Agenda Item

1

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Audit Scotland Report into Health and Social Care Integration
Reference Number:	CC-28-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

It is recommended that the IJB Committee note and comment on the Audit Scotland Report on Health and Social Care Integration which had been presented to the IJB Audit Committee on 27 May 2016.

To approve the local actions detailed in the draft Action Plan (Appendix 1).

High Level Summary:

Audit Scotland produced a report on Health and Social Care Integration in Scotland that makes 16 recommendations. A draft local action plan is attached in response to the report's recommendations.

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:

Recommendation to the IJB relates to strategic planning, governance, workforce and organisational development, transparency and accountability, locality planning and financial planning.

Recommendations made jointly to IJB, Council and Health Board relate to the relationships between the three bodies, clinical and care governance, finance, scrutiny and information sharing.

Implications :	
Service Users, Patients and Communities:	Successful implementation of the draft Action Plan will contribute to improved outcomes for service users and the community.
Human Resources and Organisational Development:	The action plan is wide reaching and we will seek advice and support from Human Resources and Organisational Development as required.
Equality, Diversity and Human Rights:	Shetland's Strategic Plan supports and promotes equalities, health and human rights.
Legal:	Audit Scotland's recommendations relate directly to the statutory functions of the Integration Joint Board.
Finance:	Audit Scotland make a number of recommendations in relation to budgeting and financial planning. These processes are in place.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Any risks to the Integration Joint Board arising from this draft Action Plan have been acknowledged and arrangements put in place to mitigate the risks.

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 was presented to the IJB Audit Committee on 27 May 2016.

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1. Introduction

1.1 The purpose of this report is to provide the Integration Joint Board with an overview of the Audit Scotland report on Health and Social Care Integration (Appendix 2), to comment on the draft action plan (Appendix 1) and the extent to which it deals with the implications for Shetland Integration Joint Board, arising from the Audit Scotland report.

2. Background

2.1 Health and Social Care Integration is the first of three planned audits by Audit Scotland on the major reform programme linked to integration. This first audit provides a progress report at what is explicitly recognised as being a relatively early stage in the process and during a transitional period.

2.2 The Public Bodies (Joint Working) (Scotland) Act 2014 enacts a key government policy and sets out the framework for integrating adult health and social care services against a background of changing demography, rising demand for services and constrained budgets.

2.3 The report's key messages are:

2.3.1 The Act introduces a significant change programme affecting most health and care services. The reforms are far reaching and ambitious and create opportunities to overcome previous barriers to change.

2.3.2 Across Scotland the required arrangements to allow Integration Authorities (IAs) and their Integration Joint Boards (IJBs) to be operational by the statutory deadline of April 1st 2016 are well embedded.

2.3.3 The report notes, however, that the required governance arrangements are complex: IJBs are responsible for the planning of

integrated services but are not entirely independent of the Council and NHS Board.

2.3.4 IJB members will need support to understand and respect significant differences in organisational cultures and background and to robustly manage conflicts of interest.

2.3.5 Greater clarity and a clear understanding of who is accountable for service delivery needs to be built into arrangements, specifically roles and responsibilities and the management of the risk of service failure.

2.3.6 Clearer procedures are required for clinical and care governance.

2.3.7 Councils and NHS Boards across Scotland are finding it challenging to agree budgets for the new IAs. This is hindered by different planning cycles and complexities of "set-aside" (acute hospital) budgets.

2.3.8 Difficulties in agreeing budgets and uncertainty about longer-term funding mean that IAs have not yet set out comprehensive strategic plans with clear targets and timescales showing how they will make a difference to people who use health and social care services.

2.3.8 Most integration authorities have still to produce robust supporting strategies for key areas such as workforce, risk management and data sharing.

2.3.9 The proposed national performance indicators do not allow clear measurement of the progress required to transfer the balance of care to the community and the linking of indicators to outcomes is incomplete such that it will be difficult to measure success.

2.3.10 The role of localities still needs to be fully developed.

2.4 Based on this, the Audit Scotland report outlines three key recommendations:

2.4.1 Partners need to set out clearly how governance arrangements will work in practice. NHS Boards and Councils therefore need to be clear about how local arrangements will work in practice, including developing a shared understanding of roles and responsibilities. In addition, IJB members will need comprehensive training and development in order to help them effectively fulfil their role.

2.4.2 Strategic plans should deliver care in different ways that better meets people's needs and improves outcomes, clearly setting out:

a. the total resources, including funding, assets and skills, that they need
b. what success will look like
c. how they will monitor and publicly report on the impact of their plans.

2.4.3 NHS boards and Councils must work with IAs to agree budgets. This should cover both their first year and the next few years in order to

give them the continuity and certainty they need to develop and implement strategic plans.

2.5 The Audit Scotland report highlights the complexity of the change programme supporting health and social care integration and notes that, if reform is to be successful, key issues still need to be addressed. As these relate primarily to governance and resources the report should be considered by the IJB's Audit and Risk Committee for consideration and mitigation, and a further report prepared and brought forward for the IJB.

2.6 This report is the first in a suite of three from Audit Scotland. The second in the series has been published in April 2016 and focuses on changing models of health and social care.

2.7 The IJB Audit Committee considered this report on the 27 May 2016. After a wide ranging discussion, there was no direction to amend the responses to the recommendations.

3. Recommendations

3.1 Note and comment on the Audit Scotland Report on Health and Social Care Integration

3.2 Note and comment on the local actions detailed in Appendix 1.

3.3 Remit the Action Plan to the IJB meeting on 8 June 2016 for approval.

4. Conclusions

4.1 The Audit Scotland report gives a national overview of the emerging issues and risks as the Public Bodies legislation begins to be implemented across Scotland. Shetland is fortunate that our long and successful track record of joint and partnership working gives strong foundation for the new governance and planning challenges, however it is clearly prudent that the Audit Committee of the IJB is able to review the recommendations and respond appropriately.

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21 April 2016

Appendices
Appendix 1- Draft Action Plan
Appendix 2 - Audit Scotland report on Health and Social Care Integration

Shetland Health and Social Care Partnership response to Audit Scotland Report on

HEALTH & SOCIAL CARE INTEGRATION

	Recommendation	Local response	Proposed local action	Owner (for IJB)
	Integration Authorities Should:			
1	Provide clear and strategic leadership to take forward the integration agenda; this includes: a. developing and communicating the purpose and vision of the IJB and its intended impact on local people b. having high standards of conduct and effective governance, and establishing a culture of openness, support and respect	a. The purpose of the IJB is set out in legislation. This and the vision of the IJB have been shared as part of the Strategic Planning process. b. The decision to establish the IJB was taken following a series of workshops and seminars involving a wide range of stakeholders to promote an understanding of the aims of integration. The IJB induction programme included sessions on the Strategic Plan – vision and outcomes and a number of sessions on different aspects of governance. Open discussion is promoted at meetings of the IJB and reports are comprehensive in terms of implications and impact on communities.	a. Regularly review the Strategic Plan which outlines the purpose and vision of the IJB. Ongoing review of range and methods of communication in order to inform the public regarding vision of IJB b. Continued Organisational Development activity to support further embedding of shared values among all IJB members and staff working in health and social care. Continuing to use the Joint Staff Forum as a mechanism to improve openness, support and respect.	Integration Joint Board & Chief Officer

2	Set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: a. setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice b. ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB	a. Addressed via Schemes of Delegation and IJB Code of Conduct. b. Seminars held prior to IJB going live to discuss governance and with third and independent sector to discuss partnership working. Comprehensive induction programme completed for all members and individual sessions with members regarding registers of interests and declaring any conflicts	a. Build information sharing and refresher training on the Scheme of Administration and other governance documents into an annual OD plan for the IJB. b. Ongoing training and development, including induction programmes for new IJB members	Integration Joint Board & Chief Officer

	Recommendation	Local response	Proposed local action	Owner (for IJB)
3	Ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: a. setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required. b. ensuring relationships between the IJB, its partners and the public are clear so each knows what to expect of the other	a. The Integration Scheme sets out the legislative context for the functions delegated to the IJB. An updated schedule can be taken to the IJB on an annual basis. The IJB will receive papers on key legislative and policy changes. b. Developed a Participation and Engagement Strategy in line with legislative requirements and agreements made in the Integration Scheme.	a. Regularly review IJB Standing Orders and Schemes of Delegation with Committees and Officers to ensure compatibility with relevant legislation. b. Develop a Communications Strategy	Integration Joint Board & Chief Officer & Chief Financial Officer
4	Be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: a. developing and maintaining open and effective mechanisms for documenting evidence for decisions b. putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice c. developing and maintaining an effective audit committee d. ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints e. ensuring that an effective risk management system in place	a. Routinely publish outcomes of engagement activity, IJB papers, minutes and agendas. b. Standing orders are in place for the IJB and its Committees. c. Audit Committee established by IJB with clear terms of reference. d. Complaints handling approach is in place, subject to further development given pending changes to complaints legislation at a national level. e. Risk Management Strategy and systems in place and subject to regular review.	a. Continue with current process including the Joint Staff Forum. b. Need to develop a local Code of Conduct. c. Continue with established process d. Local work commencing to ensure robustness in current process. e. Continue with current process.	Chief Officer & Chief Financial Officer

	Recommendation	Local response	Proposed local action	Owner (for IJB)
5	Develop strategic plans that do more than set out the local context for the reforms; this includes: a. how the IJB will contribute to delivering high-quality care in different ways that better meet people's needs and improves outcomes b. setting out clearly what resources are required, what impact the IJB wants to achieve, and how the IA will monitor and publicly report their progress c. developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils d. making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act	(a) and (b) Addressed via the Strategic Plan and development of Performance Framework c. Organisation Development and Workforce Development Strategy in development with support from NHS and Council HR. Risk Management Strategy developed. Engagement Strategy developed. Data Sharing Agreement in place. d. Addressed via the Strategic Plan	(a) and (b) Addressed via the Strategic Plan and development of Performance Framework. c. Complete the Joint OD and Workforce Strategy. d. These elements will be strengthened in Strategic Plan updates. The Community Empowerment (Scotland) Act forms an important part of the engagement strategy and locality planning (community led conversations). The Strategic Plan will set out the links with Children and Young People (Scotland) Act including named person and Children's Plan.	Integration Joint Board & Chief Officer

	Recommendation	Local response	Proposed local action	Owner (for IJB)
6	Develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: a. developing financial plans for each locality, showing how resources will be matched to local priorities b. ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively	a. Need to develop local framework. b. Performance monitoring and financial monitoring arrangements in place.	a. Framework and process for locality budgeting and local financial planning in development b. Need to develop Best Value Framework	Chief Financial Officer
7	Shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.	Addressed by Strategic Plan	Joint OK and Workforce Strategy currently being developed. Joint training plan in place.	Chief Officer
	Integration authorities should work with councils and NHS boards to:			
8	Recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early on in the relationship and that a shared understanding of the roles and objectives is maintained	Addressed by Scheme of Integration, with clear process in place for dispute resolution. Liaison group established for the chair of the IJB, the chief officer and the chief executives of the NHS board and Council; NHS Chair and Convener of the Council with planning and governance support.	IJB Membership role descriptor needs to include detail for IJB Chair	Chief Officer
9	Review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils	Combined IJB, NHS and Council Clinical Care and Professional Governance Committee and supporting structure described and in place	Evaluate effectiveness of joint arrangements	Chief Officer & Chief Social Work Officer

	Recommendation	Local response	Proposed local action	Owner (for IJB)
10	Urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners	Budgets agreed for 2016/17 – indicative for NHS	Present updated final version of the Strategic Plan and budget to IJB in June 2016 once NHS budget agreed by Scottish Government	Chief Officer & Chief Financial Officer
11	Establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and care services	IJB seminars have been open to Councillors and NHS non-executives – particularly to develop 2016/17 budgets. Regular performance management reports are available to members of NHS and Council	Ensure engagement continues through the year	Chief Officer & Chief Financial Officer
12	Put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	Data sharing agreements in place	Continue to liaise with Council and Health Board to review existing data sharing agreements and amendments or expansions required	Chief Officer & Chief Financial Officer
	The Scottish Government:			
13	Work with Integration Authorities to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services	Performance Framework in place	Continue to engage with Scottish Government in development of format of statutory annual performance report	Chief Officer
14	Work with Integration Authorities to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system	National guidance on performance reporting issue for comment	Continued engagement with Scottish Government, Shetland Islands Council and NHS Shetland on reporting frameworks and requirements	Chief Officer

	Recommendation	Local response	Proposed local action	Owner (for IJB)
15	Monitor and publicly report on national progress on the impact of integration. This includes: a. Measuring progress in moving care from institution al community settings, reducing local variation in costs and using anticipatory care plans b. Reporting on how resources are being used to improve outcomes and how this has changed over time c. Reporting on expected costs and savings result from integration	Integration Joint Boards are expected to submit first performance reports in April 2017 which will inform a national overview. Local performance monitoring framework includes quarterly reports discussed in public and linked to national outcomes	Consider likely requests from Scottish Government in development of local performance frameworks	Chief Officer
16	Continue to provide support to Integration Authorities as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.	Development sessions offered to IJB Chairs and Chief Officers Continue support for support staff involved in commissioning and governance arrangements	Await further information from Scottish Government Continue to attend national events as appropriate	Chief Officer

Health and social care series

Health and social care integration

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
December 2015

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Contents

Key facts

Over **£8 billion**

Health and social care resources will be delegated to integration authorities in 2016/17

18-29 per cent

Scottish Government estimate of the increase in the need for health and social care services between 2010 and 2030

31

Integration authorities are required to be operating by April 2016

£138-£157m

Scottish Government estimates of annual savings from integration

9

National outcomes that integration authorities are required to contribute towards

Summary

Key messages

1 The Public Bodies (Joint Working) (Scotland) Act 2014 introduces a significant programme of reform affecting most health and care services and over £8 billion of public money. The reforms aim to ensure services are well integrated and that people receive the care they need at the right time and in the right setting, with a focus on community-based and preventative care. The reforms are far reaching, creating opportunities to overcome previous barriers to change.

2 We found widespread support for the principles of integration from the individuals and organisations implementing the changes. The Scottish Government has provided support to partnerships to establish the new arrangements, including detailed guidance on key issues and access to data to help with strategic planning. Stakeholders are putting in place the required governance and management arrangements and, as a result, all 31 integration authorities (IAs) are expected to be operational by the statutory deadline of 1 April 2016.

3 Despite this progress, there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services. There is evidence to suggest that IAs will not be in a position to make a major impact during 2016/17. Difficulties in agreeing budgets and uncertainty about longer-term funding mean that they have not yet set out comprehensive strategic plans. There is broad agreement on the principles of integration. But many IAs have still to set out clear targets and timescales showing how they will make a difference to people who use health and social care services. These issues need to be addressed by April 2016 if IAs are to take a lead in improving local services.

4 There are other important issues which also need to be addressed. The proposed governance arrangements are complex, with some uncertainty about how they will work in practice. This will make it difficult for staff and the public to understand who is responsible for the care they receive. There are significant long-term workforce issues. IAs risk inheriting workforces that have been organised in response to budget pressures rather than strategic needs. Other issues include different terms and conditions for NHS and council staff, and difficulties in recruiting and retaining GPs and care staff.

there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services

Recommendations

Stakeholders have done well to get the systems in place for integration, but much work remains. If the reforms are to be successful in improving outcomes for people, there are other important issues that need to be addressed:

- Partners need to set out clearly how governance arrangements will work in practice, particularly when disagreements arise. This is because there are potentially confusing lines of accountability and potential conflicts of interests for board members and staff. There is a risk that this could hamper the ability of an IA to make decisions about the changes involved in redesigning services. People may also be unclear who is ultimately responsible for the quality of care. In addition, Integration Joint Board (IJB) members need training and development to help them fulfil their role.

- IAs must have strategic plans that do more than set out the local context for the reforms. To deliver care in different ways, that better meets people's needs and improves outcomes, IAs need to set out clearly:
  - the resources, such as funding and skills, that they need
  - what success will look like
  - how they will monitor and publicly report on the impact of their plans.
- NHS boards and councils must work with IAs to agree budgets for the new IAs. This should cover both their first year and the next few years to give them the continuity and certainty they need to develop and implement strategic plans. IAs should be clear about how they will use resources to integrate services and improve outcomes.

Integration authorities need to shift resources, including the workforce, towards a more preventative and community-based approach. Even more importantly, they must show that this is making a positive impact on service users and improving outcomes.

A more comprehensive list of recommendations is set out in (Part 4).

Background

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) sets out a framework for integrating adult health and social care services. Social care services include supporting people to live their daily lives and helping them with basic personal care like washing, dressing and eating. People are living longer and the number of people with long-term conditions such as diabetes, and complex needs, such as multiple long-term conditions, is increasing. Current health and social care services are unsustainable; they must adapt to meet these changing needs. This means shifting from hospital care towards community-based services, and preventative services, such as support to help prevent older people from falling at home or to encourage people to be more active.

2. Integrating health and social care services has been a key government policy for many years. Despite this, there has been limited evidence of a shift to more community-based and preventative services. The Act sets out an ambitious programme of reform affecting most health and social care services. The scale and pace of the changes anticipated are significant, with a focus on changing how people with health and social care needs are supported.

3. The Act creates new partnerships, known as IAs, with statutory responsibilities to coordinate local health and social care services. The Act puts in place several national outcomes for health and social care and IAs are accountable for making improvements to these outcomes. The Act also aims to ensure that services are integrated, taking account of people's needs and making best use of available resources, such as staff and money. Each IA must establish at least two localities, which have a key role, working with professionals and the local community to develop services local people need.

4. IAs are currently at various stages in their development; all are required to be operational, that is taking on responsibility for budgets and services, by April 2016. The Scottish Government has estimated that IAs will oversee annual budgets totalling over £8 billion, around two-thirds of Scotland's spending on health and social work.

About this audit

5. This is the first of three planned audits of this major reform programme. Subsequent audits will look at IAs' progress after their first year of being established, and their longer-term impact in shifting resources to preventative services and community-based care and in improving outcomes for the people who use these services.

6. This first audit provides a progress report during this transitional year. We reviewed progress at this relatively early stage to provide a picture of the emerging arrangements for setting up, managing and scrutinising IAs as they become formally established. This report highlights risks that need to be addressed as a priority to ensure the reforms succeed. The audit is based on fieldwork that was carried out up to October 2015. We hope that the issues raised in the report are timely and helpful to the Scottish Government and local partners as they continue to implement the Act.

7. We gathered audit evidence by:

- reviewing documents available at the time of our work, including integration schemes, strategic plans, and local progress reports on integration arrangements[1]
- drawing on the work of local auditors, the Care Inspectorate, and Healthcare Improvement Scotland
- issuing a short questionnaire to IAs on their timetable for reaching various milestones

- interviewing stakeholders who included, board members, chief officers and finance officers from six IAs, and representatives from the Scottish Government, the British Medical Association, the voluntary sector, the Convention of Scottish Local Authorities and NHS Information Services Division.[2]

Appendix 1 provides further information on our audit approach.

8. This work builds on previous audits that have examined joint working in health and social care. For example, our *Review of Community Health Partnerships* [PDF] highlighted the organisational barriers to improving partnership working between NHS boards and councils, and the importance of strong, shared leadership across health and social care.[3] Our subsequent report *Reshaping care for older people* [PDF] found continuing slow progress in providing joined up health and social care services.[4] This lack of progress in fundamentally shifting the balance of care from hospital to community settings, coupled with the unsustainability of current services, mean that there is a pressing need for this latest reform programme to succeed.

9. The Accounts Commission and Auditor General are currently conducting two other audits which complement this work:

- *Changing models of health and social care* examines the financial, demographic and other pressures facing health and social care and the implications of implementing the Scottish Government's 2020 vision for health and social care. We will publish the report in in spring 2016.

- *Social work in Scotland* will report on the scale of the financial and demand pressures facing social work. It will consider the strategies councils and integration authorities are adopting to address these challenges, how service users and carers are being involved in designing services, and leadership and oversight by elected members. We will publish the report in summer 2016.

Part 1

Expectations for integrated services

Integration authorities will oversee more than £8 billion of NHS and care resources

10. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a significant programme of reform for the Scottish public sector. It creates a number of new public organisations, with a view to breaking down barriers to joint working between NHS boards and councils. Its overarching aim is to improve the support given to people using health and social care services.

11. These new partnerships will manage more than £8 billion of resources that NHS boards and councils previously managed separately. Initially, service users may not see any direct change. In most cases, people seeking support will continue to contact their GP or social work services. But, behind the scenes, IAs are expected to coordinate health and care services, commissioning NHS boards and councils to deliver services in line with a local strategic plan. Over time, the intention is that this will lead to a change in how services are provided. There will be a greater emphasis on preventative services and allowing people to receive care and support in their home or local community rather than being admitted to hospital.

Change is needed to help meet the needs of an ageing population and increasing demands on services

12. Around two million people in Scotland have at least one long-term condition, and one in four adults has some form of long-term illness or disability. These become more common with age (Exhibit 1, page 10). By the age of 75, almost two-thirds of people will have developed a long-term condition.[5] People in Scotland are living longer. Combined life expectancy for males and females at birth has increased from 72 to 79 years since 1980, although there are significant variations across Scotland, largely linked to levels of deprivation and inequalities.[6] The population aged over 75 years is projected to increase by a further 63 per cent over the next 20 years.[7]

13. The ageing population and increasing numbers of people with long-term conditions and complex needs have already placed significant pressure on health and social care services. The Scottish Government estimates that the need for these services will rise by between 18 and 29 per cent between 2010 and 2030.[8] In the face of these increasing demands, the current model of health and care services is unsustainable:

- The Scottish Government has estimated that in any given year just two per cent of the population (around 100,000 people) account for 50 per cent of hospital and prescribing costs, and 75 per cent of unplanned hospital bed days.

the significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services

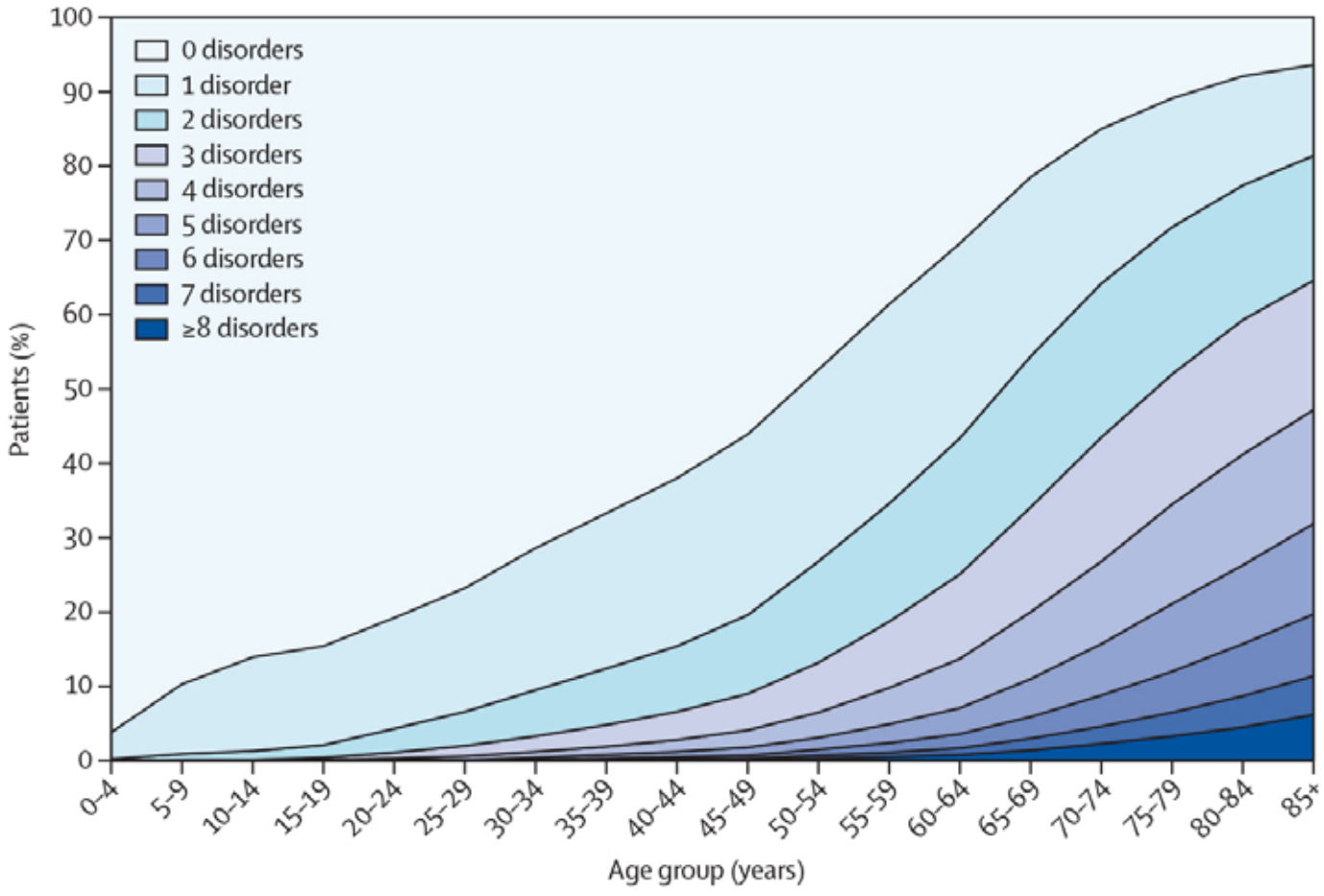
- A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place. In 2014/15, this led to the NHS in Scotland using almost 625,000 hospital bed days for patients ready to be discharged.[9]

14. As a result of these pressures, there is widespread recognition that health and social care services need to be provided in fundamentally different ways. NHS boards, councils and the Scottish Government have focused significant efforts on initiatives to reduce unplanned hospital admissions and delayed discharges, yet pressures on hospitals remain. There needs to be a greater focus on anticipatory care, helping to reduce admissions to hospitals. There also needs to be better support to allow people to live independently in the community.

