of the financial year.

7.12 Earlier guidance recommended that local authorities should specify different rates for persons under and over 60; this was based on previous DWP Guidance. However, councils

may now wish to give consideration to this in the context of the Equality Act 2010[14] and the on-going DWP alignment of state pension qualifying age for men and women (Annex B).

Income

7.13 **This describes all user income which needs to be taken into account to establish the income level for comparison with the charging threshold.** Local Authorities should consider adopting a common approach to the treatment of income (see fig 7.1. for an illustration of the calculation process).

Income from all sources should be considered and should take account of net earnings and all social security benefits with the exception of the mobility component of the Disability Living Allowance/Personal Independence Payment.

7.14 There may be local circumstances, where individual local authorities want to make local policy decisions to exclude or disregard other sources of income to reflect local needs. Examples include disregarding war pensions and gallantry awards and disability premiums. **The use of such discretion is not limited by this guidance.**

7.15 The threshold figures should be **net** of housing and council tax costs (if applicable). Housing costs will include rent and mortgage interest payments and costs for Council Tax should also be deducted. Local authorities may wish to consider including in the disregard water and sewerage costs and household insurance premiums as other housing costs. Councils may also wish to disregard other specific costs of living, for instance disability related expenditure.

Case law suggests that where a local authority does not provide 'night time' services, it is inappropriate to have regard to the higher rate of Disability Living Allowance (DLA) or Attendance Allowance (AA) in the financial assessment (R v. Coventry City Council, November 2000). In these circumstances only the middle rate for DLA and the lower rate for AA should be taken into account.

Similarly for Service Users who receive the enhanced rate of Personal Independence Payment and who do not receive 'night time' services, it is recommended that in these circumstances only the standard rate for Personal Independence Payment should be taken into account.

Earnings

7.16 Where a supported person or their partner is in receipt of earned income when assessing chargeable income Local Authorities should only take account of net earnings. In addition they should also apply minimum earnings disregard of at least £20.

Partners

7.17 Where one member of a couple is in receipt of non-residential services most Scottish Local Authorities take account of the joint income and capital in the financial assessment. The basis for charging for non-residential care charges is S87 of the Social Work (Scot) Act 1968.

[14] The Equality Act (2010) includes powers to ban discrimination against older people in the provision of goods, facilities, and services. However, provisions that benefit older people, such as free bus passes, are still allowed. Within this context, it may be that preferential thresholds for people over 60 will continue to be lawful.

7.18 While paragraph 28 of the Scottish Office Circular SWSG1/97 states that "*under section 87(1A) of the 1968 Act authorities may charge only the person receiving the service and should have regard only to that individual's means in assessing his or her ability to* pay", it goes on to state in paragraph 29 that "*Local authorities may, in individual cases, wish to consider whether a client has sufficient reliable access to resources, other than his or her own resources, for them also to constitute his or her means for the purposes of Section 87(1A). The most likely instances of this kind will arise in relation to married or unmarried couples. It will be for the authority to consider each case in the light of their own legal advice"*.

7.19 COSLA is has secured opinion from Senior Legal Counsel on this matter as follows; *"it is only the 'means' of the disabled person that can be taken into account.* ***However, the means of the disabled person could include an estimate of the value of the benefit provided by the partner in supporting the disabled person;*** *i.e. the amount that is paid in respect of the disabled person's food; share of housing costs; payment of normal bills etc. on behalf of the disabled person."*

7.20 To secure further clarification the Society of Local Authority Lawyers & Administrators in Scotland (SOLAR) agree that ". . . whilst it is right that the 'means' of the person receiving care services should be taken into account when determining their contribution toward the cost of those services, it is not right to *routinely include all* of a partners financial resources/income as part of those means; although it may be appropriate to include a proportion of that resource.

7.21 Local Authorities should determine what is a reasonable and proportionate value of any such benefit either on a case by case basis or by setting a reasonable flat rate for all. In light of the legal opinion referred to here, it is important that local authorities consider the proportion of a partner's income or capital that can be taken into account in the financial assessment. The table below sets out possible options that local authorities may wish to consider for how income/capital should be treated in the financial assessment.

Ownership of income/capital	**Treatment of Income/capital**
Solely owned by Individual	Taken into account subject to normal disregards
Solely owned by Partner	Should not routinely be taken into account as part of financial assessment. See paragraph 7.19 – 7.21 above. However the local authority should look at this on a case by case basis.
Jointly owned	Normally the individual is considered to be in possession of an equal share of any joint financial resources.
Social security benefits paid to one member of a couple at couples rates, for example, pension credit, income support etc.)	It would be appropriate for a local authority to consider what proportion of such income is "reasonable" to consider as part of the individual's means. It is for the local authority to decide what a reasonable proportion is.

Compensation Payments

7.22 Whilst Councils' charging policies may currently follow DWP guidance in relation to capital, for the purposes of compensation payments (including compensation payments held in Trust) it is recommended that Councils should establish the breakdown of any compensation award and consider whether some elements of compensation payments should be included when assessing a supported person's ability to pay a charge.

Dependent Children

7.23 It is recommended that income derived from all benefit paid for, or on behalf of, a dependent child should be disregarded.

Capital & Tariff Income

7.24 Capital can be considered as a source of income and as such councils may choose to include income based on capital held by the supported person. In calculating the income a person receives from capital they own it is recommended that councils adopt the same approach as that used by the Department of Work and Pensions (DWP) for means testing income based benefits (see table below). However, there can be no upper capital limit at which people would be refused a service, as the provision of non-residential services will always be based legally on need rather than the ability to pay.

	Disregard Capital Below	**Weekly Tariff Income**
Below state pension qualifying age	£6,000	£1 per £250[(1)]
State pension qualifying age or above	£10,000	£1 per £500[(1)]

[(1)]Some councils may interpret this as 'part thereof'.