Exhibit 1

Long-term conditions by age

The number of long-term conditions that people have increases with age.



Source: Reprinted with permission from Elsevier (*The Lancet*, 2012, 380, 37-43)

15. None of this is unique to Scotland. Other parts of the UK and Europe face similar challenges. There have been various responses across the UK, but all try to deal with the changing needs of an ageing population, putting more emphasis on prevention and anticipatory care and seeking to shift resources from hospitals to community-based care.

16. A series of initiatives in Scotland over recent years has aimed to encourage a more joined-up approach to health and social care (Exhibit 2). Perhaps the most significant of these was creating Local Health Care Cooperatives (LHCCs) in 1999 and replacing them with Community Health Partnerships (CHPs) in 2004. While these reforms led to some local initiatives, LHCCs and CHPs lacked the authority to redesign services fundamentally. As a result, they had limited impact in shifting the balance of care, or in reducing admissions to hospital or delayed discharges.[10]

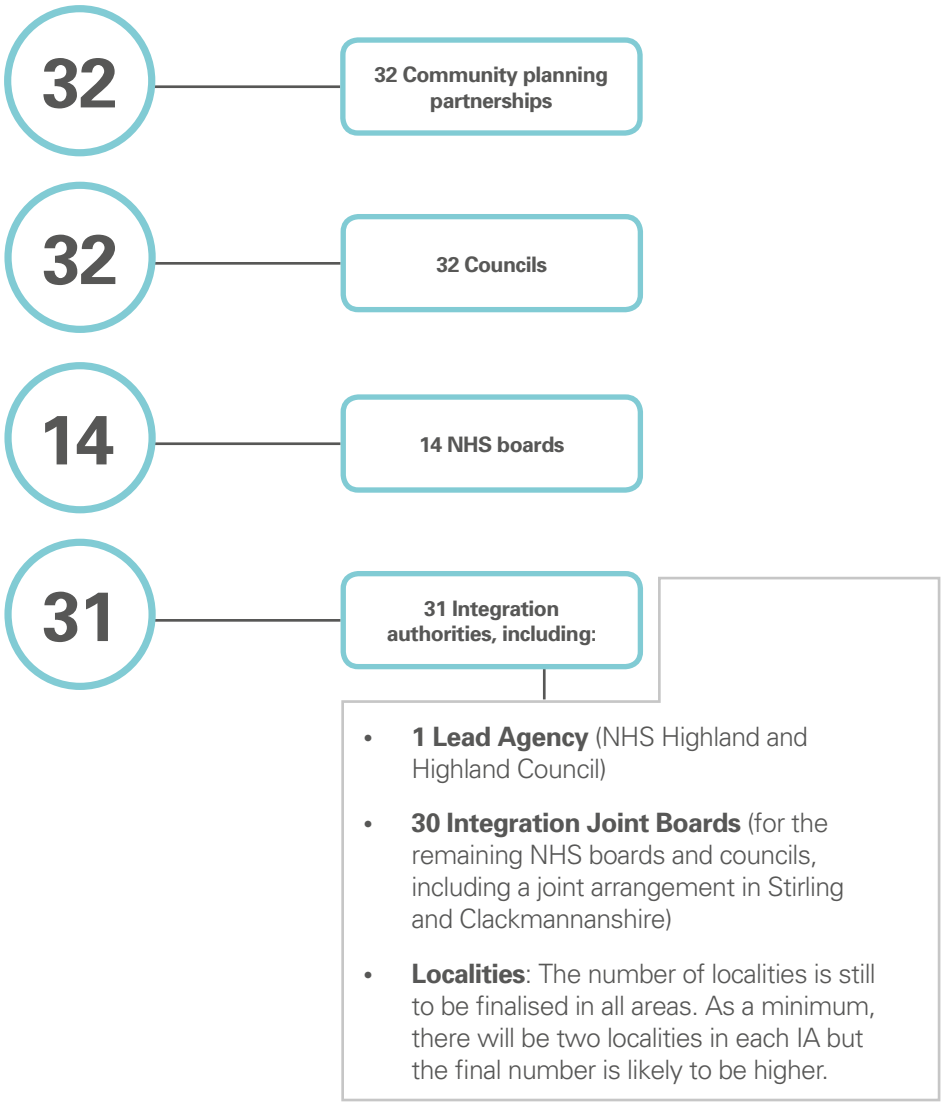
Exhibit 2
A brief history of integration in Scotland

1999	Seventy-nine **Local Health Care Cooperatives (LHCCs)** established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.
2002	**Community Care and Health (Scotland) Act** introduced powers, but not duties, for NHS boards and councils to work together more effectively.
2004	**NHS Reform (Scotland) Act**, required health boards to establish CHPs, replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs, and secondary healthcare, such as hospital services, and between health and social care.
2005	**Building a Health Service Fit for the Future: National Framework for Service Change**. This set out a new approach for the NHS that focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.
2007	**Better Health, Better Care** set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.
2010	**Reshaping Care for Older People Programme** launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.
2014	**Public Bodies (Joint Working) (Scotland) Act** introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services.
2016	All integration arrangements set out in the 2014 Act must be in place by 1 April 2016.

Source: Audit Scotland

17. The relative lack of progress of earlier attempts at integration led to the Public Bodies (Joint Working) (Scotland) Act 2014. This is the first attempt in the UK to place a statutory duty on the NHS and councils to integrate health and social care services. The Act abolished CHPs, replacing them with a series of IAs (Exhibit 3, page 12). These bodies will manage budgets for providing all integrated services. Most will not initially employ staff, but instead direct NHS boards and councils to deliver services in line with a strategic plan.

Exhibit 3
The public sector bodies overseeing health and social care services



Note: See Exhibit 4 for details of Integration Joint Board and lead agency approaches.
Source: Audit Scotland

The Scottish Government has set out a broad framework that allows for local flexibility

18. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a broad framework for creating IAs. The Act and the supporting regulations and guidance give councils and NHS boards a great deal of flexibility, allowing them to develop integrated services that are best suited to local circumstances. The main aspects of this flexible framework follow below.

Timing for establishing the new integration authorities
19. Scottish ministers must formally approve integration schemes for IAs: these set out the scope of services that are to be integrated and broad management and governance arrangements, including the structures and processes for

decision-making and accountability, controls and behaviour. Within this overall framework, IAs can choose when they become operational but all IAs must be established and operational, with delegated responsibility for budgets and services, by 1 April 2016.[11] Subject to the approval of their integration scheme, they can take on delegated responsibility for budgets and services at any time between April 2015 and 1 April 2016.

Scope of services to be integrated

20. Councils and NHS boards are required to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. The hospital services included in integration are the inpatient medical specialties that have the largest proportion of emergency admissions to hospital. These include:

- accident and emergency services
- general medicine
- geriatric medicine
- rehabilitation medicine
- respiratory medicine
- psychiatry of learning disability
- palliative care
- addiction and substance dependence service
- mental health services and services provided by GPs in hospital.

Other, non-integrated, hospital services continue to be overseen directly by NHS boards. The Act also allows NHS boards and councils to integrate other areas of activity, such as children's health and social care services and criminal justice social work.

How IAs are structured

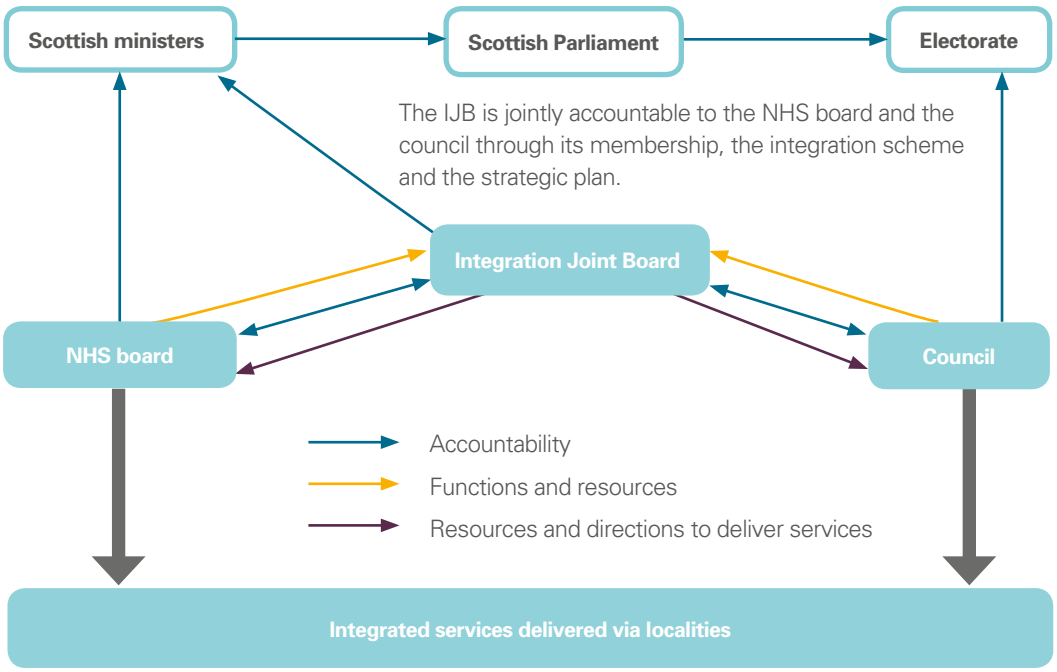
21. IAs will be responsible for overseeing certain functions that are delegated from the local NHS board and council(s). IAs can follow one of two main structural models (Exhibit 4, page 14).

22. All areas, apart from Highland, are planning to follow the body corporate model, creating an Integration Joint Board to plan and commission integrated health and social care services in their areas. IJBs are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. Partners will need to understand the implications of differences between how councils and NHS boards carry out their business, so they are able to fulfil their duties. For example:

- IJBs must appoint a finance officer. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

Exhibit 4
Integration authorities will follow one of two main models

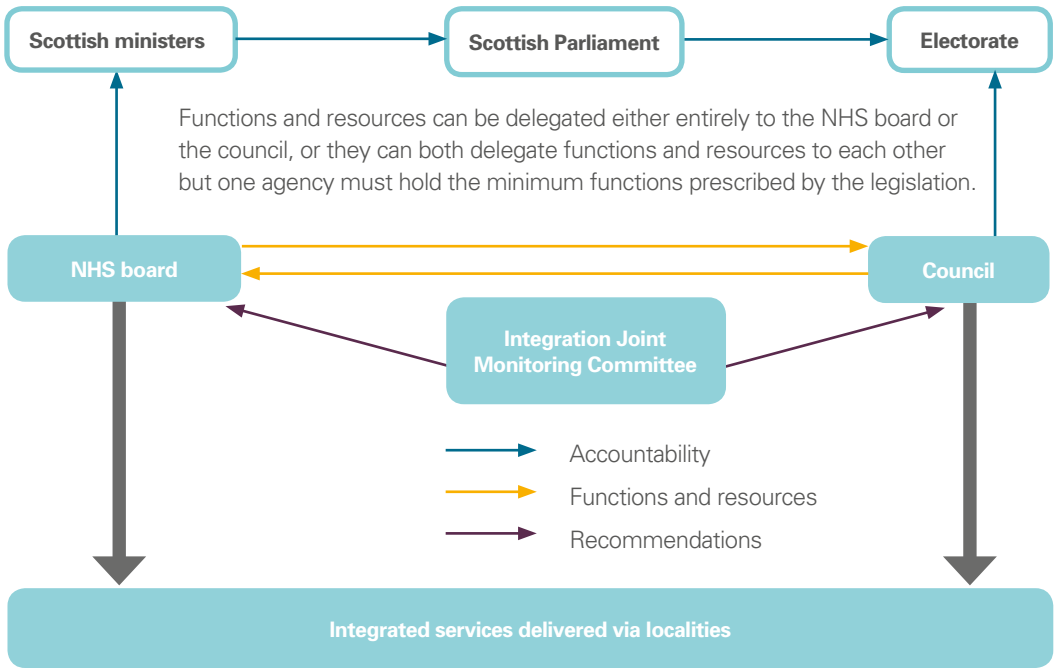
Body corporate or Integration Joint Board model



Body corporate

- NHS boards and councils delegate health and social care functions to an Integration Joint Board (IJB)
- The Act allows for partners to work jointly, for example, for two councils to work with their local NHS board to create a single IJB

Lead agency model



Lead agency

- NHS boards and councils delegate some of their functions to each other
- Carrying out of functions is overseen and scrutinised by an Integration Joint Monitoring Committee

Source: Audit Scotland

- The way local government bodies make decisions differs to NHS boards. Local government bodies in Scotland must take corporate decisions. There is no legal provision for policies being made by individual councillors.

- A statutory duty of Best Value applies to IJBs.

23. NHS boards and councils delegate budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs the NHS board and council to deliver services in line with this plan. Only Highland has chosen the lead agency model, continuing arrangements established in earlier years for integrated services.[12] Under powers first set out in the Community Care (Scotland) Act 2002, NHS Highland is the lead for adult health and care services, with Highland Council the lead for children's community health and social care services. This provides continuity with lead agency arrangements in place in Highland since 2012. The council and the NHS board cannot veto decisions taken by the lead agency. Instead, as required by the legislation, they have established an integration joint monitoring committee (IJMC). The IJMC cannot overturn a decision made by the council or NHS board, but it can monitor progress in integrating services and make recommendations.

24. Whichever model is chosen, the underlying objective remains the same. The IA is expected to use resources to commission coordinated services that provide care for individuals in their community or in a homely setting and avoid unnecessary admissions to hospital.

Membership of Integration Joint Boards (IJBs)

25. For the IAs that follow the body corporate model, board members of IJBs are a mix of voting and non-voting members. Councils and NHS boards are each required to nominate at least three voting members. The NHS board and council can nominate more members, but both partners need to agree to this and the number from each body needs to be equal. The NHS board nominates non-executive directors to the IJB, and the council nominates councillors. Where the NHS board is unable to fill their places with non-executive directors, it is able to nominate other members of the NHS board. At least two of the NHS members should be non-executive directors. The IJB should also include non-voting members, including a service user and a representative from the voluntary sector (Exhibit 5, page 16).[13]

26. Initially, IJBs are not expected to directly employ staff, operating only as strategic commissioning bodies.[14] This may change over time as the Act allows IJBs to employ staff, but this needs to be approved by Scottish ministers, rather than decided locally. A chief officer and finance officer provide support for the IJB, but they are employed by either the council or NHS board and seconded to the IJB. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

Scrutinising integrated health and social care

27. Various scrutiny bodies have an interest in the integration of health and social care:

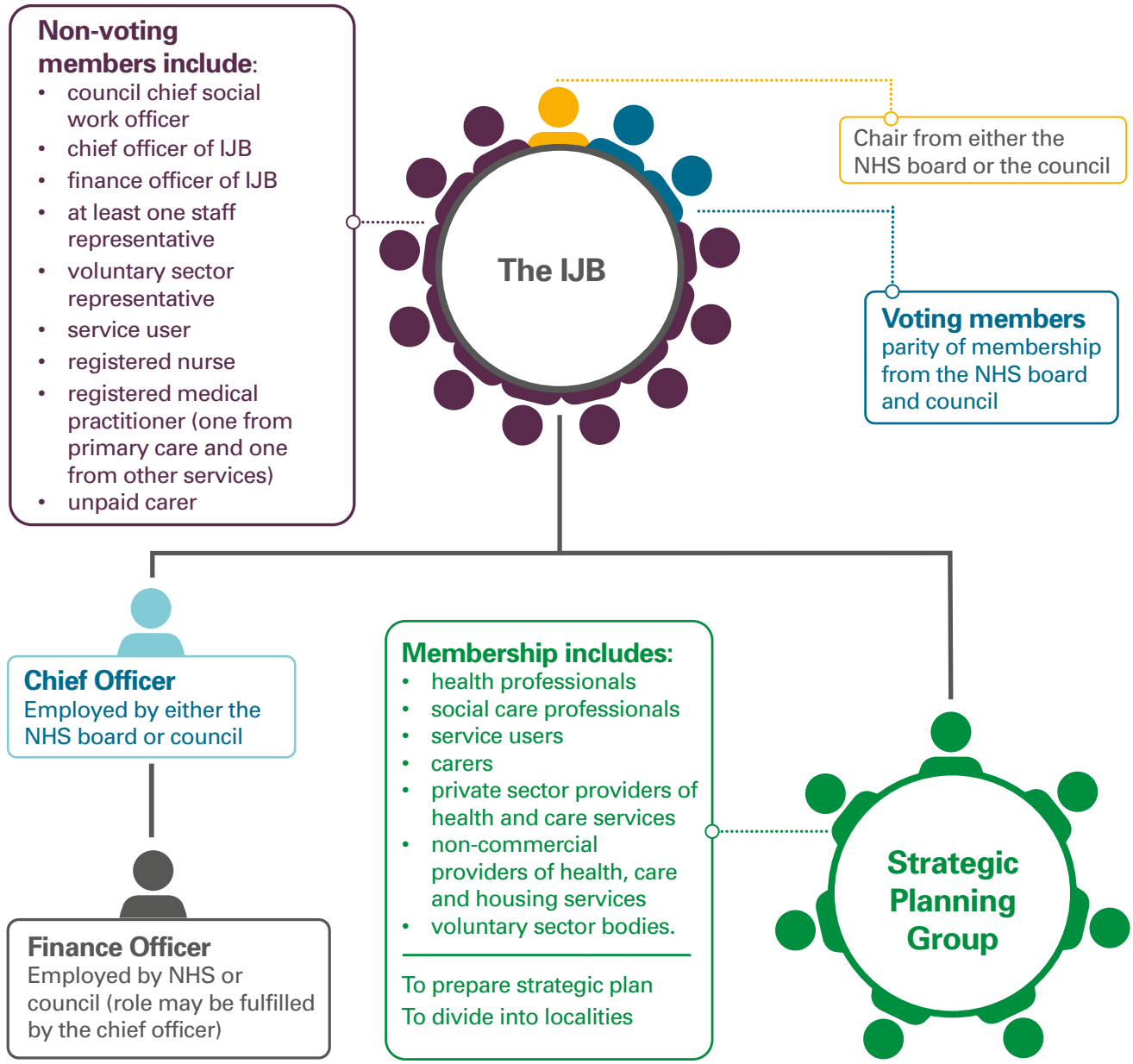
- The Accounts Commission is responsible for appointing auditors to IJBs and so has an interest in financial management and governance arrangements. As local government bodies, IJBs are also covered by the duty of Best Value as set out in the Local Government in Scotland Act 2003. The Accounts Commission has the power to audit the extent to which local government bodies are discharging their Best Value duty.

- Health and social integration is a significant national policy development. Therefore, the Auditor General for Scotland (alongside the Accounts Commission) has an audit interest in the extent to which it is being implemented at a national and local level, and in its impact on NHSScotland.

- The Care Inspectorate and Healthcare Improvement Scotland are responsible for scrutinising and supporting improvement in health and care services. Both organisations inspect individual services and work together to perform joint inspections of health and care services. These organisations will inspect the planning, organisation or coordination of

Exhibit 5

Organisation chart for a typical IJB



Source: Audit Scotland

integrated health and social care services. From April 2017, the Care Inspectorate and Healthcare Improvement Scotland are required by legislation to assess progress in establishing joint strategic commissioning and the early impact of integration.

Implications for the public, voluntary and private sectors

28. The significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services. Integration is part of the Scottish Government's focus on developing person-centred care. This is aimed at improving services, ensuring people using health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. The aim is that this will result in improved outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities.

29. Health and social care integration is complex and it is important that IAs engage with the public on an ongoing basis so that they understand the purpose of integration and are able to influence the way services change. People may not see a significant difference in the services they receive immediately, but the reforms are focused on making better use of all health and social care services. Therefore there are implications for how people use services, for example GP, A&E and community-based services. If the reforms are to be successful, IJBs, NHS boards and councils need to involve people in decisions about the implications for local services. To help with this, there is a requirement that a service user and unpaid carer are members of the IJB and that IJBs consult and engage with local people as they develop their strategic and locality plans. It is also important that IAs are clear about how they link into the wider community planning process.

30. It is not only statutory services that need to change, other providers need to be involved. Voluntary and private sector providers employ two-thirds of the social services workforce and provide many social care services across Scotland. They are significant partners in developing integrated services, with the voluntary sector represented on the IJB as a non-voting member. Our previous report *Self-directed support* [PDF] highlighted some of the ways that councils have started to change how they work with the voluntary and private sectors.[15] There are lessons here for IJBs.

Localities

31. The Act requires IAs to divide their area into at least two localities, but they can choose to create more. Localities have an important role in reforming how to deliver services. They bring together local GPs and other health and care professionals, along with service users, to help plan and decide how to make changes to local services. A representative from each locality is expected to be part of the IA's strategic planning group, helping to ensure that specific local needs are taken into account. Localities also have a consultative role. When an IA is planning a change that is likely to affect service provision in a locality significantly, it must involve representatives of the local population in that decision.

32. As part of their role in planning services, localities are expected to plan expenditure on integrated health and social care services in their area, based on local priorities and to help shift resources towards preventative and community-based health and care services.

Outcomes and performance measures

33. IAs are required to contribute towards nine national health and wellbeing outcomes (Exhibit 6). These high-level outcomes seek to measure the quality of health and social care services and their impact in, for example, allowing people to live independently and in good health, and reducing health inequalities. This is the first time that outcomes have been set out in legislation, signalling an important shift from measuring internal processes to assessing the impact on people using health and social care services. IAs are required to produce an annual performance report, publicly reporting on the progress they have made towards improving outcomes.

The Scottish Government is providing resources to help support integration

34. The integration of health and social care is a complex reform and the Scottish Government is providing support to help organisations as they establish the new arrangements. The Scottish Government will provide more than £500 million over the three years from 2015/16 to 2017/18 to help partnerships establish new ways of working that focus on prevention and early intervention in a bid to reduce

Exhibit 6

National health and wellbeing outcomes

IAs are required to contribute to achieving nine national outcomes.

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

Source: National Health and Wellbeing Outcomes, Scottish Government

long-term costs. This money is not directly to support integration, but to continue initiatives that were already under way to improve services. The money is made up as follows:

- £300 million is an integrated care fund to help partnerships achieve the national health and wellbeing outcomes and move towards preventative services
- £100 million to reduce delayed discharges
- £30 million for telehealth
- £60 million to support improvements in primary care
- £51.5 million for a social care fund.

35. The Scottish Government has provided guidance to partnerships, covering issues such as strategic commissioning of health and care services, clinical and care governance, and the role of housing services and the voluntary sector. The timescales to implement the Act are tight. For some partnerships, guidance came too late. For example, the Scottish Government issued its guidance on localities in July 2015, yet localities play an important part in strategic plans and many partnerships had already begun the strategic planning process by then. The Scottish Government plans to issue further guidance on performance reporting late in 2015. However, for some areas this is coming too late – the three Ayrshire IJBs will present their first performance reports on or before 2 April 2016 and are developing these in advance of the guidance being issued.

36. The Scottish Government is supplementing this formal guidance with a series of support networks for IJB chairs and finance officers, such as regular learning events, and through the work of the Joint Improvement Team (JIT), including support for IJBs in developing their strategic plans.[16] Healthcare Improvement Scotland and the Care Inspectorate are currently developing a support programme for IAs, tailoring training and development events to fit local needs.

37. IAs are also being supported by the Information Services Division (ISD) of NHS National Services Scotland. ISD is creating a single source of data on health, social care and demographics. It is making this information available to NHS boards, councils and IAs to help them to gain a better understanding of:

- the needs of their local population
- current patterns of care
- how resources are being used.

38. This is the first time this detailed information on activity and costs will be routinely available to partnerships to help them with strategic planning. It will also help inform decisions on how to better use resources to improve outcomes for service users and carers. ISD is also providing data and analytical support through a Local Intelligence Support Team initiative, where partnerships can have an information specialist from ISD working with them in their local area.