7.25 The approach set out above disregards income received against capital held up to a level of £6,000 for people below state pension qualifying age; or £10,000 for people of state pension qualifying age or above. For any capital held above those levels a weekly income is assumed and this is added as income in the financial assessment; as per the rates set out in the table.

7.26 It should be noted that where a supported person has capital in excess of the amount to be disregarded and is in receipt of Income Support, there will be no requirement for the Local Authority to calculate the capital tariff contribution as this exercise will have been carried out by the Department of Work & Pensions (DWP) with an appropriate adjustment to the amount of Income Support paid to the supported person.

Only available capital shall be taken into account. This precludes taking into account the value of the supported person's home in charging for domiciliary home care services.

7.27 Capital income tariff does not take into account the interest received on cash held in saving accounts. The savings themselves and any interest received are included in the overall total of capital assets held at the time that the financial assessment is carried out. Capital tariff rates seek to take all this into consideration by establishing a weekly income.

7.28 The value of a person's home is not counted as capital, neither are any business assets or money held in trust but any weekly income received from them is counted. For example, if

part of a person's home is rented out some of the rent received as weekly income is counted.

Capital Income: The cash increase in the value of a capital asset (investment or real estate) that gives it a higher worth than the purchase price. The gain is not realised until the asset is sold. A capital gain may be 'short term' (one year or less) or 'long term' (more than one year).

Tapers

7.29 The previous section deals with setting a level of income below which a user is not required to pay a charge or contribution toward the cost of the services they receive. So essentially it determines whether or not a contribution is needed – a yes or no trigger.

If a user's income is of sufficient level for a charge or contribution to be required the amount the user pays for their service will be determined by individual Local Authorities.

7.30 Having arrived at the charging threshold it is recommended that councils should not base the contribution required from the supported person on all the remaining income. Instead councils calculate the maximum contribution by determining a percentage of the remaining income which is available to the supported person over the threshold figure – this determines the maximum total contribution required from the supported person for the services they use regardless of the cost of providing those services.

An additional requirement is that the contribution should not exceed the cost of providing the service(s).

7.31 Local authorities are free to agree locally the percentage of excess income which can be required as a maximum contribution. This could range from 0% up to any higher percentage of the excess income which can be justified by the local authority.

Single Person - Below state pension qualifying age			**Maximum Contribution (£) % determined by council**							
Weekly Income (£)	**Charging Threshold (£)**	**Excess Income (£)**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
100	**132**	-32	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
120	**132**	-12	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
140	**132**	8	2.40	3.20	4.00	4.80	5.60	6.40	7.20	8.00
160	**132**	28	8.40	11.20	14.00	16.80	19.60	22.40	25.20	28.00
180	**132**	48	14.40	19.20	24.00	28.80	33.60	38.40	43.20	48.00
200	**132**	68	20.40	27.20	34.00	40.80	47.60	54.40	61.20	68.00
220	**132**	88	26.40	35.20	44.00	52.80	61.60	70.40	79.20	88.00

Single Person - State pension qualifying age or above			**Maximum Contribution (£) % determined by council**							
Weekly Income (£)	**Charging Threshold (£)**	**Excess Income (£)**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
150	**195**	-45	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
170	**195**	-25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
190	**195**	-5	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
210	**195**	15	4.50	6.00	7.50	9.00	10.50	12.00	13.50	15.00
230	**195**	35	10.50	14.00	17.50	21.00	24.50	28.00	31.50	35.00
250	**195**	55	16.50	22.00	27.50	33.00	38.50	44.00	49.50	55.00
270	**195**	75	22.50	30.00	37.50	45.00	52.50	60.00	67.50	75.00

7.32 In setting the percentage taper which people who use services will contribute, Local Authorities will be influenced by a number of factors, not least, their requirement to raise income which is required to maintain good quality services.

It is recommended that authorities make a number of calculations based on alternative considerations of assessed income (known as a "better off" calculation) to ensure that those people who use services who have higher incomes, who require low levels of services, are not financially disadvantaged through the operation of an income based charge.

Disability Related Expenditure

7.33 The Social Work (Scot) Act provides the legal basis for charging for non-residential care. Under s87 of the Act charges must be both "reasonable and practicable" for an individual to pay. Understanding the associated additional daily living costs of living with an illness or a disability is essential if local authorities are to ensure charging levels meet this test. Failure to take Disability Related Expenditure (DRE) into account as part of the financial assessment could result in charging levels which cause financial hardship and undermine the right of people living with an illness or disability to live independently.

7.34 To ensure the extra costs of being disabled are be taken into account by charging policies councils should be proactive in considering further disregard of income where additional expenditure is incurred by a service user as a result of living as a disabled person.

7.35 It is recommended that local authorities are proactive in gathering information about additional disability related expenses as part of their financial assessment process. Ideally, questions about disability related expenditure should be included in the financial assessment form. This will enable a local authority to decide whether to disregard more of a person's income or capital, over and above any existing disregards, to take account of any disability related expenditure.

7.36 Additional costs may relate to, but will not be restricted to:

- additional heating requirements
- purchase, maintenance and repair of disability related equipment
- specialist dietary requirement
- specialist clothing

- help with cleaning and other domestic tasks

7.37 Councils may wish to adopt their own approaches to the consideration of disability related expenditure (DRE) as part of the financial assessment process but this should be set out in their local charging policy.

Hardship

7.38 Where a supported person has difficulty in meeting the approved cost of the service due to their financial circumstances, it is recommended that Councils use their powers to abate or waive charges on a case by case basis.

It is unlikely that charging policies will be able to make provision for the full range of personal circumstances. This means that councils should exercise local discretionary powers to apply flexibility in cases deemed appropriate. It is neither necessary nor desirable to issue guidance on how these powers would be applied as such guidance would remove discretion and impose prescription.