Part 2

Current progress

Integration authorities are being established during 2015/16

39. Thirty-one IAs are being established, with one for each council area and a shared one between Clackmannanshire and Stirling. All partners submitted their draft integration schemes to Scottish ministers by the April 2015 deadline. Some, such as East Dunbartonshire, already plan to extend the scope of services being integrated and will resubmit their integration scheme for approval. By October 2015, 25 integration schemes had been formally approved, with the remainder expected to be agreed by the end of 2015.

40. By October 2015, six IAs had been established and taken on operational responsibility for budgets and services (Exhibit 7, page 21). The remaining IAs plan to be operational just before the statutory deadline, in March and April 2016.

Most integration authorities will oversee more than the statutory minimum services, and their responsibilities vary widely

41. The Act requires councils and NHS boards to integrate adult health and social care services. But it also allows them to integrate other services, such as children's health and social care services and criminal justice social work services.

42. The scope of the services being integrated varies widely across Scotland. Almost all the IAs will oversee more than the minimum requirement for health services, mainly by including some aspects of children's health services. But there is a wide range in responsibilities for other areas, such as children's social work services, criminal justice social work services, and planned acute health services (Exhibit 8, page 22). These differences in the scope of services included create a risk of fragmented services in some areas. Good clinical and care governance arrangements will be important to ensure that vulnerable people using integrated and non-integrated services experience high standards of care.

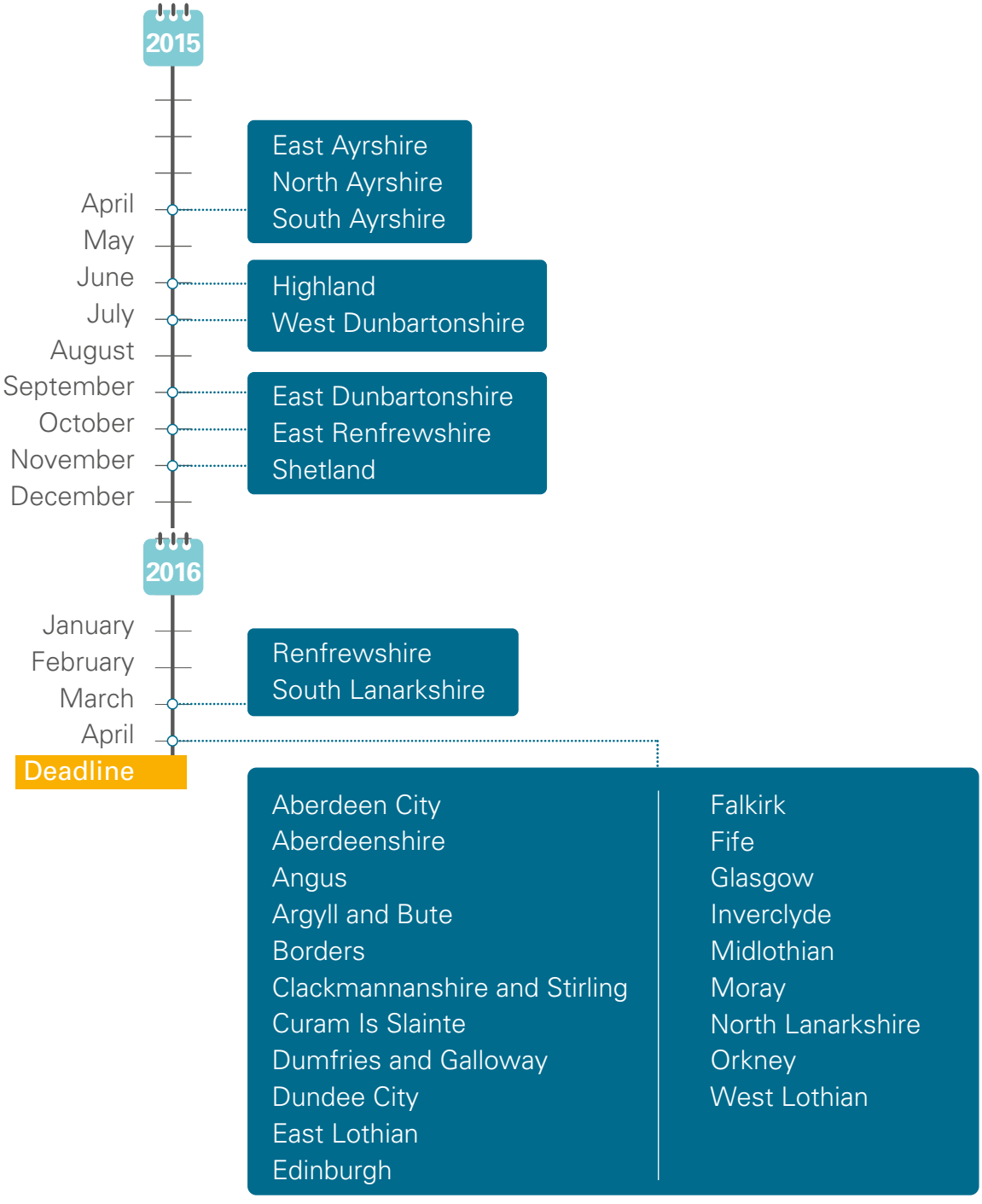
the scope of the services being integrated varies widely across Scotland

43. Among the variations the most notable are in Argyll and Bute IJB and Dumfries and Galloway IJB. These IJBs will oversee all NHS acute services, including planned and unplanned hospital services. In theory, this should allow these IJBs to better coordinate all health and care services in their area.

44. Various 'hosting' arrangements are also being implemented across the country. Where the area covered by an NHS board has more than one IJB it is often not practical or cost-effective to set up separate arrangements to deliver services for individual IJBs. This is particularly the case for specialist services, such as certain inpatient mental health services with small numbers of patients or staff. For example, North Ayrshire IJB hosts the following services on behalf of East Ayrshire and South Ayrshire IJBs:

Exhibit 7

Services will be delegated to IAs throughout 2015/16 with most delegating in April 2016



Notes:
1. The date of becoming operational is still to be agreed in Perth and Kinross.
2. Curam Is Slainte is the name for the partnership between NHS Western Isles and Comhairle nan Eilean Siar.

Source: Audit Scotland

Exhibit 8

Additional integrated services

Partnerships are integrating a wider range of services in addition to the statutory minimum.

	Children's social work services	Criminal justice social work services	Children's health services	Planned acute health services
Argyll and Bute	✓	✓	✓	✓
East Ayrshire	✓	✓	✓	–
East Renfrewshire	✓	✓	✓	–
Glasgow	✓	✓	✓	–
Inverclyde	✓	✓	✓	–
North Ayrshire	✓	✓	✓	–
Orkney	✓	✓	✓	–
South Ayrshire	✓	✓	✓	–
West Dunbartonshire	✓	✓	✓	–
Aberdeen City	–	✓	✓	–
Aberdeenshire	–	✓	✓	–
Curam Is Slainte	–	✓	✓	–
East Lothian	–	✓	✓	–
Midlothian	–	✓	✓	–
Moray	–	✓	✓	–
Shetland	–	✓	✓	–
Highland	✓	–	✓	–
Dumfries and Galloway	–	–	✓	✓
Angus	–	–	✓	–
Borders	–	–	✓	–
Clackmannanshire and Stirling	–	–	✓	–
Dundee	–	–	✓	–
East Dunbartonshire	–	–	✓	–
Edinburgh	–	–	✓	–
Falkirk	–	–	✓	–
Fife	–	–	✓	–
North Lanarkshire	–	–	✓	–
Perth and Kinross	–	–	✓	–
Renfrewshire	–	–	✓	–
South Lanarkshire	–	–	✓	–
West Lothian	–	–	✓	–

Key

- Children's social work services
- Criminal justice social work services
- Children's health services
- Planned acute health services

Notes:
1. Criminal justice social work services can include services such as providing reports to courts to assist with decisions on sentencing. Planned acute health services can include services such as outpatient hospital services.
2. The range of children's health services delegated varies by IA. They may include universal services (such as GPs) for people aged under 18, or more specialised children's health services such as school nursing or health visiting, or both universal and specialised services.
3. IAs may also be responsible for additional integrated services not listed here.
4. East Dunbartonshire plan to amend their integration scheme to include children's primary and community health services before 1 April 2016.
5. Where integration schemes have not yet been approved by ministers, the final integration scheme may vary from the information included here.

Source: Scottish Government, 2015 and Audit Scotland, 2015

- inpatient mental health services
- learning disability services
- child and adolescent mental health services
- psychology services
- community infant feeding service
- family nurse partnership
- child health administration team
- immunisation team.

IJBs are appointing voting board members and most have chief officers in post

45. Most IJBs are currently appointing board members. Our review of the 17 IJB integration schemes that Scottish ministers had approved at the time of our audit shows the following:

- Thirteen IJB boards will initially be chaired by a councillor, with the remaining four chaired by a non-executive from the local NHS board.
- Only three areas have chosen to nominate the minimum of three voting members each from the council and NHS board.[17] In 13 schemes, councils and NHS boards have each nominated four voting members. In Edinburgh, the council and NHS board each have five voting members.
- There are also local variations in the number of additional non-voting members. For example, East Renfrewshire has appointed an additional GP member to help provide knowledge on local service needs. In most cases, these variations do not add significantly to the number of IJB board members. But some IJBs have very large boards. For example, Edinburgh has 13 non-voting members, in addition to its ten voting members. The IJB board for Clackmannanshire and Stirling is expected to be even larger, reflecting the joint arrangements between the two council areas, with 12 voting members and around 23 non-voting members.

46. Almost all IJBs have now appointed a chief officer.[18] Edinburgh and Falkirk expect to have their chief officers in post by the end of 2015.[19] Chief officers are employed by either the NHS board or the council and then seconded to the IJB. Terms and conditions of employment vary between councils and NHS boards, so successful candidates choose their preferred employer, based on the packages offered.

Chief officer accountability

47. Accountability arrangements for the IJB chief officer are complex and while there may be tensions in how these arrangements will work in practice, we have attempted to set out the technical arrangements as clearly as possible. The chief officer has a dual role. They are accountable to the IJB for the

responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the NHS board and council for any operational responsibility for integrated services, as set out in the integration scheme.

Accountability to the IJB

- The chief officer is directly accountable to the IJB for all of its responsibilities. These include: strategic planning, establishing the strategic planning group, the annual performance report, the IJB's responsibilities under other pieces of legislation (for example, the Equalities Act and the Public Records Act), ensuring that its directions are being carried out, recommending changes and reviewing the strategic plan.

- Integration schemes can pass responsibility for overseeing the operation of specific services from the NHS board or council to the IJB. In these circumstances, the chief officer is accountable to the IJB for establishing the arrangements to allow it to do this. This includes setting up performance monitoring, reporting structures, highlighting critical failures, reporting back based on internal and external audit and inspection. If the council or NHS board passes responsibility for meeting specific targets to the IJB, the IJB must take this into account during its strategic planning, and the chief officer is accountable for making sure it does so.

Accountability to the NHS board and council

- All integration schemes should set out whether the chief officer also has operational management responsibilities. Where the chief officer has these responsibilities, they are also accountable to the NHS board and the council.

- Where the chief officer has operational management responsibilities, the integration scheme makes the chief officer the responsible operational director in the council and NHS board for ensuring that integrated services are delivered. The chief officer is therefore responsible to the NHS board and council for the delivery of integrated services, how the strategic plan becomes operational and how it is delivered. They are also responsible for ensuring it is done in line with the relevant policies and procedures of the organisation (for example staff terms and conditions).

- Although this is untested, the accountable officers for delivery should still be the chief executives of the NHS board and the council. But they must discharge this accountability through the chief officer as set out in their integration scheme. The chief executives of the NHS board and council are responsible for line managing the chief officer to ensure that their accountability for the delivery of services is properly discharged.

48. Although employed by one organisation only, most chief officers are line managed by the chief executives of both the council and the NHS board. This means that in some NHS board areas the chief executive is line managing several IJB chief officers. South Lanarkshire has adopted a more streamlined approach, where the chief officer reports to both the council and NHS board chief executive, but the organisation that employs the chief officer performs day-to-day line management.

Part 3

Current issues

There is wide support for the opportunities offered by health and social care integration

49. Integrated health and social care offers significant opportunities. These include improving the services that communities receive, the impact these services have on people, improving outcomes and using resources, such as money and skills, more effectively across the health and care system. The Scottish Government expects integrated services to emphasise preventative care and reduce both the level of hospital admissions and the time that some patients spend in hospital. A measure of success will be the extent to which integration has helped to move to a more sustainable health and social care service, with less reliance on emergency care.

50. Because integrated services with a focus on improving outcomes should result in more effective use of resources across the health and social care system, the Scottish Government expects integration to generate estimated annual savings of £138 - £157 million. The savings are as follows:

- Annual savings of £22 million if IAs can meet the current target to limit the delay in discharging patients to no more than two weeks and £41 million if they can reduce this further, to no more than 72 hours.
- Annual savings of £12 million by using anticipatory care plans for people with conditions that put them at risk of an unplanned admission to hospital. These plans provide alternative forms of care to try to avoid people being admitted to hospital.
- Annual savings of £104 million from reducing the variation between different IAs in the same NHS board area. The Scottish Government expects that IAs will identify the inefficiencies that cause costs to vary and, over time, reduce them.[20]

51. The Scottish Government estimated the initial cost of making these reforms to adult services to be £34.2 million over the five years up to 2016/17, and £6.3 million after this. It has not estimated the additional costs, or savings, from integrating other services such as children's health and social care or some criminal justice services.[21] It is unclear whether these anticipated savings will release money that IJBs can invest in more community-based and preventative care or how the Scottish Government will monitor and report progress towards these savings.

widespread support for the policy of health and social care integration, but concerns about how this will work in practice

52. There have been previous attempts at integration, as listed in Exhibit 2 (page 11). Our *Review of Community Health Partnerships* [PDF] highlighted that CHPs had a challenging remit, but lacked the authority needed to implement the significant changes required.[22] We also found limited progress with joint budgets across health and care services. This latest reform programme contains important new elements to help partnerships improve care. The Act:

- provides a statutory requirement for councils and NHS boards to integrate services and budgets, in contrast to previous legislation that encouraged joint working with resources largely remaining separate
- provides, for the first time, a statutory requirement to focus on outcome measures, rather than activity measures
- introduces a requirement for co-production as part of strategic planning. Co-production is when professionals and people who need support combine their knowledge and expertise to make joint decisions
- has clear links to other significant legislation, including The Children and Young People (Scotland) Act 2014 and the Community Empowerment (Scotland) Act 2015, where similar principles of co-production, engagement and empowerment apply.

53. Throughout our audit, we found there is widespread support for the policy of health and social care integration, but concerns about how this will work in practice. In this part of our report, we summarise the most important risks and issues we have identified through our audit. These are significant and need to be addressed as a priority nationally and locally to integrate health and care services successfully.

NHS boards, councils and IJBs need to be clear about how local arrangements will work in practice

Sound governance arrangements need to be quickly established

54. Good governance is vital to ensure that public bodies perform effectively. This can be a particular challenge in partnerships, with board members drawn from a wide range of backgrounds. Previous audit reports on community planning partnerships (CPPs) and CHPs have highlighted the importance of issues such as:

- a shared leadership, which takes account of different organisational cultures
- a clear vision of what the partnership wants to achieve, with a focus on outcomes for service users
- a shared understanding of roles and responsibilities, with a focus on decision-making
- an effective system for scrutinising performance and holding partners to account.

Members of IJBs need to understand and respect differences in organisational cultures and backgrounds

55. IJBs include representatives from councils, NHS boards, GPs, the voluntary sector, and service users. Everyone involved in establishing the new arrangements needs to understand, respect and take account of differences in organisational cultures so these do not become a barrier to progress. Members of the IJB need quickly to establish a shared understanding of their new role, how they will work together and measure success.

56. Voting members are drawn exclusively from councils and NHS boards and it is particularly important that they have a shared vision and purpose. There are important differences in how councils and NHS boards operate. Councils, for example, are accountable to their local electorate, while NHS boards report to Scottish ministers. There are also differences in how councils and the NHS work with the private sector. Councils have had many years of contracting services out to the voluntary and private sectors; for example, around 25 per cent of home care staff are employed in the private sector.

57. IJBs are aware of the need to establish a common understanding of the roles and responsibilities of board members. We found that many are planning opportunities for board development by providing training and support to board members. Other IJBs are also reinforcing this by developing codes of conduct to ensure that their board members follow the same standards of behaviour.

58. IJBs include representatives from a wide range of organisations and backgrounds. This inclusive approach has benefits, including a more open and inclusive approach to decision making for health and care services, but there is a risk that boards are too large. For example, the Edinburgh IJB will have 23 members and the Clackmannanshire & Stirling IJB will have around 35. As we have highlighted in previous audits of partnerships across Scotland, there is a risk that large boards will find it difficult to reach agreement, make decisions and ensure services improve.

IJB members will have to manage conflicts of interest

59. The design of IJBs brings the potential for real or perceived conflicts of interest for board members. The NHS board and council nominate all voting members of the IJB. Their role is to represent the IJB's interests. Voting members will also continue in their role as an NHS board member or councillor. As a result, there is a risk that they may have a conflict of interest, particularly where there is a disagreement as part of IJB business.[23]

60. There is a similar potential for a conflict of interest for senior managers. IJB finance officers, for example, are required to support the needs of the IJB, but may also have responsibilities to support their employer – either the local NHS board or council. Similarly, legal advisers to the IJB will be employed by the council or the NHS board and, at a time of disagreement, may have a conflict of interest.

61. There is also a particular issue for NHS board members. Some NHS boards have to deal with several IJBs, and this places significant demands on their limited number of non-executive members. As a result, the Act and its associated regulations allow for NHS executive members to be appointed as voting members of the IJB. This means that there is the possibility of individuals acting as IJB board members who commission a service, and as NHS board members, responsible for providing that service. IJBs need to resolve this tension as part of their local governance arrangements.

62. IJBs are taking action to manage these tensions. For example, they are providing training to alert board members to the need to act in the IJB's interests when taking part in IJB meetings, and declaring conflicts of interest when they arise. But underlying conflicts of interest are likely to remain a risk, particularly at times of disagreement between local partners.

Although IJBs will lead the planning of integrated services, they are not independent of councils and NHS boards

63. IJBs set out how they will deliver services in their strategic plans, which they develop through strategic planning groups. The legislation allows NHS boards and councils jointly to ask IJBs to change their strategic plans only if they think it hinders their work in achieving the national health and wellbeing outcomes. As such, NHS boards and councils cannot individually veto an IJB decision. However IJBs are not fully independent of NHS boards and councils which can influence them through the following:

- **Membership of IJBs**: Chairs, vice chairs and voting members are all nominated by NHS boards and councils.

- **The approval process to agree future budgets:** Guidance issued by the Scottish Government's Integrated Resources Advisory Group (IRAG) suggests that, for future years, each IJB develops a business case and budget request and submits this to the NHS board and council to consider.

- **Control of integration schemes:** NHS boards and councils can decide to resubmit their integration schemes, changing the terms under which the IJB operates, or replacing it with a lead agency approach.

64. IJBs may overcome the challenges of working with a large board, with different organisational cultures and tensions, but once difficult decisions have been made there are still complex relationships back to the NHS board and council to negotiate. As a result, it is not clear if IJBs will be able to exert the necessary independence and authority to change fundamentally the way local services are provided.

Only a few IJBs will oversee the operation of acute services in their area, potentially limiting their impact

65. Regulations allow NHS boards and councils to choose what role IJBs will have in relation to operational management of services, in addition to commissioning and planning services. This flexibility allows, for example, NHS boards to remain solely responsible overseeing the operation of large hospital sites. The alternative is a more complex arrangement where responsibility for overseeing the operation of an A&E department is shared across several IJBs. Where the IJB has no operational management of hospital services, the IJB will receive regular performance reports from the NHS board on hospital services, so the IJB can assess whether the NHS board is delivering services in line with the IJB strategic plan. From the 17 schemes we reviewed that establish IJBs, we found the following:

- All 17 IJBs oversee the operation of non-acute integrated services, such as district nursing.

- To date, only Argyll and Bute, and Dumfries and Galloway IJBs will oversee the operation of the acute hospital integrated services in their areas, and

the chief officer will operationally manage these services. In Argyll and Bute, this continues an arrangement that existed previously and arises because the NHS board contracts most acute services from NHS Greater Glasgow and Clyde. Argyll and Bute CHP received information from the NHS board as part of the contract monitoring process. The IJB and NHS Greater Glasgow and Clyde are in the process of agreeing the information the chief officer and IJB board members will receive on the operational performance and delivery of these services.

- In Dumfries and Galloway, the IJB will oversee the operation of all integrated services, including all acute hospital services. The chief officer will be responsible for managing the operation of these integrated services, receiving regular information from the council Chief Social Work Officer and the NHS board acute services management team. The geographical circumstances in Dumfries and Galloway help to make this arrangement possible, as there is only one IA in the NHS board area, with only one acute hospital.

There needs to be a clear understanding of who is accountable for service delivery

66. There is a risk that the complex interrelationship between IJBs and councils and NHS boards will get in the way of clear lines of accountability. Their respective roles appear to be clear: IJBs are responsible for planning and commissioning services; councils and NHS boards are responsible for delivering those services.

67. But this understanding of accountabilities could be tested when there is a service failure, either in the care of an individual or in meeting outcome targets. The consensus amongst those we spoke with during our audit is that responsibility would lie with the council or NHS board delivering the service. But it could also be argued that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered. All parties need to recognise this risk and set out clearly an agreed understanding of each other's roles and responsibilities. It is essential that the chief officer is clear about how this joint accountability will work in practice from the start.

68. Clear procedures also need to be in place for clinical and care governance. These are procedures for maintaining and improving the quality of services and safeguarding high standards of care. NHS boards use long-established clinical governance approaches within the NHS. Similarly, councils follow well-established approaches for social care. IJBs have a great deal of flexibility over this issue and are required only to consider what role they will have in supporting the councils' and NHS boards' clinical and care governance work and how integration might change some aspects of this.

69. The Act introduced a requirement that IJBs set out in their integration scheme how they will work with NHS boards and councils to develop an integrated approach to clinical and care governance. We found that, at present, most IJBs plan to retain existing arrangements, with NHS boards directly overseeing clinical governance and councils overseeing care governance. However, IJBs will need to have a role in monitoring clinical and care standards without duplicating existing arrangements. Perth and Kinross IJB has developed a new clinical and care governance framework that other IJBs are now considering. In addition, the Royal College of Nursing has developed an approach that helps IJBs, councils and NHS

boards review their clinical and care governance arrangements. The aim is to ensure consistent approaches within each integrated service, and that these are aligned to existing clinical and care governance arrangements in the NHS and councils.[24]

IAs need to establish effective scrutiny arrangements to help them manage performance

70. IAs need to establish effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives, and holding partners to account. Using the nine statutory outcome measures, listed at Exhibit 6, will help IAs to focus on the impact of health and care services. But as well as simply monitoring performance, IJB members will need to use these to help redesign services and ensure services become more effective.

71. There is also a need for regular reporting to partner organisations. This is particularly important where most members of the local council or NHS board are not directly involved in the IJB's work. Aberdeenshire Council, for example, has 68 councillors, with only five sitting on the IJB. Those not directly involved need to be kept informed on how the budgets provided to the IJB have been used and their effectiveness in improving outcomes for local people.

Councils and NHS boards are finding it difficult to agree budgets for the new integration authorities

72. At this stage, IAs are establishing financial procedures that look to be sound. While there is a range of approaches to financial monitoring and dealing with overspends and underspends, the processes outlined in the integration schemes are reasonable.

73. There are, however, significant concerns about funding. Councils and NHS boards are having great difficulty in agreeing budgets for the new IAs. At October 2015, six months before they were required to be established and commissioning health and care services, the Scottish Government had only been informed of the agreed budgets for six IAs. This uncertainty about budgets is likely to continue until early 2016. The results of the UK spending review were not announced until November 2015, and the Scottish Government will only publish its financial plans on 16 December 2015.

74. NHS boards and councils have faced several years of financial constraints and this is expected to continue in the coming years. There is a risk that, if NHS boards and councils seek to protect services that remain fully under their control, IAs may face a disproportionate reduction in their funding, despite the focus on outcomes that all partners should have. We have reported previously on increasing pressures on health and care budgets. This risk of budget overspends is a significant risk for IJBs. Other specific factors add to these difficulties in agreeing budgets:

- **Set-aside budgets:** These relate to the budgets retained by NHS boards for larger hospital sites that provide both integrated and non-integrated services. There are difficulties in agreeing these set-aside budgets, despite the Scottish Government issuing specific guidance. The current difficulties relate to how to determine the integrated and non-integrated costs for these hospitals and how to allocate a fair share to each IJB within the NHS board area. More fundamentally, however, there is a risk that NHS

boards may regard this funding as continuing to be under their control, making it difficult for IAs to use the money to shift from acute hospital care to community-based and preventative services. As a result of these uncertainties, not all of the strategic plans published so far consider the set-aside budgets or plan for the level of acute services that will be needed in future years.