7.39 It is recommended that all local authorities provide adequate information on their policies for waiving and abating charges (see section on information). This should include details of the processes by which the authority considers such requests.

7.40 In designing charging policies, councils should give consideration to the impact of such policies on the well-being of carers, many of whom may experience hardship.

Terminal Illness

7.41 Where a person, aged under 65, has a progressive disease where death as a consequence of that disease can reasonably be expected within 6 months, it is recommended that charges for social care services are waived. This prognosis should be evidenced through a DS1500 form or a letter from the individual's General Practitioner or hospital consultant. It is further recommended that the Council should have the discretion to extend the waiving of charges beyond this time period, should that be merited by the circumstances of a particular case.

Public Information

7.42 In setting out public information on charges, it will be incumbent on Local Authorities to provide plain English explanations of the basis of their charge arrangements, both in policy terms and for billing purposes. Such information should be provided in a variety of accessible formats, including translations into minority languages where appropriate. It would be good practice to secure a Crystal Mark for this information.

A standard format for charging information is seen as an essential element to a consistent and transparent approach to community care charging and there is broad agreement that that formats should be accessible to the person requiring the information.

7.43 As an aid to greater consistency templates for the presentation of charging information and other elements are included at appendix I. These will be added to over subsequent revisions of the guidance.

Leaving Hospital

7.44 Older people leaving hospital who are assessed as requiring new, intermediate or additional home care services should receive this free, for a period of up to 42 days; if they are aged 65 or over on the day of discharge and have been in NHS in-patient care for more than one day (24 hours) for treatment, assessment or rehabilitation, or had surgery as an NHS day case.

7.45 Relief from charging should not apply to discharges following admission on a regular or frequent basis as part of the person's on-going care arrangements. This would cover, for example, admissions for respite care or for on-going but episodic treatment.

Only new, intermediate or additional services provided after a person comes out of hospital will be free for a limited period. Services that were in place pre-admission and continue after discharge will continue to be chargeable.

This recommendation was set within the context of the Scottish Executive Circular No. CCD 2/2001 "Free Home Care for Older People Leaving Hospital".

7.46 After the 42-day period, local authorities will revert to their normal charging practices for home care services.

Income Maximisation & Benefit Take Up

7.47 It is recommended that all Local Authorities be proactive in promoting benefit take up for people who use services. Where possible Local Authorities should ensure that there are dedicated staff to promote and assist with Income Maximisation processes for people who use services. Benefit entitlements should be reviewed on a regular basis.

7.48 A number of local authorities have negotiated arrangements to share information with the local benefits agency, particularly on the notification of decisions. It is recommended that all local authorities which do not have such arrangements in place should take steps to implement them.

Collection of charges through third party suppliers

7.49 The collection of charges is the responsibility of Local Authorities. Some local authorities pay third party suppliers net of the individual's charge and ask suppliers to collect any charge directly from the individual. In some cases this charge is collected as cash on the doorstep by the third party provider. In many cases this will be convenient for the individual but any potential risks to individuals who may be more vulnerable, because of their age, illness or disability, must be considered before any such agreement is put in place. Any such arrangement should be considered on a case by case basis and should only be made with the agreement of the individual and after taking account of the person's capacity to consent to and manage such arrangements safely.

7.50 Local Authorities should ensure that an equalities impact assessment is carried out for any charging policies put in place to eliminate any discrimination in line with the Equalities Act 2010.

7.51 Similarly Local Authorities which enter into contractual arrangements requiring a third party provider to collect payment of charges must carry out an effective risk assessment to ensure

that all payment options offered by suppliers have sufficient safeguards to properly evidence payments made by individuals.

Figure 7.1: Supported Person's Income / Contribution Calculation Process

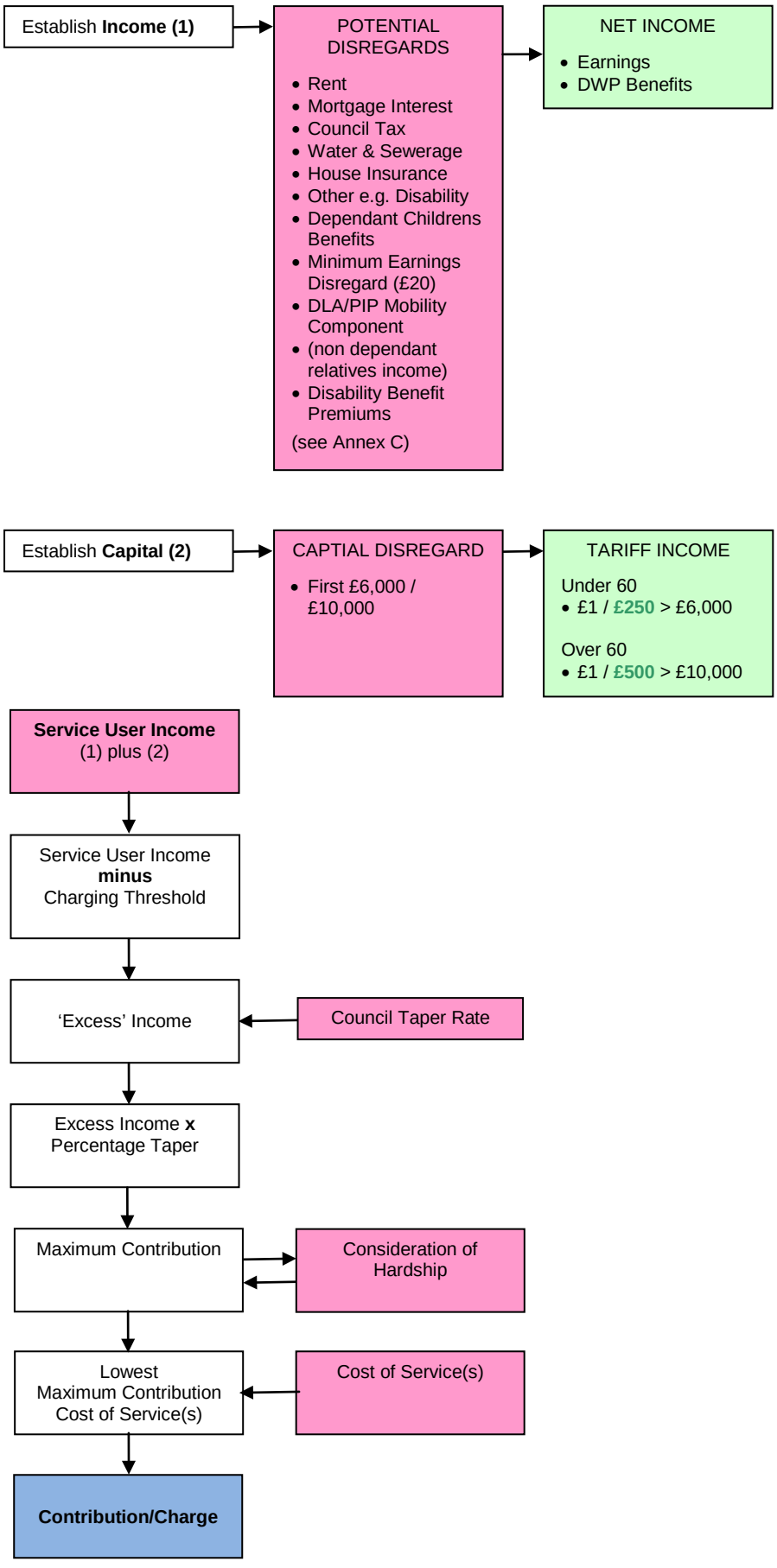
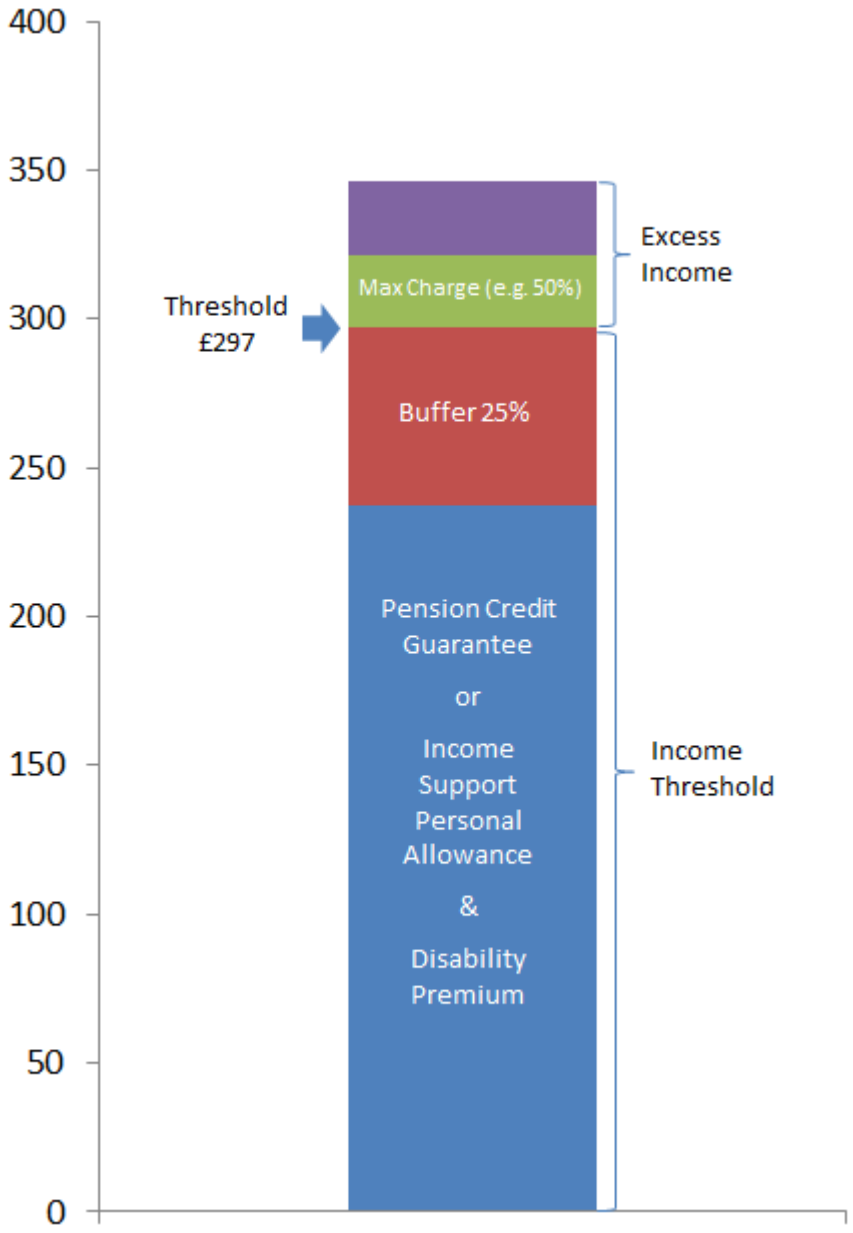


Figure 7.2 : Maximum Charge – Illustration

(Example – Couple of state pension qualifying age or above)



Annex A – Local Charges Information Template

TEMPLATE FOR LOCAL AUTHORITIES PUBLIC INFORMATION – CHARGING FOR NON-RESIDENTIAL CARE

(This template provides examples of the types of information local policies might include)

Information on Charging for Services in your Home	<*area*> Council wants to help people live at home independently, safely and for as long as possible. To help us to continue to provide services to people with a range of needs, we may need to charge you for some care and support services. These charges might affect you if you are getting services from us at the moment or if you need them in the future. Charges apply whether the service is provided by <*area*> Council or is purchased from an external provider. The figures in this guide are correct for the financial year <*date*> to <*date*>.
Why is there a charge?	Local Authorities don't have to but are allowed by law to charge adult users of non-residential services provided or arranged under the Social Work (Scotland) Act 1968 and the Mental Health (Care and Treatment) (Scotland) Act. These charges must be "reasonable" for people to pay having regard to the type of service provided and a person's ability to meet the cost. Any charges should not exceed the cost of providing the service. For means-tested services this charge will be determined by a financial assessment. You can find out more about financial assessments below.