- **Different planning cycles:** NHS boards and councils agree budgets at different times. In North Ayrshire, for example, the council agreed its 2015/16 budget in December 2014, while the NHS agreed its budget in March 2015. NHS budgets and allocations can change during the financial year. This could bring further challenges for IJBs. Similar budget-setting cycles exist across Scotland. If councils and NHS boards continue with these cycles, then IJBs will be involved in protracted negotiations for budgets and ultimately cannot expect partners to approve their plans until just before the start of each financial year. In response, NHS Forth Valley has adapted its budgeting process to allow it to provide an earlier indication of the integrated health budget to its local IAs. In addition, as part of the community planning process, there is an expectation that community planning partners will share information on resource planning and budgets at an early stage, before formal agreement.[25] This should help IAs' financial planning.

Integration authorities need to make urgent progress in setting out clear strategic plans

Most IAs are still developing their overall strategic plans, but those that are in place tend to be aspirational and lack important detail

75. Strategic planning is central to the role that IAs will have in commissioning and helping redesign local health and care services. Scottish Government guidance emphasises the importance of localities in this process, and of strategic plans to reflect the different priorities and needs of local areas.

76. At the time of our audit, only six IAs had published their strategic plans. Some, such as Aberdeen City, Aberdeenshire and Moray, have developed draft plans in advance of the formal approval of the integration schemes. Difficulties with reaching agreement on budgets are an important factor hindering IAs from developing comprehensive strategic plans. This raises concerns about the readiness of IAs to make an immediate impact in reshaping local services. Our audit involved speaking to people involved with strategic planning, including IJB board members. Many of them felt it would be at least another year before most IAs have established plans that are genuinely strategic and can redesign future service delivery rather than simply reflect existing arrangements.

77. Even where strategic plans are in place, there tend to be weaknesses in their scope and quality. They often set out the broad direction of how to provide integrated health and social care services in their areas over the next three or so years, identifying local priorities for their area and for localities. But they can be unclear about what money and staff are available, particularly over the longer term, or how to match these to priorities. They lack detail on what level of acute services is needed in an area and how they will shift resources towards preventative and community-based care. They generally lack performance measures that directly relate to the national outcomes.

78. Strategic planning is even less developed at the locality level. There is a risk that strategic planning is not joined up with locality planning. Some IAs have completed strategic needs assessments, helping to identify the different needs and priorities of individual localities. They are using these to develop local priorities and budgets. There are also significant challenges in involving a wide range of service users, voluntary organisations, GPs and other clinicians and other professional staff in the planning process. These groups are represented at IJB board level, as non-voting members. But involving these groups more widely and actively at locality level is crucial to providing community-based and preventative health and social care services.

Most IAs have still to produce supporting strategies

79. In addition to their overall strategic plans, IAs need to establish supporting strategies for important areas such as workforce, risk management, data sharing, and how they will work with people who use health and social care services. They are required to set out a broad timetable for producing these in their integration schemes.

80. We analysed the timetables in the approved integration schemes available at the time of our audit. This reveals some significant variations (Exhibit 9, page 33). Some risk management and workforce strategies have been developed and are scheduled to be agreed well in advance of the IA becoming operational. In others, however, it will be up to 12 months after the IA becomes operational before these strategies are due to be agreed and can start to contribute to progress with integrating services.

81. This raises questions about the effectiveness of some IAs, at least in the first year of their operation. It is important that IA strategies are well thought through, built on an analysis of local needs and resources and meaningful consultation, clearly setting out how the IA will deliver against the aspirations of the Act. We did not look in detail at the strategies produced at this early stage. But there is a risk that strategies produced quickly lack the detail needed to show how IAs will take practical steps that:

- improve outcomes
- integrate services
- make best use of the funds, skills and other resources available to them.

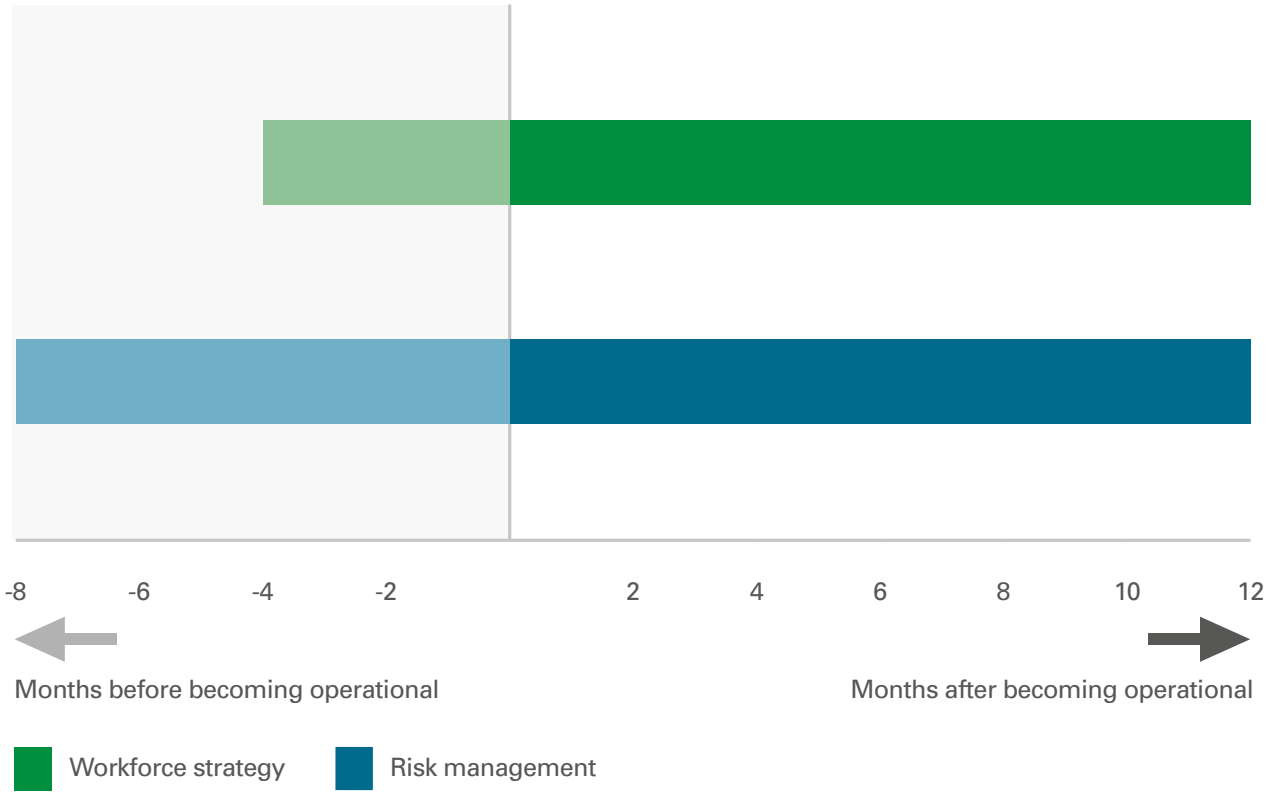
Equally, there are risks where the IA will not have plans in place until they have been operational for many months. It is important that IAs have clear strategic priorities and use these in developing:

- a workforce strategy, showing how they will redesign health and care services
- a risk management strategy to demonstrate that they are properly prioritising their work and their resources.

Exhibit 9

Range of timescales for supporting strategies

It will be up to a year before some IJBs have established workforce and risk management strategies.



Source: Audit Scotland analysis of available integration schemes

There is a pressing need for workforce planning to show how an integrated workforce will be developed

82. The health and social care workforce is critical to the success of integration. Health and social care services are personal services; it is important that staff have the skills and resources they need to carry out their roles, including providing emotional and physical support and clinical care.

83. At present, few IAs have developed a long-term workforce strategy. Developing a suitably skilled workforce is crucial to the success of integrated health and social care services. This is particularly challenging, given the wide range of people involved and the size of the workforce. NHS Scotland employs around 160,000 staff.[26] Social services employ almost 200,000, both directly employed council staff and others from the private and voluntary sector.[27] Furthermore, an estimated 759,000 people in Scotland are carers for family members, friends or neighbours.[28] IJBs need to work closely with professional and regulatory bodies in developing their workforce plans.

84. IJBs do not directly employ staff, but they are responsible for coordinating services from this varied mix of staff and carers. There will be implications for the skills and experience that staff will need to deliver more community-based support as services change. Developing and implementing workforce strategies to meet these needs will be challenging.

85. The following will add to these difficulties:

- **Financial pressures on the NHS and councils.** NHS boards and councils continue to face pressures from tightening budgets and rising demand for services. Most councils have responded to these pressures in part by reducing staff numbers and outsourcing some services to the private and voluntary sectors. These changes are less evident in the health sector. As a result, there are concerns that any future changes to the workforce will not affect health and care staff equally.

- **Difficulties in recruiting and retaining social care staff.** Over many years, councils have had difficulties recruiting and retaining care home and home care staff. Organisations in areas such as Edinburgh and Aberdeen, with high living costs, have had particular difficulties. There is a need to develop a valued, stable, skilled and motivated workforce. We found examples of organisations developing new approaches to making careers in caring more attractive. For example in Dumfries and Galloway and Aberdeen City they are considering creating caring roles that are part of a defined career path, to encourage more people into these roles.

- **The role of the voluntary and private sectors.** Voluntary and private organisations play an important role in providing care and support, but there are particular challenges in how IJBs can involve these diverse organisations as part of a coordinated workforce plan. The introduction of the national living wage will have a significant impact on the voluntary sector and their ability to provide the same level of support for health and care services. We will comment on this further in our audit of Social Work in Scotland.

86. GPs have a particularly important role but there are concerns over GPs having time available to contribute actively towards the success of integrated services. Most GPs are independent contractors, not employed by the NHS. GPs have a crucial role in patient referrals and in liaising with other health and care services. Ultimately, if there are concerns about the quality or availability of community-based services, there is a risk that GPs will refer patients to hospital to ensure they receive the care they need.

87. Throughout Scotland, there are difficulties in recruiting and retaining GPs. As a result, GPs are facing increasing pressures, at a time when a planned shift to community care and support can be expected to increase their workload. The Scottish Government has recognised this issue and has announced £2.5 million to fund a three-year programme to improve recruitment and retention of GPs and improve the number of people training to be GPs. It also has plans to revise GP contracts, to allow GPs to delegate some services to other healthcare professionals, freeing up GPs' time. However, it will be many years before these measures will have a significant impact.

The proposed performance measurement systems will not provide information on some important areas or help identify good practice

88. There is wide support for the Scottish Government's focus on health and wellbeing outcomes (set out earlier at Exhibit 6). In addition to the nine national outcomes, the Scottish Government developed core integration indicators to measure progress in delivering the national health and wellbeing outcomes and to allow national comparison between partnerships. These 23 measures, listed in Appendix 2, cover a mixture of outcome indicators – based on people's perception of the service they received – and indicators based on system or organisational information, such as people admitted to hospital in an emergency or adults with intensive care needs receiving care at home.

89. The Scottish Government has provided further support through the Information Services Division (ISD) of NHS National Services Scotland. It provided access to local data and technical support to help partnerships understand and plan for their areas' health and social care needs. The ISD data brings together health, social care and demographic information for the first time and is a significant step forward in providing partnerships with the information they need to plan locally and to measure the impact of their activity. Much of the data is already available for partnerships to use, and ISD plans to develop the data further including analysing the cost of end-of-life care.

90. Some IAs have been unable to make use of this resource as data-sharing agreements are not yet in place. ISD has access to health data but requires permission from councils to access the social work data they hold for their areas. Before councils can grant access they need to ensure they are not breaching data protection legislation and are doing this by agreeing data-sharing procedures. Most councils and NHS boards are making progress with this, but where information sharing has not been agreed IAs are having to plan without it.

91. National care standards were created in 2002 to help people understand what to expect from care services and to help services understand the standard of care they should deliver. Given the way that services have changed since then, in June 2014, the Scottish Government issued a consultation on new national care standards. The consultation proposed developing overarching standards, based on human rights, setting out the core elements of quality that should apply across all health and social care services.

92. The standards are an important part of integrating and scrutinising health and care services and it is important that they are in place quickly and publicised widely. However, overarching principles will not be finalised until April 2016; this will be followed by a consultation on specific and generic standards, with a view to them being implemented from April 2017.

93. While all these developments are clearly a step in the right direction, all partners need to consider the following issues:

- **The core integration indicators do not fully take account of all the expected benefits of the reform programme.** Overall, the Scottish Government's reform programme is expected to shift the balance of care to community-based or preventative services. However, demographic pressure will create increased demand for both hospital and community-

based services. It is not clear how the proposed indicators will measure progress in transferring from hospital to community care. There may be central data that the Scottish Government can use to track some of these changes but these should be set out clearly as part of measures to publicly monitor and report on progress. It is also unclear how the Scottish Government will track expected savings. An example is the expected annual savings of £104 million from reducing some of the variation evident in the cost of providing health and social care services across different parts of Scotland.[29] The core set of integration indicators does not attempt to give a national measure of reductions in cost variation or the savings that arise from this. Anticipatory care plans are projected to yield savings of £12 million a year, but there are no proposed indicators to assess if IAs are using them, or what impact they have on releasing resources such as skills and equipment.[30] This means the Scottish Government will not know if integration has freed up resources for other uses, in line with its expectations, or if it has achieved a shift from institutional to community-based care.

- **The process of linking measures and outcomes is incomplete and it may be difficult to measure success.** This means that the Scottish Government will be unable to see what progress is being made nationally, or to compare the different approaches adopted by IAs to identify which are most effective. For example, one of the measures seen as indicating success is 'reducing the rate of emergency admission to hospitals for adults'. (A reduction in this is seen as evidence of a positive impact on outcomes 1, 2, 4, 5 and 7, as listed at Exhibit 6.) But hospital emergency admission rates can reduce for many reasons. At present, it is up to individual partnerships to decide which additional local measures they will adopt to explore why hospital emergency admission rates are changing.

  Councils and NHS boards are required to set out in their strategic plans which local measures they will use. We compared plans for North Lanarkshire and North Ayrshire IAs, both relatively advanced in their performance management arrangements at the time of our audit. We found the following:

  – They will use different measures from each other. This has the benefit of allowing IAs to focus on their local priorities. However, it will make it difficult for the Scottish Government to compare performance across IAs to identify what approaches are working best (Exhibit 10, page 37).

  – In various places, both IAs have associated a different mix of indicators to an outcome from that set out in Scottish Government guidance. This occurs more frequently in North Ayrshire which developed its plans before the Scottish Government published its approach. But North Lanarkshire also has taken a different view on which indicators it will use to measure progress on some of the national outcomes, making it difficult for the Scottish Government to measure progress at a national level.

  – We have provided a more detailed comparison of the approaches used by North Lanarkshire and North Ayrshire IAs in a supplement to assist other IJBs when developing their plans (Exhibit 10, page 37).

Exhibit 10

Integration authorities can use different information to measure progress towards national outcomes

National Outcome	Core integration indicator			Number of additional local indicators mapped to national outcome	
	Mapped to national outcome by both	Not mapped to national outcome by both		North Ayrshire	North Lanarkshire
People are able to look after and improve their own health and wellbeing and live in good health for longer	Percentage of people who say they are able to look after their health very well or quite well	• Premature mortality rate	NL	5	19
		• Emergency admission rate	AL		
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	None	• Percentage of staff who say they would recommend their workplace as a good place to work	NA	8	8
Resources are used effectively and efficiently in the provision of health and social care services	None	• Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated	NL	10	31
		• Readmission to hospital within 28 days	NL		
		• Proportion of last six months spent at home or in community setting	NL		
		• Falls rate per 1,000 population aged 65+	NL		
		• Number of days people spend in hospital when clinically ready to be discharged per 1,000 population	NL		

NL = North Lanarkshire map this to outcome

NA = North Ayrshire map this to outcome

AL = Neither map this to outcome

Source: Audit Scotland analysis of performance frameworks

- **It is important that there is a balance between targeted local measures and national reporting on impact.** This has the benefit of providing flexibility so that local partnerships can focus their efforts on priority areas. It is important that local partnerships set ambitious targets. The reforms bring the opportunity to have local outcome measures that local people recognise as responding to specific issues in their community. However, the Scottish Government and IAs need to resolve tensions between introducing better local measures and the need for clarity at national level about the impact that IAs are having. An increasing focus on local measures means it is timely to review whether existing national measures are fit for purpose.

The role of localities still needs to be fully developed

94. Localities are intended to be the key drivers of change, bringing together service users, carers, and health and care professionals to help redesign services. The Act requires IAs to establish at least two localities within their area. Scottish Government guidance, issued in July 2015, suggests that localities should be formed around natural clusters of GP practices. Naturally, the number and size of localities vary. Edinburgh, for example, has established four localities, with an average population of around 120,000. By contrast, Shetland has seven localities, each with an average population of around 4,000. Under the Act, localities need to be involved in both planning services and play a consultative role about service change in their local area. This raises an issue about the scale and size of localities – the optimal scale for locally planning services may not be the same as that for consulting on service change.

95. With IAs still focusing on their overall budgets and governance arrangements, the arrangements for localities are relatively underdeveloped. Some have now agreed priorities and budgets for individual localities, but in most cases, work at locality level has initially focused on networking with stakeholders and on needs assessments. Localities are key to the success of integration, therefore IJBs must focus on how localities will lead the integration of health and care.

96. We found that GPs are becoming involved in locality planning. But, in many areas, there are concerns about their ability to remain fully involved in locality planning. Some GPs are also sceptical, given earlier experiences with LHCCs and CHPs, which failed to provide a fundamental shift towards preventative and community-based services. In response, the Scottish Government is piloting a new approach in ten health centres across the country. These centres will form 'community care teams' and test different ways of delivering healthcare. It is important that there is a clear link between the work of these teams and locality planning arrangements to avoid confusion.

There will be a continuing need to share good practice and to assess the impact of integration

97. The 31 IAs are putting different arrangements in place to deliver integrated health and social care services. This high level of variation is permitted by the Act and, in allowing IAs to respond to their local context and priorities, has many advantages. However, at some point, the Scottish Government and individual IAs will need to review their initial arrangements and consider how these might evolve to reflect good practice in other parts of Scotland. We hope that this report, and our subsequent audits, will contribute towards this wider review.

Part 4

Recommendations

We have made recommendations to help organisations address potential risks to the success of health and social care integration. We will monitor progress as part of our future work on integration.

The Scottish Government should:

- work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this:
  - work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system
- monitor and publicly report on national progress on the impact of integration. This includes:
  - measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans
  - reporting on how resources are being used to improve outcomes and how this has changed over time
  - reporting on expected costs and savings resulting from integration
- continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.

Integration authorities should:

- provide clear and strategic leadership to take forward the integration agenda; this includes:
  - developing and communicating the purpose and vision of the IJB and its intended impact on local people
  - having high standards of conduct and effective governance, and establishing a culture of openness, support and respect
- set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny.

This includes:

- setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice
- ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB

- ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes:
  - setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required.
  - ensuring relationships between the IJB, its partners and the public are clear so each knows what to expect of the other

- be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including:
  - developing and maintaining open and effective mechanisms for documenting evidence for decisions
  - putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice
  - developing and maintaining an effective audit committee
  - ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints
  - ensuring that an effective risk management system in in place

- develop strategic plans that do more than set out the local context for the reforms; this includes:
  - how the IJB will contribute to delivering high-quality care in different ways that better meet people's needs and improves outcomes
  - setting out clearly what resources are required, what impact the IJB wants to achieve, and how the IA will monitor and publicly report their progress
  - developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils
  - making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act

- develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes:
  - developing financial plans for each locality, showing how resources will be matched to local priorities
  - ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively
- shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.

Integration authorities should work with councils and NHS boards to:

- recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early on in the relationship and that a shared understanding of the roles and objectives is maintained
- review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils
- urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners
- establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and care services
- put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.

Endnotes

1 This included reviewing 18 approved integration schemes, 17 of which were for integration joint boards following the body corporate model and one of which was for Highland's lead agency model.

2 Clackmannanshire and Stirling, Dumfries and Galloway, East Renfrewshire, Edinburgh City, North Ayrshire and North Lanarkshire.

3 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

4 *Reshaping care for older people* [PDF], Audit Scotland, February 2014.

5 *Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland,* Scottish Government, 2012.

6 *Scotland Performs*, Scottish Government, 2015.

7 *Projected Population of Scotland (2014-based),* National Records Scotland, 2015.

8 *Finance Committee. 2nd Report, 2013 (Session 4): Demographic change and an ageing population.* Scottish Parliament, 11 February 2013.

9 *Bed days occupied by delayed discharge patients*, ISD Scotland, May 2015.

10 *Review of Community Health Partnerships* [PDF], Audit Scotland, 2011.

11 After approval of its integration scheme, an IJB is established by parliamentary order. An IJB is operational when it has delegated responsibility from the NHS board and council for integrated budgets and services.

12 The lead agency is between Highland Council and NHS Highland. NHS Highland also has an IJB with Argyll and Bute Council.

13 Where the IJB spans across more than one council area, the minimum number of voting members is different. For IJBs of two council areas, at least two councillors from each council are required. For IJBs of more than two areas at least one councillor from each council is required. In both cases, the NHS board must nominate board members equal to the total number of councillors.

14 As IJBs have no plans to directly employ staff in this early stage of development, we are not commenting on related potential risks and issues. We are likely to return to this issue in more detail in future reports on integration.

15 *Self-directed support* [PDF], Audit Scotland, June 2014

16 The Joint Improvement Team is a partnership between the Scottish Government, NHSScotland, COSLA (Convention of Scottish Local Authorities) and the voluntary, independent and housing sectors.

17 East Dunbartonshire, Shetland and West Dunbartonshire.

18 Some areas, have a chief officer designate. This happens where, although recruitment for a chief officer is complete, until the IJB is established it cannot formally appoint the chief officer.

19 Falkirk currently has an interim chief officer in post and expects to make a permanent appointment to this role by the end of the year.

20 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

21 Ibid.

22 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

23 We explore these tensions more fully in our report *Arm's-length external organisations (ALEOs): are you getting it right?* [PDF], Audit Scotland, June 2011.

24 *RCN briefing 2: Clinical and care governance in an integrated world,* May 2015, Royal College of Nursing.

25 *Agreement on joint working on community planning and resourcing*, Scottish Government and COSLA, September 2013.

26 *NHS Scotland Workforce Information Quarterly update of Staff in Post, Vacancies and Turnover at 30 June 2015*, ISD Scotland, 2015. This figure refers to all staff in NHS Scotland, not just those working in integrated services.

27 *Scottish Social Service Sector: Report on 2014 Workforce Data*, Scottish Social Services Council, 2015.

28 *Scotland's Carers,* Scottish Government, March 2015.

29 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

30 Ibid.

Appendix 1

Audit methodology

We reviewed a range of documents during our audit. Where available, this included:

- the Act and national guidance and regulations on implementing the Act
- 18 approved integration schemes[1]
- strategic and related financial plans
- minutes, papers and agendas for IJB meetings
- internal audit reports and local reports on integration arrangements
- financial audit information
- joint inspection reports from the Care Inspectorate and Healthcare Improvement Scotland.

We interviewed stakeholders in the following IA areas:

- Clackmannanshire and Stirling
- Dumfries and Galloway
- East Renfrewshire
- Edinburgh City
- North Ayrshire
- North Lanarkshire.

We drew on the work already carried out by:

- the Care Inspectorate
- Healthcare Improvement Scotland
- local auditors.

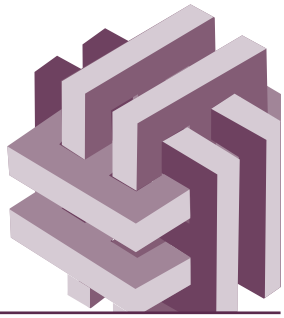
We also interviewed staff from:

- the Scottish Government
- the Joint Improvement Team
- the British Medical Association
- the Convention of Scottish Local Authorities
- NHS Information Services Division
- the Care Inspectorate
- Healthcare Improvement Scotland
- the voluntary sector.

Note: 1. We reviewed 17 integrations schemes establishing IJBs for Argyll & Bute, East Ayrshire, East Dunbartonshire, East Lothian, East Renfrewshire, City of Edinburgh, Eilean Siar, Inverclyde, Midlothian, North Ayrshire, North Lanarkshire, Renfrewshire, Shetland Isles, South Ayrshire, South Lanarkshire, West Dunbartonshire and West Lothian, and Highland's integration scheme setting out its lead agency approach.

Appendix 2

Scottish Government core integration indicators



Outcome indicators, based on survey feedback, available every two years, include:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good.
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.*

Outcome indicators derived from organisational/system data, primarily collected for other reasons, available annually or more often, include:

- Premature mortality rate.
- Rate of emergency admissions for adults.*
- Rate of emergency bed days for adults.*
- Readmissions to hospital within 28 days of discharge.*
- Proportion of last six months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.*
- Proportion of care services graded 'good' or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
- Percentage of people who are discharged from hospital within 72 hours of being ready.*
- Expenditure on end-of-life care.*

* Indicates indicator is under development.

Health and social care integration

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ISBN 978 1 909705 76 0 AGS/2015/10

Agenda Item

2

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Risk Registers – IJB/Directorate
Reference Number:	CC-35-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:
That the IJB are asked to review and direct on any issues which they see as significant to sustaining and progressing service delivery.
High Level Summary:
This report summarises the high level risks that affect the Directorate and IJB for all service areas.
Corporate Priorities and Joint Working:
The Parties (NHS Shetland (NHSS) and Shetland Islands Council (SIC)) have identified a core set of risks that relate to health and social care services for delegated integration functions.
Key Issues:
The IJB is invited to comment on any issues which they see as significant to sustaining and improving service delivery.

Implications :	
Service Users, Patients and Communities:	A robust approach to risk management at all levels of the IJB is essential in order to prevent or reduce potentially negative impacts on the Community.
Human Resources and Organisational Development:	Risk management promotes best practice and seeks to protect staff across the Health & Social Care Directorate.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
Legal:	There are no legal implications arising directly from this report. Legal issues are considered as an integral part of the risk

	management process.
Finance:	There are no financial consequences arising directly from this report.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Risk management is a continuous process which requires that risk information be presented periodically for consideration. The IJB Risk Register and the Directorate Risk Register ensure that we are actively managing risks, mitigating negative impacts and promoting positive risk taking.

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. The IJB is responsible for the operational oversight of service delivery of its delegated functions and through the Chief Officer will be responsible for the operational management of integrated services.
Previously considered by:	This report has not been presented to any other formal meeting.

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Risk Registers – IJB/Directorate
Reference Number:	CC-35-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The purpose of this report is to present to the IJB the Risk Registers that include strategic and operational risks that affect all areas of business relating to the IJB and the measures being taken to address those risks.

1.2 Risk management is an integral part of the IJB's activities.

2. Background

2.1 The Risk Registers used to be appended to the Performance Report however Council Internal Audit have requested that these reports be considered separately.

2.2 Risk Management team have been working with the Directorate to facilitate the management of the high level risks in the IJB Risk Register (Appendix 1).

2.2 All Directorate risks have been reviewed by the Operational Management Group which provides a high level overview of service areas risks (Appendix 2).

2.3 Recognising and highlighting risks facing the IJB will help ensure that appropriate controls are considered and put in place.

3. Conclusions

3.1 Embedding a structured and consistent approach to managing risk ensures that the IJB is best placed to deliver on these.

3.2 The role of the IJB is to review and direct on any issues which they see as significant to sustaining and progressing service delivery.

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16 May 2016

Appendices
Appendix 1 – IJB Risk Register
Appendix 2 – Directorate Risk Register

Background documents
Community Health & Social Care Directorate Plan

Risk Register - Integration Joint Board

	Current				Target		
Risk & Details	**Frequency**	**Severity**	**Risk**	**Current and Planned Control Measures**	**Frequency**	**Severity**	**Risk**
IJB0003 - Policies - effect of Health & Social Care Integration governance arrangements through the Integration Joint Board are not fully implemented. Risk that when in place they will not be effective.	Unlikely	Major	Medium	• There is a mechanism for calling an informal Liaison Group at a senior level for members of the Council, Health Board and IJB to discuss issues including governance where the Group can inform any remedial action required.	Unlikely	Significant	Medium
IJB0017 - Policies - effect of Strategic Planning for Health & Social Care is ineffective. The Strategic Plan does not reflect the needs of communities and identify appropriate communication strategies.	Unlikely	Major	Medium	• Participation and Engagement Strategy in place. Action plans developed for the preparation of the strategic plan. Strategic planning group in place. Work in localities is being developed engaging with a wide range of stakeholders including staff, service users, other service providers, community representatives.	Unlikely	Significant	Medium
IJB0018 - Policies - effect of the IJB fails to direct service delivery to meet the outcomes required, these include local and national outcomes, service standards and quality measures and targets.	Unlikely	Major	Medium	• Direction will be through the detail of the Strategic Plan.The Strategic Plan for 2015/16 has already been developed and approved by the Council and the Health Board and the IJB. Quarterly performance monitoring is well estabilised. A Strategic Plan for 2016/19 has been presented to the IJB.	Unlikely	Significant	Medium
IJB0019 - Partnership working failure Failure of the IJB to agree a Strategic Plan or Budget proposals. Failure to agree the budget or the budget recovery plan for the identified shortfalls in NHS budget allocation to the IJB for 2015/16 and future years could lead to overspend or a lack of direction to the Council and the Health Board through the comissioning process.	Likely	Major	High	• Where failure of IJB to agree means there is a dispute between the Council and the Health Board. Then a dispute resolution mechanism in the integration scheme can be used. IJB standing orders also cover failure to agree. IJB has agreed proposals for a 2016-19 Strategic Plan and for 2016/17 budgets, however, recovery plans for 2016/17 have not yet been fully developed.	Possible	Major	High
IJB0020 - Partnership working failure Poor attendance or lack of commitment to the IJB from among its members.	Likely	Major	High	• Need to look at ways of taking into account the diverse commitments of members. In particular clinical commitments of clinicians on the IJB. Commitment has been given to find backfill and look at individual work plans.	Possible	Significant	Medium
IJB0021 - Technological - Other Failure to provide adequate corporate services support to the IJB eg. finance, legal, committee services, ICT & HR	Possible	Major	High	• During the implementation phase the transition programe board brought together representatives of corporate support servicesfrom the council and the Health Board. A link group will continue to meet under the direction of the Director of Corporate Services in order to ensure a co-ordinated approach to Corporate support services. Key joint groups will continue to work on key technical areas. These include the Local Partnership Finance Team, Joint Staff Forum and Data Sharing Partnership	Unlikely	Significant	Medium
IJB0022 - Policies - effect of the IJB fails to adequately identify community needs through the planning processes and is unable to differentiate the particular differences between localities and so cannot begin to address issues arising within a defined community.	Possible	Major	High	• Locality planning in the development of the Strategic Plan. The planning process for the Strategic Plan 2016-19 included conversations at a locality level. Locality leads need to be identified.	Unlikely	Significant	Medium

Risk Register - Directorate Community Health & Social Care

Risk & Details	Current Frequency	Severity	Risk Profile	Current and Planned Control Measures	Target Frequency	Severity	Risk Profile
EM0039 - Strategic priorities wrong Management capacity issues	Possible	Significant	Medium	• The structure will ensure that there is adequate management capacity including professional leadership for adult social work. The structure for CH&SC will ensure that there is adequate management capacity including professional leadership for adult social work within the directorate.	Unlikely	Minor	Low
EM0048 - Physical - People / Property - Other CH&SC has a high number of staff performing relatively physical tasks. If staff are injured through manual handling, they may be off work, they may allege negligence by the organisation and make a civil claim, and it may lead to a shortage of staff.	Possible	Significant	Medium	• Moving and handling training part of yearly plan for staff development. Risk assessment processes in place for clients/patients	Unlikely	Significant	Medium
EM0034 - Professional Errors and Omissions Services operate within a complex legislative, contractual and compliance environment. Clients/patients are many and varied in age, vulnerabilities and needs	Unlikely	Significant	Medium	• Monitoring by professional leads re skills and capacity. Staff training plan developed each year. Incidentsfully investigated. Clinical, Care & Professional Governance Committee structure in place.	Rare	Significant	Low
EM0035 - Demographic change Maintaining and improving the oral health of the local population	Likely	Major	High	• Review taking place of current Dental Service staffing levels and skill mix to ensure the model in place is working effectively with flexibility for the future. Encourage local development of independent NHS dental practices to help mitigate this risk	Possible	Minor	Medium
EM0031 - Modernisation - too slow Inability to deliver cost-effective, safe Mental Health Service	Almost Certain	Major	High	• Following reviews of mental health and dementia, there are action plans in place which are being closely monitored to ensure progress on strengthening the services. With the additional funding allocated from health, recruitment of staff has been successful.	Possible	Minor	Medium
EM0044 - Key staff - loss of Difficulty in ensuring sustainable provision of services and retention of skills in small and remote communities.	Likely	Significant	High	• Cover provided using permanent or temporary staff. Temporary cover provided by community and hospital staff banks. Use of agency locum staff as a last resort. More focussed approach to supervision and performance management to aid staff retention. Good workforce development plan - long term monitoring of key posts and review of recruitment processes.	Possible	Significant	Medium
EM0007 - Partnership working failure Conflict of interest between roles of NHS and Council.	Possible	Significant	Medium	• Development of joint strategies incorporated in Strategic Plan which will be agreed by the Parties. Contributing to the Shetland Local Outcomes Implementation Plan.	Unlikely	Minor	Low

EM0018 - Legal / Compliance - Other NHS and Council are required to comply with Scottish Social Services Council and National Care Standards	Possible	Significant	Medium	• Regular inspections; Staff aware of the standards required. Recent joint inspection of older people's services will give overview of quality	Rare	Significant	Low
EM0023 - Business continuity plan inadequate Response to an emergency situation	Possible	Significant	Medium	• Business continuity plans in place for community health and social care services. Involvement in planning and exercises.	Possible	Minor	Medium
EM0021 - Legal - Other Inability to provide consistent, high quality, sustainable Out of Hours Care	Likely	Major	High	• Opportunities to extend ANP model. National review of out of hours primary care delivery with local project in place. Community Nursing review will consider level of out of hours provision.	Unlikely	Minor	Low
EM0002 - Deadlines - failure to meet Delayed Discharges	Possible	Significant	Medium	• Create capacity through use of Integrated Care Fund. Create capacity through use of Integrated Care Fund with rapid access to resources which avoid unnecessary hospital admission and expedite timely discharge. Whole system approach to reducing bottlenecks in the pathway.	Possible	Minor	Medium
EM0004 - Staff number/skills shortage Reduced response to an emergency situation on Remote areas of Shetland and the outer islands	Unlikely	Major	Medium	• Emergency response arrangements in place. Coastguard Search and Rescue Helicopter will respond to life and limb threatening injuries/illness. Memorandum of Understanding in place with Direct Flight for transfer of “walking wounded” NHS Shetland continuing discussions with SAS and GAMA regarding additional helicopter coverage, especially for urgent (rather than emergency) transfer. Temporary control measure (for managing situation short term) to ensure staff on NDI have increased stock of Oxygen and consumables. Longer term need to conduct training needs analysis and increase staff skill set to support ill patients for longer period of time (if timeliness of air evacuation options not enhanced). Continue to develop First Responder schemes on NDIs to support the nurse in caring for critically ill patient	Unlikely	Major	Medium
EM0014 - Key staff - loss of Inability to recruit to key posts	Likely	Significant	High	• Work closely with both HR departments on recruitment and retention. Develop schemes to attract people to health and care work. Develop dynamic joint health and care roles.	Possible	Minor	Medium
EM0013 - Economic - OtherAdult Protection Issues	Possible	Minor	Medium	• The professional leads are tasked with ensuring that there are adequate levels of skill and capacity to manage protection issues. Training is a key requirement for staff working in services so they have the knowledge to raise issues. Training on Adult Protection being prioritised. Adult Protection included in the clinical and care governance framework.	Unlikely	Minor	Low
EM0010 - Contractual Liabilities Assumed/Imposed Lack of robust contracting arrangements	Possible	Significant	Medium	• SLAs in place. Joint Commissioning & Procurement Strategy being developed.	Unlikely	Minor	Low

EM0016 - Economic - Other Not achieving full use of the Integrated Care Fund	Likely	Significant	High	• Plans are reflected in the Strategic Plan. Early development of plans.	Possible	Minor	Medium
EM0045 - Failure of Key supplier Budgets / Service planning	Likely	Significant	High	• The Strategic Plan sets out direction and more detailed plans on how to spend specific funds. Need to better coordinate service planning and budget setting through the IJB to ensure budget is aligned to agreed service priorities.	Possible	Minor	Medium
EM0046 - Customer / Citizen - Other Task Duplication	Almost Certain	Significant	High	• Agreement for lead organisation for functions or on use of one template and/or system. Clinical and care governance framework in place.	Possible	Minor	Medium

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Shetland's Local Outcomes Improvement Plan 2016-20
Reference Number:	CC-33-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

The Integration Joint Board (IJB) note the report presented as background to the development of the Local Outcomes Improvement plan (LOIP) which was presented to Policy & Resources Committee on 18 April 2016 and Shetland Islands Council on 20 April 2016.

The IJB sign up to Shetland's Local Outcomes Improvement Plan 2016-20

The IJB support its implementation as a statutory Community Planning partner.

High Level Summary:

The LOIP is a shared expression of ambitions and related commitments for communities in Shetland. By agreeing the LOIP, partners are jointly responsible for ensuring the Shetland Partnership (Community Planning Partnership) delivers on the commitments in the plan. The IJB will be individually responsible for how it acts as a partner to help ensure these commitments are fulfilled.

Corporate Priorities and Joint Working:

As the Action Plan for delivering the Community Plan, the LOIP is strategically important for the IJB as a key Community Planning Partner.

A top priority for the IJB well supported by the LOIP is to support older people across Shetland so they can get the services they need to help them live as independently as possible.

Key Issues:

This process would be based on a series of five workshops, themed around the Scottish Government's 5 National Outcomes, which also cover the outcomes of the Community Plan – namely: Healthier; Safer, Wealthier and Fairer, Greener and Smarter.

The LOIP also includes a section on 'Ways of Working' – these are approaches and philosophies that partner agencies are encouraged to promote and use when designing and delivering services to support progress towards achieving priorities and outcomes; they include: prevention, intergenerational working and co-production.	
Implications :	
Service Users, Patients and Communities:	The Shetland Partnership Summit offered an opportunity for delegates to comment on the LOIP and provide Quality Assurance in the sense that the priorities identified 'ring true' for the wider Shetland Community. The LOIP also sets out the Shetland Partnership's approach to community involvement during the course of the plan, an approach designed to deliver improved outcomes through compliance with the Community Empowerment (Scotland) Act 2015.
Human Resources and Organisational Development:	None known, however Directorate and service planning arrangements will detail any Human Resources implications arising from the LOIP where necessary.
Equality, Diversity and Human Rights:	The LOIP is a high-level document that supports policy development and has, therefore, not been subject to a formal Integrated Impact Assessment. In saying this, however, it should be noted that reducing inequalities has been a central aim in developing the LOIP and that many of the priorities identified are specifically intended to improve outcomes for groups who may otherwise be disadvantaged or marginalised.
Legal:	As noted, the Community Empowerment (Scotland) Act 2015 requires Community Planning Partnerships to produce a LOIP. The LOIP will require further review in line with statutory guidance once issued. The IJBs role as a Community Planning Partner and lead agency for Community Planning, could be subject to challenge were the LOIP not adopted and supported.
Finance:	There are no direct financial implications arising from this report. The IJB is responsible for the planning of integrated care services and will consider the LOIP within its strategic planning process going forward.
Assets and Property:	There are no issues arising from this report
Environmental:	The LOIP supports Community Planning environmental priorities under the 'greener' theme, these include: adapting to and mitigating climate change; protect and enhance our natural environment and promote the benefits to society (including health) it provides; and, resource and energy efficiency.
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 its responsibilities in overseeing implementation of the LOIP in Shetland.
Previously considered by:	This report has not been presented to any other formal meeting.

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Shetland's Local Outcomes Improvement Plan 2016-20
Reference Number:	CC-33-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 This report presents the background to the development of the Shetland Local Outcomes Improvement Plan (LOIP) and outlines the decision required by the IJB.

1.2 The LOIP is a shared expression of ambitions and related commitments for communities in Shetland. So every community planning partner should agree its content.

1.3 By agreeing the LOIP, partners are jointly responsible for ensuring the Shetland Partnership (Community Planning Partnership) delivers on the commitments in the plan. The IJB is individually responsible for how it acts as a partner to help ensure these commitments are fulfilled.

1.4 The Shetland Partnership Board endorsed the draft LOIP 2016-20 at its meeting of 10 March 2016.

2. Background

2.1 Up until now, the 'action plan' for delivering Shetland's Community Plan has been known as the Single Outcome Agreement (SOA). The current Community Plan 2013-20 (see background documents) had an SOA that ran from 2013, with annual reviews and a significant update scheduled for 2016.

3.2 As such, the Shetland Partnership agreed in March 2015 to initiate a development process that would deliver a new Single Outcome Agreement for the period 2016-20 some 12 months hence.

3.3 Three development priorities were also identified; these would form the basis for discussions in the workshops. The development priorities were:

- Developing a smaller number of evidence-based priorities to provide the focus for Community Planning in Shetland.
- Developing priorities that seek to address inequalities in Shetland.
- Developing priorities that require Partnership Working – i.e. they cannot be achieved by any one partner.

3.4 Concurrent with planning the workshops, detail emerged on the content of the Community Empowerment (Scotland) Act 2015 – this legislation received Royal Assent in July 2015 and makes a number of provisions regarding Community Planning.

3.5 A requirement for Community Planning Partnerships to facilitate the creation of Local Outcomes Improvement Plans (LOIPs) was included among these provisions; these are intended to take the place of Single Outcome Agreements.

3.6 As such, the development process was able to take account of these provisions, to a degree, and the development workshops became the first step in the drafting of the LOIP 2016-20.

3.7 Evidence presented by Thematic Groups from across the Shetland Partnership led to a number of priorities being identified for each Outcome Area and these, together with actions (to deliver priorities), indicators (to measure progress towards delivering priorities and outcomes) and contextual information have been included in the LOIP document.

3.8 The LOIP was discussed at the Shetland Partnership Board on 3 December 2015 and at the Shetland Partnership Summit, which took place on the 18 February 2016 and brought together delegates from across the Shetland Partnership, partner agencies and community groups to carry out quality assurance on the priorities, actions and indicators as presented by Thematic Group representatives.

3.9 Following this, the LOIP was brought to the meeting of the Shetland Partnership Board on 10 March 2016, where it was discussed before being endorsed and recommended to partner agencies.

3.10 The LOIP 2016-20 is presented at Appendix A.

3. Conclusions

3.1 The LOIP 2016-20 has been developed through a robust and wide-ranging development process; this has resulted in a focused set of priorities that will form the basis for Community Planning for the remaining lifespan of the Community Plan.

5.2 The IJB is asked to recommend that the LOIP is adopted, and its implementation supported as a Community Planning Partner.

5.3 The role of the IJB is to review and direct on any issues which they see as significant to sustaining and progressing service delivery.

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16 May 2016

Appendices
Appendix 1 – Shetland Local Outcomes Improvement Plan 2016-20

Background documents
Shetland's Community Plan -
http://www.shetland.gov.uk/communityplanning/documents/CommunityPlan2013FINAL.pdf

Shetland's Outcome Improvement Plan – DRAFT

Formerly known as the Single Outcome Agreement (SOA)

March 2016

Contents

Foreword

Ralph Roberts,

Chair, Shetland Partnership Performance Group

Chief Executive, NHS Shetland

Welcome to the Shetland Partnership's Local Outcomes Improvement Plan (LOIP) 2016-20 – this sets out the activity of the Shetland Partnership to deliver the Shetland Community Plan[1]. The LOIP describes the priorities we have identified that will have the greatest benefit to Shetland and how we are going to deliver these over the next four years.

But first, a brief word on terminology. Up until now, the 'action plan' for the Shetland Partnership was termed the 'Single Outcome Agreement' (SOA) and, since the inception of the Community Plan in 2012/13, the Shetland Partnership has had a Single Outcome Agreement that was reviewed annually[2]. The LOIP is similar to the SOA, with a few crucial differences. SOAs were agreements drawn up between local partners delivering services in Shetland and the Scottish Government; the LOIP is a local plan drawn up between partners and *communities*. Also, the LOIP is specifically designed to bring together the efforts of Community Planning partners to address *inequalities*, both in Shetland as a whole and in any communities that are particularly disadvantaged – this can include both geographical communities and communities that share common interests or characteristics.

Creating a LOIP for their local area is a responsibility that has been given to Community Planning Partnerships by the Community Empowerment (Scotland) Act 2015. This is a piece of legislation that has big implications for the Shetland Partnership helping to shape the development of the LOIP and helping guide our approach to securing community participation in Community Planning. Since the Shetland

[1] http://www.shetland.gov.uk/communityplanning/documents/CommunityPlan2013FINAL.pdf
[2] http://www.shetland.gov.uk/communityplanning/community_planning.asp

Partnership had already committed to reviewing our SOA at this stage of the Community Plan, the new legislation and the chance to produce the LOIP has come at a perfect time.

We have come a long way since the Community Plan was launched, and our progress has also helped shape our thinking about how to develop the LOIP and what should be included in it. The section 'Shetland in Context' sets out some of the progress we have made and how this has played into developing our work for the next four years. The Shetland Partnership has matured and developed in this time and we have new ideas about how best to add value to Shetland life through Community Planning. This includes the greater emphasis on addressing inequalities and the desire to create a more focused strategic plan through the LOIP.

We remain committed, however, to the original outcomes outlined in the Community Plan. The LOIP is more focused than the SOA, the total number of outcomes has been reduced from the original eight outlined in the Community Plan to 5 in this document. The LOIP also reflects a greater focus on a smaller number of key priorities for the Shetland Partnership to work towards.

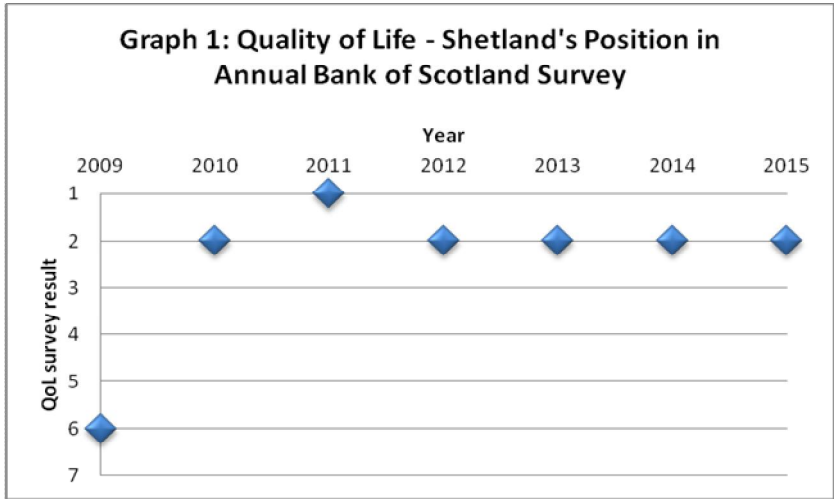
The section 'Shetland Partnership Outcomes – What We Will Do' details the specific priorities and actions that the Shetland Partnership is focusing on in 2016-20 to achieve the outcomes of the Community Plan. The section 'Community Planning in Shetland – Ways of Working' details approaches across the Partnership that will enhance the work of partner organisations and improve the participation of communities in Community Planning.

We will continue to develop our thinking and approaches to Community Planning and, in this respect, the LOIP can be seen as marking a transition between the previous approach, focused on the SOA and contributions from partner agencies, to a new approach focused on delivering improved outcomes on behalf of an empowered Shetland Community.

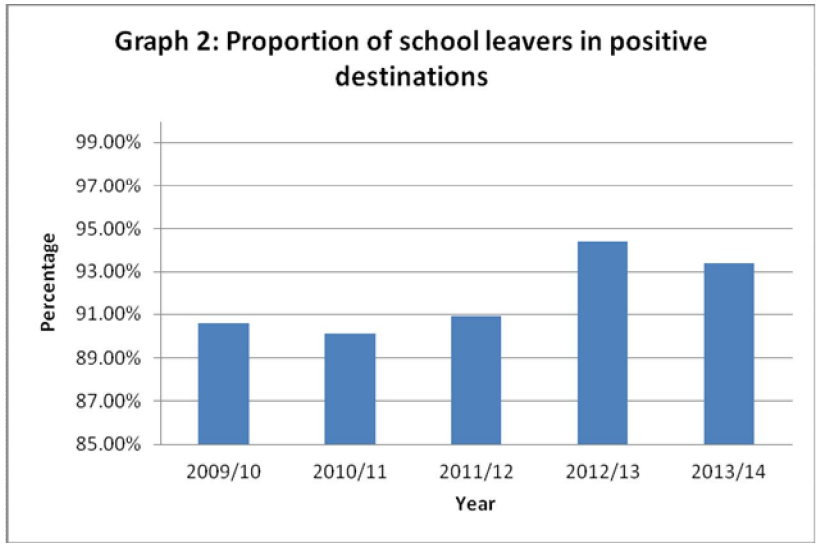
I hope you find this document helpful in describing the work planned for local Community planning and that you will remain committed to working in partnership and delivering on behalf of the Shetland Partnership.

Context

This section gives some background to the Shetland Partnership's progress towards achieving our outcomes since 2013, which helps to explain why we have decided on the priorities we have identified for the next four years. The data and evidence presented here shows where we need to improve or change our approach in order to achieve the outcomes of the Community Plan and will, therefore, help us focus our efforts on the key priorities we need to be working together to deliver.



The Shetland Partnership has been working for the last three years to better understand Shetland as a place. Gathering evidence across a range of indicators has allowed for the analysis of trends to demonstrate how well we are achieving the outcomes set out in the Community Plan.