Annex A – Local Charges Information Template

What can I be charged for?	If you receive care at home from <*area*> Council's social work service you may be required to contribute towards the cost of the services you receive.
Will all services be charged for?	Not all services provided to support people at home are subject to charges. The following services are chargeable: <remove/retain as required> • Care at Home (including Supported Accommodation, Supported Living, and Housing Support Services) • Day Care • Community Alarms & Telecare • Laundry Services • Meals on Wheels • Lunch Clubs • Aids and Adaptations • After Care Services for people with a mental illness • Care and Support Services for those who have or have had a mental illness (in or not in hospital) • Transport The following services are free and are NOT subject to a charge: • Criminal Justice Social Work Services • Information and Advice • Needs Assessment • Care Management • Personal Care for Older People • Home Care services for 42 days on discharge from hospital

<table>
<tr>
<td>Who is exempt from being asked to pay?</td>
<td>The following people cannot be charged for care services:

• People who are terminally ill
• People aged over 65 just receiving Personal Care
• People with a mental illness who are subject to a Compulsion Order</td>
</tr>
<tr>
<td>Who will be asked to pay?</td>
<td>For all other users of non-residential services the Charging Guidance suggests a level of weekly income below which someone cannot be asked to pay care charges. These are known as minimum income thresholds and are:

<table>
<tr><th></th><th>2015/16</th><th>2016/17</th></tr>
<tr><td>Single person under pension qualifying age</td><td>£123</td><td>£132</td></tr>
<tr><td>Couple under pension qualifying age</td><td>£188</td><td>£201</td></tr>
<tr><td>Single person over pension qualifying age</td><td>£177</td><td>£195</td></tr>
<tr><td>Couples over pension qualifying age</td><td>£269</td><td>£297</td></tr>
</table>

If your assessable weekly income is less than your income threshold figure you should not be charged for a service.

If your assessable weekly income is more than your income threshold figure you may be charged for a service.

<% taper> of the difference between a person’s (or couple’s) assessed income and this threshold will be the maximum charge for the following services:

<insert relevant services></td>
</tr>
</table>

Annex A – Local Charges Information Template

How will charges be calculated?	The services you receive will always be based on your needs and the charge will be based on your ability to pay. When we assess your income to see how much you can pay, this is known as a financial assessment. A financial assessment will be carried out if you receive a chargeable service.
What happens during a financial assessment?	An officer from the council will come and visit you at home to undertake a financial assessment. The officer is required to have proof of all income and capital held. You should therefore have available for inspection any Pension or Benefit statements, and bank or savings books relating to your financial affairs.
Q and As about financial assessments • What information must I provide? • What if I refuse to provide this information? • What income and expenditure is taken into account in the Financial Assessment? • What income and expenditure are excluded? • What costs are to be deducted in arriving at the assessable income level? • Will my partner's information be included in the financial assessment? • I have children, will that affect my financial assessment? • Will my savings be taken into account?	

• How will my capital be calculated? • Will the capital value of my house be taken into account? • Will my Benefits be taken into account? • I get payment from the Independent Living Fund. Will this be counted in the income and expenditure assessment? • What happens if someone's finances are managed by another person? • Can I get a full benefits check at the same time? • Do I have to have a financial benefits check done? • Do I have to tell you if my income or savings change? • Do I have to pay if no care or support service is provided because I am in hospital or on holiday? • If my Home Carer is on holiday do I have to pay? • Will I be charged for the full hour if only part of an hour of care or support is given? • If I need more than one home carer will I be charged for both? • Will my Self-Directed Support or Direct Payments be affected? • Will I have to contribute if I am 65 or over? • What happens if I can afford to pay but do not? • What should I do if I am finding it difficult to pay? • What happens to the information I give you? • When will the financial assessments begin? • What if I am unhappy with any part of the financial assessment?	

Financial assessment examples	<insert three worked examples of financial assessments>
What calculation is made to determine my care charge?	To determine the maximum amount you can afford to contribute towards your care package, the following calculation will be completed: <u>Example A</u> Total Assessed Income (A) Less Applicable Housing Costs (B) Less Applicable Disregards (C) Less Relevant Income Threshold (D) Equals residual income (E) Maximum charge (F) is equal to residual income (E) multiplied by a taper of <taper %>.
In what circumstances would charges be waived?	***Information about any capacity the council has to abate or waive charges under 'Cases of Hardship' and details of what types of issue are considered hardship for either client or carer which warrant abatement.***
Further questions	If you have any further questions please phone us on <*telephone number*> or email us on <*email address*>.