Many of these trends are positive and, in general, Shetland remains a very good place to live and the majority of the people who live here experience a good quality of life - in 2015 Shetland was again ranked in the top 3 for Quality of Life in Scotland (Graph 1)[3]. Our children and young people are also generally experiencing positive outcomes – 93.4% of our school leavers in 2013/14 went on to positive destinations against a backdrop of strong performance since 2009 (Graph 2). The methodology for measuring this has now changed, broadening to include all those who are 'participating' in activity post-school; however, Shetland still performs very well with

[3] http://www.lloydsbankinggroup.com/Media/Press-Releases/2016-press-releases/bank-of-scotland/orkney-retains-the-title-for-best-rural-quality-of-life/

95.1% classed as participating in the first half of 2015/16[4]. People in Shetland also consistently report that they feel safe in their community (99% according to latest Scottish Household Survey data from 2014[5]).

The Shetland Partnership uses data such as the indicators presented above to determine how to best meet the needs and achieve positive outcomes for the people of Shetland through Community Planning. Generally, as demonstrated in the cases above, Shetland performs well across a number of key measures. We therefore have had to look a little deeper into the available information and also include case studies, stories and other information sources when determining our priorities.

The development process for the LOIP 2016-20 has involved a series of five workshops themed around the Scottish Government's 5 National Outcomes, which are also covered by the outcomes of the Community Plan. The themes were:

Wealthier and Fairer
Smarter (Learning and Supportive)
Greener
Safer
Healthier (Healthy and Caring)

Each workshop involved the relevant thematic group (see our Partnership Guide[6]) presenting relevant data to show areas where we were performing well and where we could improve under each theme. Having heard the available evidence, members of the Shetland Partnership attending the workshop then got the opportunity to discuss what the priorities should be for delivering the outcomes in the Community Plan.

Priorities have also been informed by the work of Shetland's Commission on Tackling Inequalities, an initiative established by the Shetland Partnership Board in summer 2015. The Commission has looked at a variety of evidence demonstrating where inequalities exist in Shetland under a number of categories. Given that reducing inequalities and the negative outcomes that result is a key element in designing the LOIP,

[4] https://www.skillsdevelopmentscotland.co.uk/media/35877/shetland-briefing-151127-digital.pdf
[5] http://www.gov.scot/Topics/Statistics/16002/LATables2014/ShetlandIslands2014
[6] http://www.shetland.gov.uk/communityplanning/documents/PartnershipGuide.pdf

this information has been invaluable in helping to define where the Shetland Partnership should focus their efforts collectively and as individual partners.

The Shetland Partnership's Annual summit, held in February 2016, also provided a valuable opportunity to involve a wide range of partners, stakeholders and community representatives in helping to shape the LOIP. During this event, delegates heard presentations from the Improvement Service[7] and the Commission on Tackling Inequalities[8] before entering workshops to discuss the priorities identified under each outcome – as introduced by Thematic Groups[9]. These discussions have formed part of the quality assurance process for the LOIP as a whole and have helped to ensure that the Shetland Partnership and the wider community have been able, to an extent, to take ownership of the activities that this Plan will guide for the next four years.

Each Community Plan outcome area now has a small number (generally 3) of defined priorities that the Shetland Partnership is working to deliver over the next 4 years and the 'Shetland Partnership Outcomes – What We Will Do' section of this document outlines what these priorities are, what actions are planned to achieve them and what data we will use to measure progress. An example from each outcome area is set out below to show how this evidence has been used and why the priorities have been selected.

Outcome A

Priority: Ensuring that the needs of our most vulnerable children and young people are met

As demonstrated by Graph 2, Shetland is a very good place for the majority of our children to grow-up and the chances of progressing from school to employment, further/higher education and training are high. Recognising this, there is a need to re-focus on those of our children and young people who do not attain these positive outcomes and develop targeted strategies to help this more vulnerable group. In the first instance, there is a need to identify who these children and young people are to allow partners to work together to develop bespoke, family-based solutions to the often complex issues they face.

[7] http://www.shetland.gov.uk/communityplanning/1.ShetlandCommunityPlanningOutcomesPresentation-Feb2016.pptx
[8] http://www.shetland.gov.uk/communityplanning/documents/2.CommissionPresentation-ShetlandPartnershipSummit-Feb2016.ppt
[9] http://www.shetland.gov.uk/communityplanning/documents/3.ThematicGroupsPresentation-ShetlandPartnershipSummit-Feb2016.ppt

The Shetland Partnership wants to work together as agencies and with families to ensure that the most vulnerable children and young people in Shetland can thrive.

Outcome B

Priority: Improve mental health and resilience

The key action in relation to this priority focuses on reducing loneliness and stigma to improve the outcomes of people with poor mental health and help prevent poor mental health in the first place. Research into deprivation and social exclusion in Shetland (2006)[10] and peer-research carried out by young people in Shetland (2011)[11] both demonstrated a link between people feeling part of their community and their mental health and wellbeing. Stigma, associated with people being 'labelled' in negative ways within their community, was seen as a major factor in exacerbating poor outcomes for individuals and families. Further research at a national level[12] indicates that loneliness (a mismatch between relationships we have and the relationships we want), increases the risk of depression; can lead to a 64% increased risk of developing clinical dementia; increases the risk of high blood pressure; and, is an equivalent risk factor for early death to smoking 15 cigarettes a day.

Shetland's Commission on Tackling Inequalities has also come to the conclusion that this is an area that should be prioritised, based on the evidence outlined above. The Shetland Partnership aims to prevent the negative consequences of loneliness and stigma through raising awareness of the issues and helping communities develop their own solutions through *co-production*. Please see page 41 in the 'Ways of Working' section for an example of how this may proceed.

[10] Research into Deprivation and Social Exclusion in Shetland (2006): http://www.shetland.gov.uk/communityplanning/documents/Dep.andsocialexclusionexecsummary-eperring.pdf

[11] Poverty is Bad – Let's Fix It!! (2011): http://www.shetland.gov.uk/youth_services/documents/Shetland20Report0Final20Draft.pdf

[12] [12] Joseph Rowntree Foundation (2013): https://www.jrf.org.uk/report/loneliness-resource-pack

Outcome C

Priority: Reduce the harm caused by alcohol

The misuse of alcohol is a common factor in a number of areas that impact negatively on the quality of life of people in Shetland. Alcohol contributes to harm to people and property through vandalism, anti-social behaviour, drink-driving, violence (domestic and non-domestic) and fires (deliberate and accidental). There is a distinct overlap between mental health and substance use/misuse; ongoing audits of suicide and sudden deaths in Shetland show that alcohol is almost always a factor – either a significant quantity has been used immediately prior to death, or there has been a history of unhealthy drinking patterns. Almost 1 in 10 cases in Accident and Emergency are alcohol related, and of these, a third have Mental Health issues[13]. Alcohol and drugs are the top cause for child protection referrals in Shetland, and resulted in 11 registrations on the Child Protection Register in 2013/14.

All of the above outcomes have negative impacts on individuals, families and communities in Shetland. The Shetland Partnership aims to change the culture in relation to alcohol in Shetland to reduce problem drinking. This culture change will include empowering licensees and vendors to refuse alcohol to those who have already had enough and to help communities and families assist those who may be at risk of harm through alcohol misuse.

[13] Scottish Community Safety Network, SOA development workshop presentation November 2015

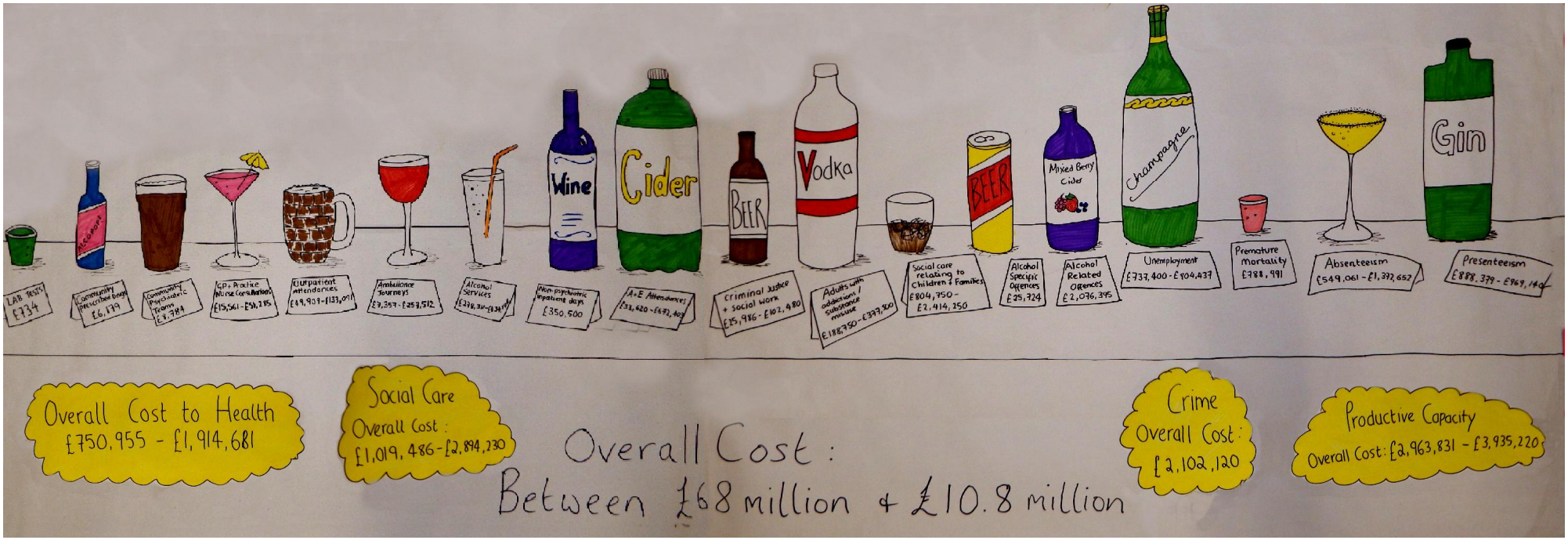


Figure 1: The costs of alcohol in Shetland per year (from Alcohol Focus Scotland[14])

Not only will this result in better outcomes for people living in Shetland, it will also represent a significant saving to public services locally – as demonstrated in figure 1 the costs associated with alcohol misuse are enormous when considered as a whole. There are significant benefits to reducing the harmful impacts of alcohol, for example, research shows that every £1 spent on young peoples' drug and alcohol interventions brings a benefit of £5-£8[15].

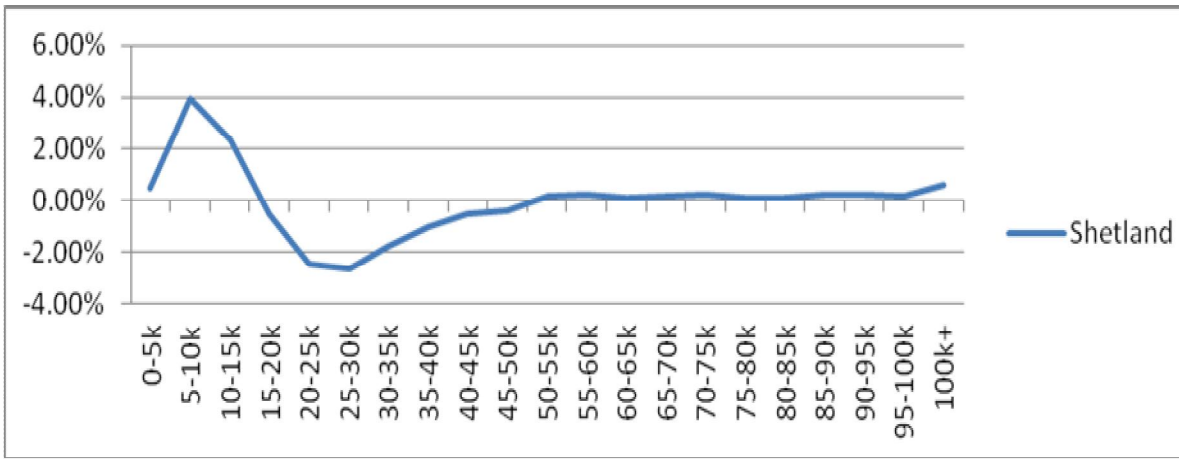
[14] http://www.alcohol-focus-scotland.org.uk/media/61624/The-Cost-of-Alcohol-Shetland-Islands.pdf . Illustration by Jill Hood

[15] National Treatment Agency for Substance Misuse(2014): http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf

Outcome D

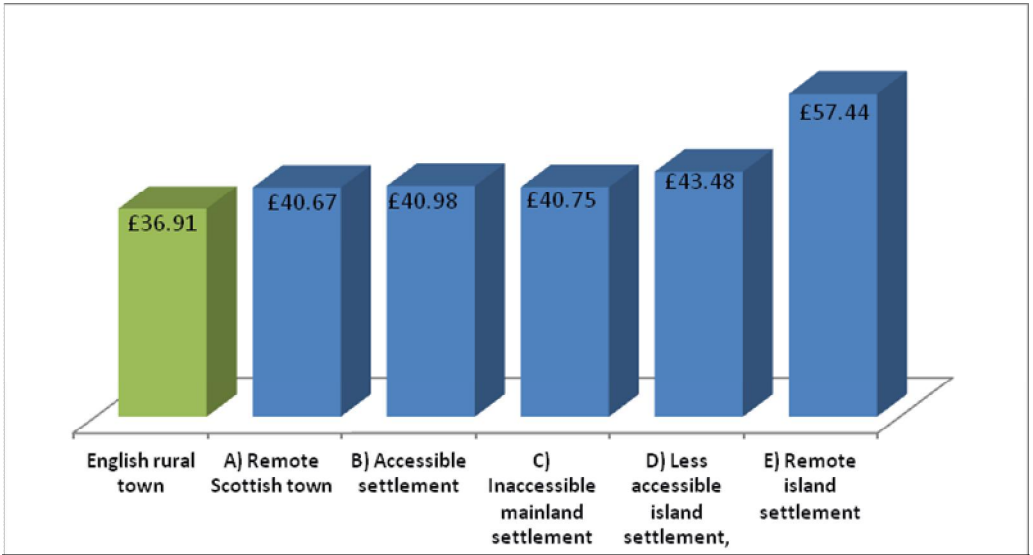
Priority: Make the best use of existing assets, infrastructure and human capital for sustainable economic development

Shetland's economy has been in rude health for a number of years now and, where the previous SOA emphasised maximising economic growth, this Plan seeks to consolidate economic prosperity for Shetland while sharing the benefits of this more widely in society. Graph 3, opposite, shows the proportional difference in pay-banding in Shetland for the period 2008 to 2014. It demonstrates that, during a period where the overall Shetland economy was performing well, the proportion of people earning in the low-middle income bands decreased while the proportion of people in low-very low income bands increased. There has been little change in the percentage of households with an overall income of £45,000 or more a year, but there has been a 2-3% shift in the number of households within, for example income bands £20,000-£30,000 to lower household incomes. This indicates that, whilst employment levels are high, earnings are reducing for those earning a typical household income – this raises the prospect of 'in-work' poverty, where the money a household brings in is not sufficient to avoid the negative outcomes associated with poverty despite employment being available to householders. Gender segregation (unequal distribution of men and women) in the workplace may also be a factor and it is thought that this results in a higher proportion of underemployment, part-time and lower paid employment for female workers compared to males.



Graph 3: Proportional Difference in Banding by £5,000 Bands, Shetland, 2008 to 2014

This is exacerbated further by the high cost of living in Shetland, as demonstrated by the Minimum Income Standard[16] – this report shows that living costs (such as food, energy, transport) are significantly higher in Shetland than in England. For example:



Graph 4: Weekly Food Basket by Area Type (Minimum Income Standard for remote rural Scotland 2013)

- For a single person living in a Northern Isles town, such as Lerwick, their weekly budget is 33.3% higher than for an equivalent person living in urban UK and 23.4% higher than for a person living in an English rural town;
- For a single person living remotely from a town in the Northern Isles, such as in Hillswick, their weekly budget is 74.1% higher, and 40.8% higher for their urban and rural England counterpart;

Graph 4, opposite, gives an example of the disparity of costs for people living in different areas by analysing a typical weekly food basket.

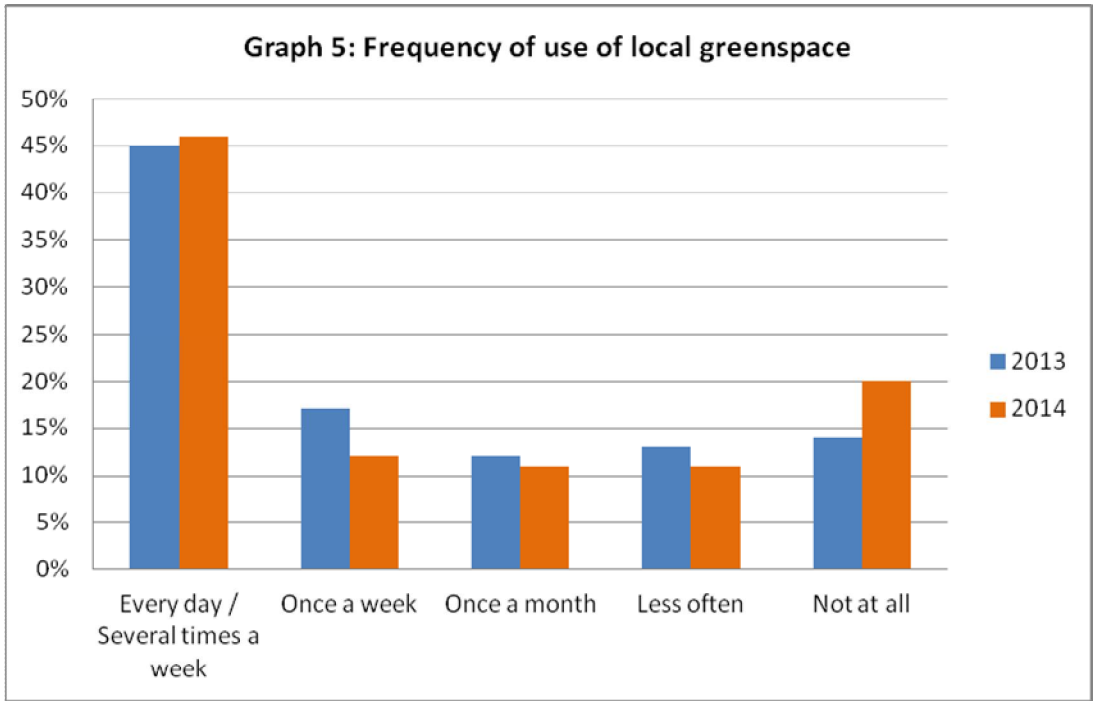
The priorities in this outcome area have been heavily influenced by the Commission on Tackling Inequalities. The Shetland Partnership wants to maintain strong economic performance while reducing inequalities by targeting approaches and resources where they can most benefit the groups who are currently disadvantaged.

[16] http://www.hie.co.uk/common/handlers/download-document.ashx?id=1bdb4dc2-9521-4998-853b-e2cbdf9258d2

Outcome E:

Priority: To protect and enhance our natural environment and promote the benefit to society (including health) that it provides

Shetland is renowned for its natural environment. This is an important contributing factor in what makes Shetland a good place to live and the diversity of wildlife and landscape in Shetland are a significant draw in terms of tourism and the economic benefits this brings. However, Shetland remains vulnerable to environmental degradation and losing the benefits that the natural environment can bring to individuals and communities if we do not act to protect and enhance the assets we have. People in Shetland tend to be more satisfied with local green-space (89% vs. 76%) and access it more often (46% vs. 37%) than the Scottish average; however, the proportion of people who never access local green-space is increasing locally (Graph 5)[17]. We would like to reverse this trend; the social benefits and benefits to physical and mental health of people accessing their local natural spaces are considerable.



Communities who value the amenity of their local environment are also likely to be happier communities and people will be less likely to engage in crimes such as vandalism. These communities are places where people want to live and are more resilient as a result. Physical activity through outdoor access is an important source of exercise for a wide range of people and can prevent issues such as obesity and heart disease as well as helping to

[17] http://www.gov.scot/Topics/Statistics/16002/LATables2014/ShetlandIslands2014

keep older people active into older age and better able to support themselves. Active travel – cycling or walking to work and school – also ties in with this, keeping people fit while protecting the environment by reducing the emissions of carbon dioxide and other pollutants from vehicles. The Shetland Partnership wants to maximise the opportunities for people to access the natural environment in Shetland, while taking measures to ensure that harmful impacts are minimised.

Common Themes

There are two common themes running through the priorities set out in the LOIP of **equity** and **resilience**. Equity refers to making life better for everyone in Shetland by targeting the most vulnerable and disadvantaged in our communities and helping them achieve positive outcomes. Resilience is about helping people and communities to sustain positive outcomes and allowing them to face challenges as they arise. The Shetland Partnership will continue to support and develop these themes and they may form the basis for discussion with communities when developing future plans to look beyond this LOIP.

Shetland Partnership Board Priorities

Community Planning in Shetland aims to make Shetland the best place to live and work by helping to create communities that are:

Wealthier and Fairer
Leaning and Supportive
Healthy and Caring
Safer
Greener

The LOIP demonstrates the priorities for the Shetland Partnership as a whole; however, the Shetland Partnership Board has also taken the step of identifying 3 (or 4) top priorities that we will seek to deliver by 2020. These priorities represent the areas where we really need to focus activity to improve the lives of people in Shetland and where we can make the most difference by working together.

They are:

- Making the best use of existing assets, infrastructure and human capital for sustainable socio-economic development.
- Ensuring the needs of our most vulnerable children and young people are met.
- Supporting the development of a digital, diverse and innovate business base.

Shetland Partnership Outcomes – What We Will Do

Outcome A **Shetland is the best place for children and young people to grow up**			
Priority	**Actions**	**Timeline**	**Responsible Officer and/or Group**
To ensure the needs of our most vulnerable children and young people are met.	Identification of vulnerable children and young people across the partnership.	August 2016.	ICYPSPG
	Build resilience and self esteem of the most vulnerable and improve outcomes for them using preventative, family-based approaches	December 2019.	ICYPSPG
	We will have an electronic system to support staff working with GIRFEC in Shetland having embedded the new GIRFEC process.	April 2017.	ICYPSPG

	Deliver the Looked After Children Strategy.	March 2018.	ICYPSPG
	Development of nurturing communities.	April 2019.	ICYPSPG
	Ensure there are facilities for meeting needs for short term care and respite.	April 2017.	ICYPSPG
To hear the voices of our children and young people.	Bring together different strands of work on engagement so that children and young people in Shetland are appropriately involved and their voices are better heard. E.g. Pupil Councils, Youth Voice, Members of Scottish Youth Parliament	August 2016.	ICYPSPG
	Monitor and measure the impact of the children and young people's voices being heard and feedback to them. Increase the number of children and young people's views recorded in GIRFEC and looked after children plans.	April 2018.	ICYPSPG

To support children and young people to develop physical competence and confidence from the earliest age	Support pre-school years to reach daily targets for physical activity by encouraging active play, and active travel at home and in care settings.	April 2018	ICYPSPG
	Support active schools and partners to engage all school aged children in sports and physical activity including targeting those most in need.	April 2017	ICYPSPG

Indicator (s) – linked to priorities				
Priority	**Indicator**	**Baseline (with date)**	**2020 Target**	**Update Schedule**
To ensure the needs of our most vulnerable children and young people are met.	% of pupils gaining 5+awards at level 5.	50% in 2012/13	55%	**Schedule needed**
To ensure the needs of our most vulnerable children and young people are met.	Every LAC has an Individual Education Plan.	**Choose starting point.**		Quarterly
To ensure the needs of our most vulnerable children and young people are met.	LAC Reviews are carried out within required timescales.	**Can choose which figure to start at.**		Quarterly

To ensure the needs of our most vulnerable children and young people are met.	Primary and secondary exclusion rates?	**Can ONLY use Shetland wide figures because of low numbers.**		On INSIGHT website, local measure for Attainment V's Deprivation.
To ensure the needs of our most vulnerable children and young people are met.	Proportion of pupils entering positive destinations.	93.4% in 2013/14	95%	**Schedule needed**
To hear the voices of our children and young people.	% of children and young people's views being recorded in GIRFEC and looked after children plans.	**Baseline needed**	**Targets needed**	**Schedule needed**
To hear the voices of our children and young people.	% of schools with Pupil Councils	**Baseline needed**	100%	**Schedule needed**
To support children and young people to develop physical competence and confidence from the earliest age	Participant sessions	39,376 in 2014/15	To be agreed	**Annual**
To support children and young people to develop physical competence and confidence from the earliest age	Distinct participants	55% of school population were distinct participants in 2014/15	75%	**Annual**

Indicators – related to outcome			
Indicator	**Baseline (with date)**	**2020 Target**	**Update Schedule**
% of children at P1 check at risk of overweight or obesity	19.3 (08/09) 22.6 (09/10) 21.8 (10/11) 23.4 (11/12) 21.2 (12/13) 17.9 (13/14) 27.1 (14/15)	12% at P1 check at risk of overweight.	Annual

Outcome B **We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age**			
Priority	**Actions**	**Timeline**	**Responsible Officer and Group**
Increase physical activity (amongst those least active)	We will encourage and enable the inactive to be more active and we will encourage and enable the active to stay active throughout life through the development of a local Sport, Physical Activity and Health Strategy which will include: • Improving our active infrastructure – people - i.e. volunteering capacity and places – including footpaths; indoor and outdoor facilities (e.g. leisure centres) • Building on localities based models, including Sports Hubs and health improvement locality working, to increase physical activity; targeting those who can most benefit (e.g. walking groups and chair-based	Development of a local Sport, Physical Activity and Health Strategy by March 2017 and ongoing implementation to 2022	Sport, Physical Activity and Health Strategy Group

	exercise for older people; decrease costs of sport & leisure activities for poorer families) • Improving opportunities to participate, progress and achieve in physical activity including sport. • Using 'return on investment' work to inform the development of the Strategy.		
Improve mental health and resilience	We will support individuals to be part of their community, to reduce loneliness and increase community connectedness	Development of specific programmes of work by April 2017	TBC
	We will support wellbeing and resilience in communities through physical activity and sport (as above)	Implementation across Shetland by April 2019 Through Sports, Physical Activity and Health Strategy (as above)	

People are the key assets in their community	We will support individuals to be part of their community, to reduce loneliness and increase community connectedness (as above)	Development of specific programmes of work by April 2017 (as above)	TBC
	We will develop self-management capacity and resources within the community; for people with long term conditions; older people and other vulnerable groups.	Implementation of specific programmes by April 2017	
	We will support people to live as independently as is appropriate for each individual, in their own communities, through all partners working together with individual communities; utilising WYFY and local asset based approaches	Implementation of specific programmes by April 2017	

Indicator (s) – linked to priorities				
Priority	**Indicator**	**Baseline (with date)**	**2020 Target**	**Update Schedule**
Physical activity	Physical Activity Levels	41% in 2011	50% by 2022	Annual
Mental health	Suicide Rate*	24.8/100K (2008-2012)	13/100K (2018-2022)	Annual

People are in the key assets their community	Suggested: 90% of all WYFY plans include assessment of and planning for social inclusion (?)	TBC	TBC	Annual

*small numbers mean we do fluctuate year on year but the trend over the last 10 years is reducing and we are below the Scottish average.