Annex B – DWP Alignment: Pension Credit & Women Pension Age / Men Pension Age

State Pension age for women affected by the equalisation of State Pension Age

Date of birth	**Date of State Pension age**
6 March 1952 to 5 April 1952	6 March 2014
6 April 1952 to 5 May 1952	6 May 2014
6 May 1952 to 5 June 1952	6 July 2014
6 June 1952 to 5 July 1952	6 September 2014
6 July 1952 to 5 August 1952	6 November 2014
6 August 1952 to 5 September 1952	6 January 2015
6 September 1952 to 5 October 1952	6 March 2015
6 October 1952 to 5 November 1952	6 May 2015
6 November 1952 to 5 December 1952	6 July 2015
6 December 1952 to 5 January 1953	6 September 2015
6 January 1953 to 5 February 1953	6 November 2015
6 February 1953 to 5 March 1953	6 January 2016
6 March 1953 to 5 April 1953	6 March 2016
6 April 1953 to 5 May 1953	6 May 2016
6 May 1953 to 5 June 1953	6 July 2016
6 June 1953 to 5 July 1953	6 September 2016
6 July 1953 to 5 August 1953	6 November 2016
6 August 1953 to 5 September 1953	6 January 2017
6 September 1953 to 5 October 1953	6 March 2017
6 October 1953 to 5 November 1953	6 May 2017
6 November 1953 to 5 December 1953	6 July 2017
6 December 1953 to 5 January 1954	6 September 2017
6 January 1954 to 5 February 1954	6 November 2017

Annex B – DWP Alignment: Pension Credit & Women Pension Age / Men Pension Age

6 February 1954 to 5 March 1954	6 January 2018
6 March 1954 to 5 April 1954	6 March 2018
6 April 1954 to 5 May 1954	6 May 2018
6 May 1954 to 5 June 1954	6 July 2018
6 June 1954 to 5 July 1954	6 September 2018
6 July 1954 to 5 August 1954	6 November 2018
6 August 1954 to 5 September 1954	6 January 2019
6 September 1954 to 5 October 1954	6 March 2019
6 October 1954 to 5 November 1954	6 May 2019
6 November 1954 to 5 December 1954	6 July 2019
6 December 1954 to 5 January 1955	6 September 2019
6 January 1955 to 5 February 1955	6 November 2019
6 February 1955 to 5 March 1955	6 January 2020
6 March 1955 to 5 April 1955	6 March 2020
6 April 1955 to 5 April 1959	65th birthday

Annex C – Potential Disregarded Benefits/Income List

Adoption (Scotland) Act 1978 (section 51A) Payments
Age-Related payments Act 2004 Payments
Armed Forces Compensation Scheme
Armed Forces Independence Payment
Backdated Benefits
Bereavement Payment
Budgeting Loan
Capital – various different levels of disregard
Carers Allowance (previously Invalid Care Allowance)
Carers Premium
Certain payments made to trainees
Charitable and special funds
Child Benefit
Child related premiums paid to pre April 2003 Income Support Claimant
Child Support Maintenance Payments
Child Tax Credits
Children's Benefits
Christmas bonus
Christmas Bonus paid with benefits
Cold Weather Payments
Concessionary Coal payments
Council Tax Benefit / Council Tax Reduction
Dependency increases paid with certain benefits
Difference between higher and lower rate of Attendance Allowance and higher and middle rate of DLA care when the person is not receiving night-time services
Difference between enhanced and standard rate of Personal Independence Payment (Daily Living Component) when the person is not receiving night-time services
Direct Payments made by a local authority under Section 12B of the Social Work (Scotland) Act 1968 to Individuals in respect of a care service that they or a dependent child have been assessed as requiring
Disability benefits paid to client's partners where the partner is not a service user
Disability Living Allowance (Mobility component)
Disability payment in respect of child
Discretionary Housing Payments
Earnings
Far East Prisoner of War payment
Gallantry Awards (e.g. GC, VC, similar from abroad)
Guarantee Credit
Guardian’s Allowance
Housing Benefit
Income from a “home income plan” annuity
Income from a mortgage protection policy

Annex C – Potential Disregarded Benefits/Income List

Income frozen abroad
Income in kind
Income Support
Independent Living Fund Payments
Industrial Disablement Benefit
Industrial Injuries Benefit
Industrial Injury Disability Benefit
Kinship Care payments
Personal Independence Payment (Mobility Component)
MOD Pension
Non-dependent child payments
Non-therapeutic Earnings
Partner's earnings
Personal property, such as household goods, family car etc.
Scottish Welfare Fund – Community Care Grants
Scottish Welfare Fund – Crisis Grants
Social Fund payments
Student Loan Repayment
Sure Start Maternity Grant
Tax Credits
The Macfarlane Trust
The value of any ex-gratia payments from the Skipton Fund to people infected with Hepatitis C as a result of NHS treatment with blood or blood products
Therapeutic Earnings
Trainees' training premium and travelling expenses
Victoria Cross/Japanese Prisoner of War Payments
Victoria or George Cross payments
War Pensioner's Mobility Supplement;
War Widow(er)'s supplementary pension
War Widow's Pension (but not War Widows' Special Payments).
War Widows Pension (pre 1973)
War widows special victims awards
War Widows/Widowers Pension and War Disablement Pension.
War Widows' Special Payments
Where the Service User is a student, any grant payment for a public source intended for the childcare costs of a child dependent
Winter Fuel Payments
Work expenses paid by employer, and expenses paid to voluntary workers Earnings disregard of £20.00 per week.

The following may also be disregarded in calculations

- Contributions towards rent / mortgage after housing benefit
- Contributions towards Council Tax / Water & Sewerage.