Indicators – related to outcome			
Indicator	**Baseline (with date)**	**2020 Target**	**Update Schedule**
Smoking prevalence : reduce percentage of adults who smoke	22.4% in 2012	5% by 2022	Annual in Sept
Alcohol related hospital admissions	477/100K (2014)	300/100K	Annual
Reduce premature mortality (from CHD among under 75s)	63.9 per 100,000 in 2013*	64.7 per 100,00 European Age Standardised rate	Annually in Jan

Outcome C **Shetland is a safe place to live for all our people, and we have strong, resilient and supportive communities**			
Priority	**Actions**	**Timeline**	**Responsible Officer and/or Group**
Keeping People Safe	Carry out an analysis to understand the increase in reported domestic abuse incidents and the drivers behind this for comparison against national rate	March 2017	Domestic Abuse Partnership
	As part of the Implementation of the revised Domestic Abuse Strategy (2017-22), undertake a review of the Domestic Abuse Partnership and its associated sub-groups to ensure that preventing gender based violence is resourced and supported jointly across the partnership	March 2017	Domestic Abuse Partnership

	Consider how to approach working with perpetrators, linking with work on Community Justice to reduce reoffending	March 2018	Domestic Abuse Partnership
	Deliver the Shetland Anti-Bullying Strategy, including the development of information and training on prejudice-based bullying and a relevant linked indicator	March 2018	Lindsay Tulloch, Shetland Together
Reduce the harm caused by alcohol	Reduce the harm caused by alcohol through the delivery of the Shetland Alcohol and Drugs Partnership strategic plan	March 2018	Shetland Alcohol & Drugs Partnership
	Refresh and deliver Drink Better Strategy and action plan	March 2017	Shetland Alcohol & Drugs Partnership
	Working with licensees & vendors , supporting and empowering them to refuse alcohol to drunk customers	March 2018	Community Safety and Resilience Board

	Continue support for OPEN Peer Education with Young people including input from Police Youth Volunteers	March 2018	Shetland Alcohol & Drugs Partnership
Improve Community Justice outcomes for those at risk of offending or reoffending, victims, families and communities	Deliver the Community Justice Transitional Plan	April 2017	Community Justice Partnership
	Identify and develop appropriate measures for Community Justice (i.e. reoffending, diversionary activities, community sentencing	April 2017	Community Justice Partnership
	Prioritise support for a campaign to reduce stigma in communities, developing community-based solutions in relation to Community Justice which support full participation, and improved outcomes for victims, persons who have been convicted of offences and their families'	April 2020	Community Justice Partnership
Build community resilience	Develop up to two community resilience plans as a pilot (linking with Community Forum / Localities work)	April 2017	Vaila Simpson, Shetland Islands Council

	Develop multi-agency approaches to identifying the most vulnerable people in communities and putting in place measures to prevent harm	March 2018	Billy Wilson, Scottish Fire and Rescue Service
	Carry out analysis of unintentional harm data (deaths, emergency hospital admissions, SFRS data, water safety incidents and A&E attendance data) to develop our understanding of this in Shetland and to link with the Building Safer Communities Programme	March 2018	Vaila Simpson, Shetland Islands Council

Indicator (s) – linked to priorities				
Priority	**Indicator**	**Baseline (with date)**	**2020 Target**	**Update Schedule**
Keeping people safe	Domestic abuse reporting	Pending completion of action above	Pending completion of action above	Pending completion of action above
	Anti-bullying strategy indicator	Pending completion of action above	Pending completion of action above	Pending completion of action above
Reduce the harm caused by alcohol	No. of alcohol related A&E attendances	706 (2014/15)	Decrease by 20%	Annual data
	No. of problem drinkers	12.2% (2014/15)	10%	Annual data
Community Justice	Community Justice indicator	Pending completion of action above	Pending completion of action above	Pending completion of action above

Community Resilience	Unintentional Harm statistics	Pending completion of action above	Pending completion of action above	Pending completion of action above

Outcome D - WEALTHIER AND FAIRER **Shetland has sustainable economic growth and all our people have the chance to be part of island life.**			
Priority	**Actions**	**Timeline**	**Responsible Officer and Group**
D1: Attracting more people to Shetland to live, work, study and invest.	Develop a 10 year plan to attract people to live, work, study and invest	Final Draft of Plan to be presented to SPB end March 2016. Implementation 2016-2025.	Rachel Hunter (HIE) and Development Partnership
	Develop and deliver the Local Housing Strategy, supporting SPB's ambition, where feasible, to attract more people to live, work, study and invest in Shetland.	New Local Housing Strategy estimating completion by September 2016.	Anita Jamieson (SIC) and Development Partnership
	Develop and deliver a refreshed Transport Strategy, supporting SPB's ambition, where feasible, to attract more people to live, work, study and invest in Shetland.	The Transport Strategy Refresh is being developed alongside the Shetland Inter Island Transport Study (SIITS) reflecting the significance of the relationship between the two. The SIITS will complete Stage 1 in June 2016 and the Transport Strategy Refresh will be concluded at the same time.	Michael Craigie (SIC) and Development Partnership
D2: Make the best use of existing assets, infrastructure and human	Develop a shared policy approach in relation to fostering resilient rural communities and	Working group to be set up by end April 2016	Vaila Simpson (SIC) and Development Partnership

capital for sustainable socio-economic development	sustainable community assets	Desktop research to be carried out by end June 2016 Action plan and timescales to develop a shared approach to be developed by end August 2016 Action plan to be ratified by Development Partnership September 2016	
	Deliver the Shetland Skills Investment Plan	Skills Strategy group to oversee delivery 2016-19.	Dave McCallum (SDS) and Skills and Learning Strategy Group
	Understand the level and issues surrounding in-work poverty in Shetland	Establish cross agency project group-April 2016 Data gathering – June 2016 Project development and delivery commencing Winter 2016/17	Emma Perring (SIC) and Development Partnership
	"Fair Islands" (working title). Project to address gender balance, gender segregation and stereotyping in Shetland in order to encourage more women and girls into non-traditional sectors	Occupational Segregation Working Group set up September 2015. Action Plan to be developed	Rachel Hunter (HIE) and Development Partnership

		by end June 2016. Action plan to be ratified by Development Partnership September 2016. Delivery of plan 2016-18.	
	Identify groups at most risk from "digital exclusion" and use existing resources to address gaps identified to enable barriers to access and lack of know-how to be overcome	Community Learning and Development Partnership Review March 2017	June Porter (SIC) and Community Learning and Development Partnership
D3: Supporting the development of a digital, diverse and innovative business base.	Ensure partners working on broadband projects co-ordinate to ensure that superfast broadband is available to all premises by 2020	2020.	Neil Grant (SIC) Development Partnership
	Investigate how mobile connectivity could be improved across Shetland.	Plan to be developed by 2020 –	Douglas Irvine (SIC) Development Partnership
	Develop an action plan to support the development and growth of the creative industry sector in Shetland	Baseline information on the creative industry sector to be complete by end June 2016. Action plan to reach final draft stage by end September 2016. Action plan to be endorsed by Development Partnership by December 2016. Deliver of three year action	Rachel Hunter (HIE) Development Partnership

		plan to 2019.	
	Pilot one innovative leadership development programme across the business base	Working group to be set up by September 2016. Programme development 2016-2017 Programme delivery from mid 2017.	Lead officer TBC (Development Partnership)
	Promote the business benefits of the living wage to the private and third sector.	Promotional campaign to be developed by end March 2017. Promotion to be embedded in HIE/Business Gateway interactions with clients until 2020.	Rachel Hunter (HIE) and Development Partnership
	Develop a plan to develop up to three Island Innovation Zones in Shetland.	Plan to be developed by end December 2017.	Douglas Irvine (SIC) and Development Partnership

Indicator (s) – linked to priorities
What indicator(s) will tell us how well we are delivering this priority?
New measures or is data currently available on current SOA indicator list?
How often will indicator be updated?

Priority	Indicator	Baseline (with date)	2020 Target	Update Schedule

D3	Business start-up rate (per 1,000) population	4.5 (2012-13)	5	Annually – calendar year. Scottish Clearing Bank Data.
D2	Proportion on out of work benefits (JSA or equivalent)	1.5% (2012/13)	1.3%	Annual average DWP
D2	Youth out of work claimant count	3.5% (2012/13)	2%	Annual data DWP
D1	Number of new homes	SIC HOUSING TO COMPLETE		
D3	No of Shetland businesses formally signed up to Living Wage accreditation schemes (Scottish Business Pledge or Living Wage Foundation)	3 (2016)	12	Data available on following websites: https://scottishbusinesspledge.scot/your-pledge/pledge-wall/ http://www.livingwage.org.uk/employers
D2	% difference between male and female gross weekly earnings	23.4% (2015)	18.3%	Extracted from NOMIS data- annual data.
D1 D2	Number of FE/short course students enrolled at Shetland's Colleges	5367 (2012/13)	5903	Source: Shetland in Statistics 2014. *NB 2020 Projection subject to conclusion of SIC Tertiary Education Review*
D1 D2	Number of HE students enrolled at Shetland's Colleges	279 (2012/13)	307	Source: Shetland in Statistics 2014. *NB 2020 Projection subject to conclusion of SIC Tertiary Education Review*

D2	No of Modern Apprentices in training in Shetland	309 (September 2015)	362	SDS WEBSITE https://www.skillsdevelopmentscotland.co.uk/in-your-area/shetland-islands/

Indicators – related to outcome			
Indicator	**Baseline (with date)**	**2020 Target**	**Update Schedule**
% of premises able to link to superfast broadband	33% (2015)	100%	HIE Data NB. This is a Scottish Govt target.
NB The Shetland Skills Investment Plan and *10 Year Plan will have more detailed indicators*			

Outcome E **We deliver all our services in an environmentally sustainable manner to safeguard and enhance our outstanding environment which underpins all our actions and our economic and social well-being**			
Priority	**Actions**	**Timeline**	**Responsible Officer and/or Group**
1. Mitigate, and adapt to, climate change	Protect and restore blanket bog. Map indicative areas of active blanket bog to establish baseline (SBRC)	3 peatland restoration projects in place by end 2015. No net loss of active blanket bog – ongoing. Blanket bog mapping repeat every 10 years.	Juan Brown, Environment Partnership
	Adopt National Flooding Plan with identified actions for local implementation	December 2016	Mary Lisk, Environment Partnership
	Raise awareness of climate change through engagement with communities in Shetland to inform a Local Action Plan	April 2017	Mary Lisk, Environment Partnership

	Develop Local Action Plan for recognised effects of climate change on Shetland using public consultation to define scope of actions needed	April 2019	Mary Lisk, Environment Partnership
	The Environment Partnership and Carbon Management Board will support partners to improve their environmental/ sustainability/ carbon/ climate change data gathering processes and reporting; encouraging collective responsibility and holding each other to account	March 2017 (Review Annually)	Mary Lisk, Environment Partnership/ Carbon Management Board
2. To protect and enhance our natural environment, and promote the benefits to society (including health) that it provides.	Publish and implement Shetland Environment Strategy	Publish – June 2016 Implement – ongoing Review – annually	Juan Brown, Environment Partnership
	Protect our aquatic environment (achieve Water Framework Directive Area Advisory Group water quality targets)	97% water bodies in good or better condition by 2015, 98% by 2020. Ongoing actions by partners	Juan Brown, Environment Partnership
	Develop online interactive map as single point of information to promote the natural environment and help people access nature	Launch 'Shetland Map' by end 2016	Juan Brown, Environment Partnership

	Maximise the opportunity for, and promote benefits of, active travel and access to nature	Timetable for actions and targets within 'access and amenity, chapter of Environment Strategy Ongoing – all	Juan Brown, Access and Amenity Sub-group
3. Resource and energy efficiency	Consider approaches to developing a Sustainable Energy Action Plan for Shetland; aiming to deliver, for example: • A programme of energy efficiency works in all partners properties to include where appropriate the use of renewable energy • Agree a Shetland standard for all partners in procurement of materials • Investigating the potential for small-scale, low-carbon, dispersed, community based district heating schemes and other community-based solutions to increase the heating options available in Shetland • Sustainable Energy solutions that maximise Community Empowerment	Scoping of Plan by April 2017	Mary Lisk, Carbon Management Board

	Develop a new Shetland Waste Strategy to include increasing recycling in Shetland (both commercial and domestic) to support the national waste strategy targets	April 2019	Mary Lisk, Environment Partnership

Indicator (s) – linked to priorities				
Priority	**Indicator**	**Baseline (with date)**	**2020 Target**	**Update Schedule**
Mitigate, and adapt to, climate change; Resource and energy efficiency	Carbon Emissions	34, 500 t CO^2 (2007/8)	42% reduction	Annual
To protect and enhance our natural environment, and promote the social benefits it provides.	Proportion of water bodies in good or better condition (Water Framework Directive Area Advisory Group targets)	89% (2013)	98%	Annual (issues of note reported quarterly)
	All biodiversity category targets are met	2 out of 10 category targets not met (seabirds and waders).	All category targets	Annual (issues of note reported quarterly)
	Favourable Condition of nature sites	96% of all features of protected nature sites (where there is on-site control) in favourable condition (or recovering	98% (by March 2018)	Annual (issues of note reported quarterly)

		due to management) (Jan 2015). % of Local Nature Conservation Sites in favourable condition. 100% of geological sites in favourable condition.	90% (ongoing) 99%	Annual (issues of note reported quarterly) Annual (rolling 5 year monitoring programme)
	Scottish Household Survey responses to 7 'greenspace' questions (there will be a time-lag associated with these data)	Responses to 5 questions better than national average, 2 average (2013).	Responses to all questions better than national average.	Annual (but likely about 2 years behind).
	Number of people attending environmental events and key nature sites	48,721 (2014)	53,000	Annual (issues of note reported quarterly)
Resource and Energy Efficiency	Fuel Poverty	53% (2014)	less than 50%	Annually

Community Planning in Shetland – Ways of Working

This section describes how we are going to support Community Planning outcomes through ways of working – these are not specific actions but rather approaches and philosophies that will allow us to work together effectively to deliver better outcomes with and for communities in Shetland.

Community Involvement

Participation of individuals and communities has always been a key element of community planning, and now even greater emphasis has been given to ensuring this is at the heart of Community Planning through the Community Empowerment Act 2015.

The Strengthening Community Involvement project was initiated by the Shetland Partnership Board to explore ways in which community involvement in Shetland can be strengthened. The consultation for this project provided a vision for how public agencies in Shetland will work together and with communities by bringing together Councillors, Community Councillors and representatives of constituted groups e.g. Parent Councils or Community Development Organisations, on a regular basis to speak about issues arising from the community or on the community planning agenda.

This would enable elected representatives to share issues within an area and allow communication with agencies to be streamlined. It would also provide a clear framework within which community involvement in Shetland could function effectively. Community Forums could be responsible for planning for the future, resolving issues and scrutinising delivery of the Local Outcomes Improvement Plan in their area.

Communities could also have the opportunity to develop a local plan if needed. The Community Empowerment Act 2015 proposes that locality plans are for smaller areas where there are significantly poorer outcomes than elsewhere in the local authority area, or in Scotland generally. The local plan would feed into the Shetland Community Plan. It would be owned, developed and updated by the community. If it

was agreed that a local plan was not needed, any issues identified at the Forum would inform the Shetland Community Plan. It should be noted that some communities in Shetland already have development plans; for example, Northmavine and Fair Isle.

Each Community Forum would be linked with and report to the Shetland Partnership Board (SPB), which has responsibility for involving communities in establishing the needs of communities in an area and addressing them. Each Forum would be supported by a senior manager from the SPB, who would provide a champion role for the process and be able to unlock any barriers that might exist.

This would ensure three ties of community involvement in Shetland:

- Developing and sustaining two-way communication directly with communities - day-to-day discussions and information sharing within communities, including visiting schools, working outside, meeting groups, which enables agencies to be able to key into what communities are thinking and facing
- More formal dialogue, such as at Community Forum level, where elected representatives come together to raise issues and respond to agency requests
- Strategic decision-making bodies utilising structures for involvement and the views of communities to inform their work

The Community Forum approach will be tested as a pilot project in the South Mainland of Shetland during 2016/17. The pilot will help to develop the Forum idea and set out the ethos and rationale for Shetland's approach to community involvement and ensure links with the locality work of the Integrated Joint Board.

Co-production and Community Connections

The Shetland Partnership is encouraging an approach to service planning and delivery that employs *co-production* at its heart. Co-production means: "delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change[18]"

[18] New Economics Foundation, referenced by Scottish Co-Production Network http://www.coproductionscotland.org.uk/about/what-is-co-production/

'Community Connections' is about assisting people to make connections within their communities, allowing them to build better relationships and more fully take advantage of the opportunities living in Shetland can bring. Research[19] into poverty and social isolation in Shetland has shown that people experience a poor quality of life when they do not feel part of the community in which they live and this is made worse by issues of socio-economic inequality. Physical barriers to inclusion such as access to social opportunities in more remote areas for those without a car have been recognised as problematic, but more subtle barriers such as stigma (real or perceived) are also known to have an impact.

There has been success in helping some individuals and families make better connections with their communities through, for example linking up people who could provide transport to nursery or football training for young children. This has allowed children to participate more fully in the opportunities present in their community while allowing parents to connect with other parents and build friendships and support networks. This is accomplished largely by members of the community once the initial connections are facilitated by agency staff and is an excellent example of co-production. The Shetland Partnership will be encouraging all partner agencies to work hard to develop these sorts of community based solutions to improve outcomes for people in Shetland in a way that is sustainable and relatively low cost.

The Shetland Partnership and Partner Agencies will seek to maximise opportunities for co-production whenever possible and employ the Community Connections model as a means of improving outcomes for families and communities.

Intergenerational working

Bringing people from different generations together can have wide ranging benefits for communities, families and individuals: "Intergenerational practice aims to bring people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations and contributes to building more cohesive communities. Intergenerational practice is inclusive, building on the positive resources that the younger and older have to offer each other and those around them"[20]

[19] Research into Deprivation and Social Exclusion in Shetland (2006):
http://www.shetland.gov.uk/communityplanning/documents/Dep.andsocialexclusionexecsummary-eperring.pdf[19]
Poverty is Bad – Let's Fix It!! (2011):
http://www.shetland.gov.uk/youth_services/documents/Shetland20Report0Final20Draft.pdf

[20] Beth Johnson Foundation (2009), referenced by Generations Working Together http://generationsworkingtogether.org/about/intergenerational-practice/

The Shetland Partnership encourages all partners to take an approach of 'generations working together' to address the challenges and realise opportunities in Shetland. Partners should seek opportunities to bring together people of different age groups together to share and exchange skills, experience and perspectives in a way that increases community cohesion and has mutual benefits across generations.

Integrated Impact Assessment

Shetland's Integrated Impact Assessment is a tool to systematically analyse a new or existing policy or service to identify what impact, or likely impact, it will have on different groups within the community. The assessment identifies any negative and positive impacts on vulnerable groups including those affected by poverty and those covered by equality legislation. If negative impacts are identified, action can then be taken to reduce or remove them, such as by making reasonable changes to how a particular group receives a service.

The Integrated Impact Assessment tool was developed by broadening out the scope of the Equality Impact Assessment previously used by the Council. This means that the actual and potential effects of a proposed policy on communities, individuals, vulnerable groups, local economic conditions and the environment is considered as an integral part of the policy development. This allows potential effects to be removed or mitigated against before the policy is approved.

Collaborative Leadership

The Christie report was published in 2011 and set the context for public service reform. A key message was that public services need to get much better at delivering outcomes, moving to prevention and tackling inequalities, all in the context of less money. The complex and interrelated nature of these issues mean that they can only be addressed through collaboration. And the scope of this collaboration should extend towards increasingly involving citizens in co-designing and co-producing services. The Scottish Leaders Forum Conference in November 2014 reaffirmed the central importance of collaboration, creativity and citizen involvement in public service design and delivery.

Collaborative leadership is about the delivery of results across boundaries between different organisations. David Archer and Alex Cameron, in their book *Collaborative Leadership: How to succeed in an interconnected world,* say *"Getting value from difference is at the heart of the collaborative leader's task...they have to learn to share control, and to trust a partner to deliver, even though that partner may operate very*

differently from themselves."[21]

Leaders and teams who, in the course of their everyday work, are seeking to deliver better outcomes through collaboration can be supported to develop their skills, knowledge and expertise in this area by the Enabling Collaborative Leadership Programme offered through Workforce Scotland.

Early intervention / prevention

Since the Christie Commission Report[22], there has been an expectation, through the operational activity and strategic planning of public agencies, to move resources to prevention and early intervention.

The Christie Commission was established in 2010 by the Scottish Government to develop recommendations for the future provision of public sector services. These recommendations were within the context of a predicted reduction in public sector spending and a realisation that doing less of the same thing was not going to achieve the savings required in the timescales required and without significant negative impact on services and outcomes for people and communities. The recommendations were based on a belief that with the right planning and delivery, better outcomes can be achieved with less money; the beginning of the prevention and early intervention agenda.

An aspect that can get lost is the link between the report and tackling inequalities, but essentially they are all interlinked. To target resources to those who are struggling or not achieving at an early enough stage to break the cycle of disadvantage will improve the life-chances of individuals and save public sector resources.

The Shetland Partnership is aiming to work more effectively together in ways that emphasise preventing poor outcomes from occurring, rather than treating the symptoms when they do occur. This is reflected in many of the priorities described in the previous section; however, partners represented on the Shetland Partnership will also be carrying this message out in their day-to-day work to ensure that the required decisive shift to prevention can happen across Shetland.

[21] Archer, David; Cameron, Alex (2008). Collaborative leadership – how to succeed in an interconnected world.
[22] http://www.gov.scot/resource/doc/352649/0118638.pdf

Working together

In order to deliver all the Shetland Partnership's priorities for 2016-20, all partners will be required to work together. This may seem an obvious statement from a Community Planning Partnership; however, as the Shetland Partnership has evolved since 2013 it has been recognised that a more explicit commitment to partnership working was required for the next 4 years. This has helped us provide a smaller, more focused list of priorities and will hopefully make the process of scrutiny and performance monitoring easier for the Shetland Partnership Board.

It also demonstrates more clearly where the Shetland Partnership 'adds value' to the community in Shetland – solving the problems that can only be solved by agencies working together and with communities. In some cases this is about helping the relatively small number of people who do not currently experience good outcomes and in others it is about working more closely together to help make reducing resources go further.

Sharing resources

In line with the Scottish Government's Agreement on Joint Working and Resourcing, the Shetland Partnership will draw upon the totality and breadth of Partners' resources in order to improve local outcomes for communities and to ensure that the individual and collective decisions of partners are in the best interests of communities and the public sector as a whole.