INCOME		
Capital (Tariff Income):	above pension age[15]	**£1 / £500**
	below pension age	**£1 / £250**
Non-dependent Relatives Income		**YES** (proportion of partners income can be counted)
Compensation (Care Element)		**YES**
DISREGARDS		
Disability Related Expenditure (DRE)		**YES**
Capital (Disregard):	above pension age	**£10,000**
	below pension age	**£6,000**
Potential Disregarded Benefits		(see list[16])
CHARGING THRESHOLDS[17]		
Capital Upper Limit (above which full charge is made) (income based benefits / non-residential rate)		**£16,000**
Single Person - below pension age		**£132**
Single Person - above pension age		**£195**
Couple - below pension age		**£201**
Couple - above pension age		**£297**

[15] Prior to 2014/15 the guidance recommended that local authorities use different rates for persons aged under 60, and over 60, and used the terms 'older people' and 'others'. This was based on previous DWP guidance and sought to reflect the different levels of benefit received by people of state pension qualifying age or above; data used in the development of the template relates to those categories.
The guidance now refers to these groups as 'people below state pension qualifying age' (para 7.9) and 'people of state qualifying age or above' (para 7.10) and suggests that councils may now wish to give consideration to this in the context of the Equality Act 2010 and the on-going DWP alignment of state pension qualifying age for men and women (Annex B).
[16] For consistency this lists the names of benefits and payments which councils may *consider* for disregard.
[17] Based on 2015/16 DWP Benefit Rates

Appendix 3 – COSLA Financial Assessment Template – Minimum Standard

INCOME		
Capital (Tariff Income):	above pension age	**£1 / £500**
	below pension age	**£1 / £250**
Non-dependent Relatives Income		**YES** (proportion of partners income can be counted)
Compensation (Care Element)		**YES**
DISREGARDS		
Disability Related Expenditure (DRE)		**YES**
Capital (Disregard):	above pension age	**£10,000**
	below pension age	**£6,000**
Potential Disregarded Benefits		(see Annex c of COSLA guidance)
CHARGING THRESHOLDS		
Capital Upper Limit (above which full charge is made) (income based benefits / non-residential rate)		**£16,000**
Single Person - below pension age		**£132**
Single Person - above pension age		**£195**
Couple - below pension age		**£201**
Couple - above pension age		**£297**

Shetland Islands Council

Equality Impact Assessment

Part 1

Title of document being assessed	Care and Support Charging Policy
Is this a new or an existing policy, procedure, strategy or practice being assessed?	Existing policy with modification and updates from 2015/16.
Please give a brief description of the policy, procedure, strategy or practice being assessed	The policy is with regard to charging for non- residential services provided to clients of the Community Health and Social Care service
What is the intended outcome of this policy, procedure, strategy or practice?	The intended outcome is that where individuals are able to they will contribute to the cost of their care package. This will support the council's ability to maintain provisions to meet assessed need whilst also undergoing service redesign and internal efficiency measures.
Please list any existing documents which have been used to inform this Equality and Diversity Impact Assessment	COSLA National Strategy and Guidance, Charges applying to Non-residential Social Care Services. This includes references to high level principles including non-discrimination and equality, anti-poverty measures, and the Equality Act 2010, and Human Rights Act 1998.
Has any consultation, involvement or research with people from protected characteristics informed this assessment? If yes please give details.	In drawing up the guidance, COSLA undertook consultation with a range of organisations including representatives of Age Scotland, Coalition of Carer's, Independent Living in Scotland, Scottish Consortium for Learning Disability, Alzheimer's Scotland and Capability Scotland. Locally, consultation has taken place with Citizen's advice Bureau, Advocacy Shetland, Carer's representatives and other 3rd sector groups, as well as taking customer feedback into account.
Is there a need to collect further evidence or to involve or consult people from protected characteristic on the impact of the proposed policy? (Example: if the impact on a group is not known what will	There is a need to collate information regarding the impact on people subject to this policy. The new financial assessment has allowed for collation of information on disability related expenditure. The policy allows for the waiving or abating of charges on an individual basis where it is considered that people will experience hardship as a result of the policy.

you do to gather the information needed and when will you do this?)	

Part 2

Which protected characteristics will be positively or negatively affected by this policy, procedure or strategy?

Please place an X in the box which best describes the overall impact. It is possible for an assessment to identify that a positive policy can have some negative impacts and vice versa. When this is the case please identify both positive and negative impacts in Part 3 of this form.

If the impact on a protected characteristic is not known please state how you will gather evidence of any potential negative impacts in the relevant section of Part 1.

	Positively	**Negatively**	**No Impact**	**Not Known**
Ethnic Minority Communities (consider different ethnic groups, nationalities, language barriers)			X	
Gender			X	
Gender Reassignment (consider transgender and transsexual people. This can include issues such as privacy of data and harassment)			X	
Religion or Belief (consider people with different religions, beliefs or no belief)			X	
People with a disability (consider attitudinal, physical and social barriers)	X	X		
Age (consider across age ranges. This can include safeguarding, consent and child welfare)			X	

Lesbian, Gay and Bisexual			X	
Pregnancy and Maternity (consider working arrangements, part-time working, infant caring responsibilities)			X	
Other (please state)				

Part 3

Have any positive impacts been identified? (We must ensure at this stage that we are not achieving equality for one group at the expense of another)	Continued implementation of this policy will assist in ensuring that the standard of care provided can be maintained across Shetland
Have any negative impacts been identified? (Based on direct knowledge, published research, community involvement, customer feedback etc.)	Individuals may feel that they cannot afford charges that apply. We need to ensure that the financial assessment is being undertaken accurately and consistently. Previous feedback has been collated and the policy has been adapted to take account of concerns. Data on disability related expenditure has and will continue to be collated, and there is a process for abating or waiving charges where hardship is expected. Previous negative age related differences in charging have been removed. Feedback from clients will continue to be monitored, and efforts will be made to adapt the policy in response

	to concerns in future. An additional buffer has been introduced in line with the COSLA Guidance which will further remove people from these charges.
What action is proposed to overcome any negative impacts? (e.g. involving community groups in the development or delivery of the policy or practice, providing information in community languages etc)	As above.
Is there a justification for continuing with this policy even if it cannot be amended or changed to end or reduce inequality without compromising its intended outcome? (If the policy shows actual or potential unlawful discrimination you must stop and seek legal advice)	Yes – the policy has been altered in response to feedback.
How will the policy be monitored? (How will you know it is doing what it is intended to do? e.g. data collection, customer survey etc)	Formal and informal feedback will continue to be collated.

Agenda Item

8

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	IJB Business Programme 2016/17
Reference Number:	GL-17 *Cover*
Author / Job Title:	Jan-Robert Riise, Executive Manager – Governance and Law (SIC)

Decisions / Action required:

The Integration Joint Board is asked to consider its business planned for the remaining quarters of the current financial year to 31 March 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 during the current 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:	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 has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions 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 IJB agreed, at its meeting on 20 November 2015 (Min. Ref. 19/15), that a business programme be reported quarterly from April 2016 following the IJB adoption of its Strategic Commissioning Plan for 2015/16.

END

Agenda Item

8

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	27 April 2016
Report Title:	IJB Business Programme 2016/17
Reference Number:	GL-17 Report
Author / Job Title:	Jan Riise, Executive Manager – Governance and Law

1. Introduction

1.1 This report presents an updated IJB Business Programme 2016/17 for the Integration Joint Board (IJB). The IJB Business Programme is attached at Appendix 1.

2. Background

2.1 The purpose of this report is to inform the IJB of the planned business to be presented to the IJB for the financial year to 31 March 2016 for the IJB to consider and advise regarding any changes or additions required to that programme.

2.2 The IJB agreed that 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.

- Quarterly PPMF (Planning and Performance Management Framework) meetings for the IJB have been scheduled. These meetings are time restricted, with a specific focus on PPMF only and therefore no other business will be permitted on those agenda.

- "Budget" meetings are budget setting meetings, where other agenda items can be added, if time permits, or if required as part of the budget setting process.

- In consultation with the Chair, Vice Chair and relevant Officers, and if required according to the circumstances, the time, date, venue and location of any meeting may be changed, or special meetings added.

Recommendations

3.3 It is recommended that the IJB considers its business planned for the current financial year to 31 March 2017, and RESOLVES to approve any changes or additions to the Business programme.

4. Conclusions

4.1 The quarterly presentation of the IJB Business Programme for 2016/17 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:
Anne Cogle, Team Leader - Administration
anne.cogle@shetland.gov.uk

19 April 2016

Appendices

Appendix 1: IJB Business Programme for 2016/17

Background Documents

None

Integration Joint Board - Shetland Health and Social Care Partnership
Meeting Dates and Business Programme 2016/17

Chair: Mr Cecil Smith, SIC / Vice-Chair: Dr Catriona Waddington, NHS
as at Tuesday, 19 April 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.	• Action Plan – Mental Health Review (CC21) • Audit Scotland – Care Home Inspectorate Reports (CC19 – Community Care) • SIC Policy Care and Support Charge 2016/19 (CC23) • Primary Care Strategy (to include high level implementation plan) (CC25) • Area Management (CC22) • Audit Scotland – Care Home Inspectorate Reports (CC24 Newcraiglea) • Shetland Autism Strategy (CC26) • 2016/17 Business Programme
	Wednesday 8 June 2016 at 2 p.m.	• Appointment of Non-Executive Director [NHS] to the IJB – *[including appointment to IJB Audit Committee]* • Performance Report • Audit Commission report on health and social care integration • Risk Registers – IJB and Directorate • 2016/17 Business Programme
	Friday 24 June 2016 at 11 a.m.	This date needs to move because of the EU Referendum on 23 June and unavailability of committee services staff to administer the meeting. • Draft 2015/16 Accounts • Oral Health Strategy • Strategic Commissioning Plan & Budget
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 • Care Inspectorate and Healthcare Improvement Scotland Joint Inspection of health and social work services for older people in Shetland • Q1 Financial Accounts • Primary Care Strategy Action Plan • 2016/17 Business Programme
	Friday 23 September 2016 at 11 a.m.	• 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 • Shetland Autism Strategy Action Plan • 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 • 2016/17 Business Programme
	Wednesday 15 March	• Q3 Financial Accounts

Integration Joint Board - Shetland Health and Social Care Partnership
Meeting Dates and Business Programme 2016/17
Chair: Mr Cecil Smith, SIC / Vice-Chair: Dr Catriona Waddington, NHS
as at Tuesday, 19 April 2016

	2017 at 2 p.m.	

Planned business still to be scheduled - as at Tuesday, 19 April 2016
None
END OF BUSINESS PROGRAMME as at Tuesday, 19 April 2016

IJB Audit Committee		
Quarter 1 1 April 2016 to 30 June 2016	**Date of Meeting**	**Business**
	Friday 27 May 2016 at 10 a.m.	• Shetland Health & Social Care Partnership response to Audit Scotland Report on Health & Social Care Integration • Changing Models of Health & Social Care • 2016-17 Internal Audit Plan • Inspection Action Plan (Stephen) • Community Care Resources - Internal Audit Plan Update
	Friday 24 June 2016 at 10 a.m.	This date needs to move because of the EU Referendum on 23 June and unavailability of committee services staff to administer the meeting. • Draft 2015/16 Accounts
Quarter 2 – 1 July 2016 to 30 September 2016	Friday 26 August 2016 at 10 a.m.	• *To be confirmed*
	Friday 23 September 2016 at 10 a.m.	• Final 2015/16 Accounts
Quarter 3 - 1 October to 31 December 2016	Friday 11 November at 10 a.m.	• *To be confirmed*
Quarter 4 1 January 2017 to 31 March 2017	Friday 3 March 2017 at 10 a.m.	• *To be confirmed*

Planned business still to be scheduled - as at Tuesday, 19 April 2016
None
END OF BUSINESS PROGRAMME as at Tuesday, 19 April 2016