The Agreement placed clear expectations on key partners such as local authorities, NHS Health Boards and Public Bodies to commit to shared budget and resource planning and to demonstrate this commitment through engagement with Community Planning and through their own formal budget making and accountability arrangements.

The Shetland Partnership Resources Group has been established to co-ordinate shared budget and resource planning to deliver the Shetland Partnership's LOIP 2016-20 and to achieve the aims of the Community Plan.

Health Inequalities

Reducing the harmful impacts of inequalities on people and communities has been a key focus for the development of the LOIP, a key element

of this is *health inequalities*. Health inequalities describe the disparity of health outcomes experienced by those who are socio-economically disadvantaged compared to those who are more affluent. Factors such as diet, smoking, alcohol, mental health and low physical activity can impact on everyone's health but have the greatest effect on those who are most disadvantaged.

The Shetland Partnership has now sought to embed an approach to reducing health inequalities across the LOIP in an effort to address the complex factors that contribute to health outcomes through all Partnership activities. This is demonstrated in some of the priorities that have been identified in a range of outcome areas – such as 'Increase physical activity (amongst those least active)' in outcome B and 'reduce the harm caused by alcohol' in outcome C. However, it is hoped that this will

The Shetland Partnership will seek to address health inequalities through all of its activities and by embedding an approach to reducing harmful impacts to health across all of the outcomes in the LOIP

Assessing & Improving Our Performance

The information set out in the 'Context' section has been of use in defining priorities; however, we need to keep monitoring trends and collecting information to inform our progress and ensure we are doing the right things to improve outcomes. This section sets out some of the processes we have in place to help us do this.

LOIP indicators

The indicators linked to the Shetland Partnership's priorities, as set out in the 'Shetland Partnership Outcomes – What We Will Do' section, will be used to monitor how well we are progressing towards delivering these priorities and achieving our outcomes. In some cases, these indicators are still to be established and actions have been planned to collect and analyse data as necessary to inform progress. Progress will be reviewed annually, actions redefined and targets adjusted where necessary. Indicators and progress against actions are monitored quarterly by the Shetland Partnership Performance Group.

Community Outcomes Profile

We are continually working to improve our understanding of Shetland as a place to allow for the most effective planning and decision making across the Shetland Partnership. To this end, the Shetland Partnership are working with the Improvement Service to develop tools that will allow us to look deeper still into data and evidence to enhance our understanding. This 'Community Outcomes Profile' will have a specific focus on inequalities, providing a 'dashboard' of information that tells us how well we are doing in relation to a range of outcomes. This may include looking at smaller geographic scales than the Shetland-wide level we currently tend to use; or, defining communities across Shetland according to shared characteristics and planning appropriately to best meet their needs.

The profile(s) we develop will help us in our ongoing efforts to better understand where the Shetland Partnership can add most value and also guide us in developing our approach to working with communities as set out in the Community Empowerment (Scotland) Act 2015.

Our Commitment to Community Planning

NB: Some logos to be changed/added

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Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Shetland's Local Outcome Improvement Plan (LOIP) 2016-20. Healthier (Healthy and Caring) Theme: reporting arrangements
Reference Number:	CC-39-16 F
Author / Job Title:	Dr Susan Laidlaw, Consultant in Public Health Medicine

Decisions / Action required:

That the IJB:

1. Support the partnership work that is being carried out to achieve the outcome: *We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age.*
2. Consider if the IJB wishes to receive a regular report on progress against this outcome for information, and if so at what frequency.
3. Note that the reporting on the LOIP as a whole (ie all the outcomes) is through the Performance Group to the Shetland Partnership Board.

High Level Summary:

'Healthy and Caring' is one of the five themes in the LOIP with the associated outcome: *We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age.*

There are three priority areas within this outcome (Increase physical activity amongst those least active; Improve mental health and resilience; Ensure that people are the key assets in their community) each with a number of actions. Some actions are led by services within the IJB remit, whilst others are through other partnership groups.

Reporting on progress against all the outcomes and actions in the LOIP is to the Shetland Partnership Board, through the Shetland Partnership Performance Group. The IJB has members on the Shetland Partnership Board who will therefore receive the overall report.

However, the IJB may consider it useful to receive a regular report itself specifically on progress against the 'Healthy and Caring' outcome and actions.

Corporate Priorities and Strategic Aims:

The Shetland Partnership Board is required to produce a LOIP under the Community Empowerment (Scotland) Act 2015.

Key Issues:
There are a number of priorities and actions within the LOIP which are of relevance to the remit and priorities of the IJB and the IJB may therefore wish to receive a regular progress report. However this would involve some duplication of the reporting process, as the process for reporting on progress against the LOIP is via the Shetland Planning Board. The progress report would only be on those actions within the 'Healthy and Caring' theme. For the other themes there are individual partnership groups responsible for the reporting process.

Implications :	
Service Users, Patients and Communities:	The actions within the LOIP are for the benefit of the Shetland Community.
Human Resources and Organisational Development:	None identified
Equality, Diversity and Human Rights:	None identified
Partnership Working	All the actions in the LOIP involve partnership working.
Legal:	There is no legal requirement for the IJB to receive this report.
Finance:	None identified
Assets and Property:	None identified
Environmental:	Not applicable
Risk Management:	No issues

Policy and Delegated Authority:	The IJB has the authority to decide if it wishes to receive this report or not.	
Previously considered by:	No other committees.	

"Exempt / private" item	Not applicable

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Shetland's Local Outcome Improvement Plan (LOIP) 2016-20. Healthier (Healthy and Caring) Theme: reporting arrangements
Reference Number:	CC-39-16 F
Author / Job Title:	Dr Susan Laidlaw, Consultant in Public Health Medicine

1 Introduction

1.1 This report describes the elements of Shetland's Local Outcome Improvement Plan which are of particular relevance to the Integration Joint Board and discusses whether or not the IJB would wish to see a regular report on progress against key priorities; given that progress against the LOIP as a whole is reported to the Shetland Partnership Board.

2 Background

2.1 'Healthier (Healthy and Caring)' is one of five themes in the LOIP, the others being Wealthier and Fairer, Smarter (Learning and Supportive); Greener; Safer. Linked to each of the five themes is a single outcome, with a set of associated priorities, actions and indicators.

2.2 For four of the themes, there is generally one thematic group that leads on the work and is responsible for reporting on progress against its outcome and actions to the Shetland Partnership Board via the Shetland Partnership Performance Group, on a quarterly basis:

- Wealthier and Fairer - Economic Development Partnership and Community Learning & Development Partnership

- Smarter - Integrated Children & Young People's Strategic Planning Group
- Greener - Environment Partnership
- Safer - Community Safety and Resilience Board

2.3 There are also a number of sub-groups and other partnerships that lead on specific areas of work and feed into one of the overarching thematic groups.

2.4 However, for the Healthier theme we do not have the same structure in place. Within the predecessor to the LOIP (the Single Outcome Agreement) this theme was split into two separate sets of outcomes, priorities and actions for 'Healthy' and 'Caring'. Responsibility for completing the actions and reporting on the indicators and outcomes sat with the Health Action Team (lead by Public Health) for the Healthy outcome; and with the Community Health and Care Partnership for the Caring outcome. Neither of these groups is still in existence and therefore a different approach is required.

2.5 As described in Appendix A, there are a number of different pieces of work sitting within the 'Healthier 'theme. Some of these are being led by services and teams which are within the IJB remit, whilst others are through other partnership groups.

3 LOIP reporting arrangements

3.1 It is planned that the Public Health Team will collate information and monitoring data from the individual pieces of work that sit within the 'Healthier' theme to create an overarching report on progress against the theme's outcome and indicators. This will feed into the reporting process for the LOIP, ie through the Shetland Partnership Performance Group to the Shetland Partnership Board.

3.2 In addition, it is suggested that this report could also be presented to the Integration Joint Board for information. This would mean that the IJB has oversight of the progress against the outcome, including all the actions whether or not they are core IJB business. But it would also result in some duplication of the reporting process.

3.3 It should also be noted that there are other priorities within the LOIP that involve services within the remit of the IJB. These are outlined in Appendix B, and all fall within the 'Safer' theme. These are currently reported through the Shetland Community Safety and Resilience Board to the Performance Group.

4 Recommendations

That the IJB:

4.1 Support the partnership work that is being carried out to achieve the outcome: *We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age.*

4.2 Consider if the IJB wishes to receive a regular report on progress against this outcome for information, and if so at what frequency.

4.3 Note that the reporting on the LOIP as a whole (ie all the outcomes) is through the Performance Group to the Shetland Partnership Board.

5 Conclusion

5.1 There are a number of priorities and actions within the LOIP which are of relevance to the remit and priorities of the IJB and the IJB may therefore wish to receive a regular progress report.

5.2 However this would involve some duplication of the reporting process, as the process for reporting on progress against the LOIP is via the Shetland Planning Board.

5.3 The progress report would only be on those actions within the 'Healthy and Caring' theme. For the other themes there are individual partnership groups responsible for the reporting process.

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27th May 2016

Appendices:

Appendix A: Healthier Theme - outcome, priorities, actions and indicators

Appendix B: Other priorities of relevance to IJB

Background Documents: Shetland Local Outcome Improvement Plan 2016-2020

Appendix A: Healthier Theme - outcome, priorities, actions and indicators

Outcome B: We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age.

Within the healthier theme there are three priorities with associated actions aimed at achieving the above outcome. These are:

Priority: Increase physical activity (amongst those least active)

We will encourage and enable the inactive to be more active and we will encourage and enable the active to stay active throughout life through the development of a local 'Physical Activity, Sport and Health Strategy' (proposed title) which will include:

- Improving our active infrastructure – people - i.e. volunteering capacity and places – including footpaths; indoor and outdoor facilities (e.g. leisure centres).
- Building on localities based models, including Sports Hubs and health improvement locality working, to increase physical activity; targeting those who can most benefit (e.g. walking groups and chair-based exercise for older people; decrease costs of sport & leisure activities for poorer families).
- Improving opportunities to participate, progress and achieve in physical activity including sport.
- Using 'return on investment' work to inform the development of the Strategy.

These actions will be carried out by partners co-ordinated through a 'Physical Activity, Sport and Health Strategy' Group.

Priority: Improve mental health and resilience

- We will support individuals to be part of their community, to reduce loneliness and increase community connectedness.
- We will support wellbeing and resilience in communities through physical activity and sport (through Strategy above).

These actions link in to work being planned through the Community Learning and Development Partnership; and also will be within the remit of the 'Physical Activity, Sport and Health' Strategy

Priority: (Ensure that) People are the key assets in their community

- We will support individuals to be part of their community, to reduce loneliness and increase community connectedness (as above).
- We will develop self-management capacity and resources within the community; for people with long term conditions; older people and other vulnerable groups.
- We will support people to live as independently as is appropriate for each individual, in their own communities, through all partners working together with individual communities; utilising WYFY and local asset based approaches.

There is a self management project currently underway, lead through Public Health.

Indicators (note that these are under review and requite further development)

Priority	Indicator	Baseline (with date)	2020 Target	Update Schedule
Physical activity	Physical Activity Levels	41% in 2011	50% by 2022	Annual
Mental health	Suicide Rate*	24.8/100K (2008-2012)	13/100K (2018-2022)	Annual
People are in the key assets in their community	Suggested: 90% of all WYFY plans include assessment of and planning for social inclusion	TBC	TBC	Annual

The suicide rate, whilst very important, are not a good indicator of overall mental health and wellbeing within small communities. We are therefore looking at other more meaningful indicators to add in.

Appendix B: Other priorities of relevance to IJB

All the other priorities and actions that are of particular relevance to the IJB sit within the 'Safer' theme. The most relevant actions are highlighted here. The outcome for the Safer theme is '*Shetland is a safe place to live for all our people, and we have strong, resilient and supportive communities'.*

Priority: Keeping People Safe

- Carry out an analysis to understand the increase in reported domestic abuse incidents and the drivers behind this for comparison against national rate.
- As part of the Implementation of the revised Domestic Abuse Strategy, undertake a review of the Domestic Abuse Partnership and its associated sub-groups to ensure that preventing gender based violence is resourced and supported jointly across the partnership.
- Consider how to approach working with perpetrators, linking with work on Community Justice to reduce reoffending.

These three actions are being led through the Shetland Domestic Abuse Partnership.

Priority: Reduce the harm caused by alcohol (Shetland Alcohol & Drug Partnership)

- Reduce the harm caused by alcohol through the delivery of the Shetland Alcohol and Drugs Partnership Strategic Plan.
- Refresh and deliver Drink Better Strategy and action plan.
- Working with licensees & vendors, supporting and empowering them to refuse alcohol to drunk customers.

Priority: Improve Community Justice outcomes for those at risk of offending or reoffending, victims, families and communities

- Deliver the Community Justice Transitional Plan.
- Identify and develop appropriate measures for Community Justice (i.e. reoffending, diversionary activities, community sentencing.
- Prioritise support for a campaign to reduce stigma in communities, developing community-based solutions in relation to Community Justice which support full participation, and improved outcomes for victims, persons who have been convicted of offences and their families',

Priority: Build community resilience (Community Planning & Development)

- Develop multi-agency approaches to identifying the most vulnerable people in communities and putting in place measures to prevent harm.
- Carry out analysis of unintentional harm data (deaths, emergency hospital admissions, SFRS data, water safety incidents and A&E attendance data) to develop our understanding of this in Shetland and to link with the Building Safer Communities Programme.

Agenda Item

5

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Performance Overview - *Cover*
Reference Number:	CC-34-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

That the IJB are asked to comment, review and direct on any issues which they see as significant to sustaining and progressing service delivery.

High Level Summary:

This report summarises the activity and performance within the functions delegated to the IJB. Future reports will be continue to be developed to include more detail on the performance of the set aside services from Q1 for 2016/17.

Corporate Priorities and Joint Working:

The Parties (NHS Shetland (NHSS) and Shetland Islands Council (SIC)) have identified a core set of indicators that relate to health and social care services for delegated integration functions. Future reports will include more detail on the performance of the services that are in the set aside budget of the IJB.

Key Issues:

The IJB is invited to comment on any issues which they see as significant to sustaining and improving service delivery. The IJB's role is to monitor performance of the delivery against the Strategic Plan.

Key areas for the IJB to note are:

(1) Psychological Therapies – resources have been identified to recruit a local full-time Consultant Clinical Psychologist which will help address the long waits.
(2) Appendix 3 in relation to indicators LDP003a and LDP003d, Information Services Division have been contacted as it appears that DNAs (Did Not Attends) have not been captured by the system
(3) In Appendix 2 a reduction in overtime hours has been managed by staff being successfully recruited to some of the vacant posts
(4) Appendix 5 Complaints show the number received from the health part of the directorate. For social care more robust recording of complaints is being addressed within a project that is being undertaken now. . Future reports will show a more balanced view.

Implications :	
Service Users, Patients and Communities:	The Scheme of Integration states that the Parties will listen and respond to community needs and aspirations. Performance will form part of the discussions that the IJB has with communities.
Human Resources and Organisational Development:	There is a continued focus on recruitment and retention including supervision, learning and development and some recent successful recruitment to key posts. The service continues to work in partnership with HR services across both Parties.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
Legal:	The IJB must monitor performance with regard to the functions delegated to the IJB by SIC and NHSS (the Parties) under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 . The IJB and the Parties must share information in this regard. Performance monitoring allows the IJB to measure performance and monitor progress towards achieving agreed national and local outcomes.
Finance:	Performance monitoring allows the IJB to make decisions on priorities and to direct expenditure to particular areas through the strategic planning process.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Effective performance management is an important component of that which requires the production and consideration of these reports. Failure to deliver and embed this increases the risk of the IJB not working efficiently, failing to focus on customer needs and being subject to external scrutiny. Key risks are reviewed regularly using the IJB Risk Register and the Directorate Risk Register – both are appended to the main 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. The IJB is responsible for the operational oversight of service delivery of its delegated functions and through the Chief Officer will be responsible for the operational management of integrated services.
Previously	This report has not been presented to any other formal meeting.

considered by:	

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Performance Overview
Reference Number:	CC-34-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The IJB must consider performance against the Strategic Plan. Performance monitoring allows the IJB to understand progress against priorities and to direct through the Chief Officer, particular actions.

1.2 This report summarises the activity and performance of services delegated to the IJB. This report provides performance monitoring required as part of the Scheme of integration.

2. Background

2.1 In Appendix 1 the IJB can view the Projects and Actions for the Community Health & Social Care Directorate with current progress statements.

2.2 In Appendix 2 the Sickness Absence is steadily decreasing due to the hard work of Team Leaders and Managers working with their respective HR departments to ensure consistent application of the Maximising Attendance Policies for both Parties.

2.3 The National Core Suite of Indicators in Appendix 3 are in the process of being developed nationally. For completeness the whole template is shown and as indicator values are provided, these will be included in future reports. The Local Delivery Plan is the suite of indicators generated by NHSS that are relevant to the IJB.

2.4 In Appendix 4 the IJB can view indicators which are grouped under the headings of the 9 National Health & Wellbeing outcomes.

2.6 In Appendix 5 the IJB can see complaints recorded to date. When there is a complaint which relates to a situation where the actions of both the NHS and the Council are involved, there is an agreed joint process for the investigation stage. Thereafter the Council is obliged to deal with complaints about its services in terms of the statutory social work complaints procedure. The

appendix highlights health complaints. A project is underway to ensure that social care complaints received are recorded on the designated system.

2.7 The IJB is asked to comment, review and direct on any issues which they see as significant to sustaining and improving service delivery.

3. Conclusions

3.1 The role of the IJB is to review and direct on any issues which they see as significant to sustaining and progressing service delivery.

Contact Details:

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16 May 2016

Appendices
Appendix 1 – Projects and Actions – Community Health & Social Care Services
Appendix 2 – Corporate Indicators
Appendix 3 – National Core Suite of Indicators & Local Delivery Plan
Appendix 4 – National Health & Wellbeing Performance Indicators
Appendix 5 – Complaints

Background documents
Community Health & Social Care Directorate Plan

Appendix 1 - Projects and Actions - Community Health and Social Care Services

Shetland Islands Council

Generated on: 27 May 2016

PPMF Quarterly Report - Community Health & Social Care

Supporting adults to be independent

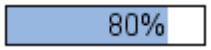
Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP017b Implement findings outlined within Mental Health review	Implement findings outlined within Mental Health review	Significant issues, likelihood of failing to meet target	Planned Start	06-Jan-2015	71%	A number of actions in progress but needing completion. Refreshed action plan being drafted.	Mental Health
			Actual Start	06-Jan-2014			
			Original Due Date	31-Mar-2015			
			Due Date	31-Mar-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP024 Develop Integrated Locality Service Plans	Develop Integrated Locality Service Plans	Likely to meet or exceed target	Planned Start	07-Nov-2014	50%	2016/17 Strategic Plan approved. Work for 2017/18 will continue to develop locality service plans.	Social Care Directorate
			Actual Start	02-Nov-2015			
			Original Due Date	31-Mar-2015			
			Due Date	31-Dec-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP026 Develop a joint Organisational Development and Workforce Strategy	Develop a joint Organisational Development and Workforce Development Strategy	Experiencing some issues, with a risk of failure to meet target	Planned Start	01-Apr-2015	70%	Joint Strategy currently in draft form	Social Care Directorate; Simon Bokor-Ingram
			Actual Start	11-Nov-2015			
			Original Due Date	31-Mar-2016			
			Due Date	31-Jul-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP031 Develop Anticipatory Care plans	Develop Anticipatory Care plans within localities that include all of the available assets	Experiencing some issues, with a risk of failure to meet target	Planned Start	01-Apr-2015	70%	Being monitored more frequently. Renewed focus with Chief Nurse (Community) leading project within Integrated Care Fund.	Health & Social Care Director's (Direct) Section; Social Care Directorate
			Actual Start	12-Nov-2015			
			Original Due Date	31-Mar-2016			
			Due Date	30-Dec-2016			
			Completed Date				

Vulnerable and disadvantaged people

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP025 Assist Shetland Partnership with implementing the redesign of community justice.	Assist Shetland Partnership with implementing the redesign of community justice.	Likely to meet or exceed target 	Planned Start	07-Nov-2015	 	Transition phase is progressing well and we are on target to reach the deadlines of 2016.	Social Care Directorate
			Actual Start	12-Nov-2015			
			Original Due Date	31-Mar-2015			
			Due Date	31-Dec-2016			
			Completed Date				

Code & Title	Description	Expected outcome	Dates		Progress	Progress statement	Lead
DP029 Solidify the governance and management of Adult Social Work	Solidify the governance and management of Adult Social Work	Likely to meet or exceed target 	Planned Start	01-Apr-2015	 	Permanent Executive Manager appointed in August 2015.	Health & Social Care Director's (Direct) Section; Social Care Directorate
			Actual Start	12-Nov-2014			
			Original Due Date	31-Mar-2016			
			Due Date	31-Mar-2016			
			Completed Date	31-Aug-2015			

Appendix 2 - Sickness Absences - Community Health & Social Care Services

Shetland Islands Council

NOTE: Sickness absences are very seasonal, therefore this quarter is compared to the same quarter last year (rather than compared to the previous quarter).

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	Previous Years			Last year Quarter 4	This year Quarter 4	
Code & Short Name	2012/13	2013/14	2014/15	Q4 2014/15	Q4 2015/16	(past) Performance & (future) Improvement Statements
	Value	Value	Value	Value	Value	
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	6.8%	5.8%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.

Appendix 2 - Sickness Absences - Other Directorates for comparison

Code & Short Name	Previous Years			Last year Quarter 4	This year Quarter 4
	2012/13	2013/14	2014/15	Q4 2014/15	Q4 2015/16
	Value	Value	Value	Value	Value
OPI-4C Sick %age - Whole Council	4.1%	3.6%	4.2%	5.2%	4.0%
OPI-4C-A Sick %age - Chief Executive's "Directorate"	3.6%	1.4%	2.4%	4.9%	7.3%
OPI-4C-B Sick %age - Children's Services Directorate	2.8%	2.8%	3.7%	4.4%	3.4%
OPI-4C-F Sick %age - Corporate Services Directorate	3.0%	1.6%	2.4%	3.3%	2.4%
OPI-4C-G Sick %age - Development Directorate	3.7%	2.7%	4.2%	5.6%	3.4%
OPI-4C-H Sick %age - Infrastructure Directorate	4.0%	3.4%	4.0%	5.2%	4.1%

Appendix 2 - (cont) Council-wide Indicators

Shetland Islands Council

Generated on: 27 May 2016 11:21

Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2012/13	2013/14	2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	
	Value	Value	Value	Value	Value	Value	Value	
OPI-4A Staff Numbers (FTE) - Whole Council	2474	2248	2191	2206	2144	2164	2169	Managers continue to carefully manage staff numbers and associated costs and reflects recruitment pressures in some areas.
OPI-4A-E Staff Numbers (FTE) - Community Health & Social Care Directorate	642	530	517	515	481	493	492	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4A-E+NHS Staff Numbers (FTE) - Community Health & Social Care Directorate inc. NHS						682	676	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4C Sick %age - Whole Council	4.1%	3.6%	4.2%	4.1%	3.2%	3.5%	4.0%	A reduction from previous year reflects a greater focus in maximising attendance.
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	6.3%	5.4%	5.6%	5.8%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.
OPI-4E Overtime Hours - Whole Council	71,644	56,552	64,738	24,014	16,270	21,383	17,404	Overtime and Overtime budgets are devolved to departmental level. Overtime is often the most cost effective way to utilise existing teams and ensure prompt service to our customers.
OPI-4E-E Overtime Hours - Community Health & Social Care Directorate	2,470	1,856	5,675	1,483	2,201	2,644	1,218	Recent recruitment will reduce overtime
E01 FOISA responded to within 20 day limit - Health & Social Care Services	93%	79%	91%	100%	93%	85%	96%	Continue to strive to meet target.

Appendix 3 - Key Directorate Indicators - Community Health & Social Care Services

Shetland Islands Council

Corporate Services & Chief Executive - Key Directorate Indicators

Generated on: 27 May 2016 11:22

Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	
	Value	Value	Value	Value	Value	Value	Value	
E1 Percentage of adults able to look after their health very well or quite well				Not measured for Quarters				It is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often
E2 Percentage of adults supported at home who agree that they are supported to live as independently as possible	68%		78%	Not measured for Quarters				Improvement of 10% from previous survey but still below national average. (Source: Health and Care Experience Survey 2015/16)
E3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	80%		80%	Not measured for Quarters				Value remains the same as previous survey but now above national average by 2%.
E4 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	64%		60%	Not measured for Quarters				Decrease of 4% since last survey and still significantly below national average.
E5 Percentage of adults receiving any care or support who rate it as excellent or good	81%		79%	Not measured for Quarters				Decrease of 2 % since last survey, still below national average.
E6 Percentage of people with positive experience of care at their GP practice	82%		89%	Not measured for Quarters				Improvement of 7% since last survey, now above national average.
E7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	80%		84%	Not measured for Quarters				Improvement of 4%, now the same as national average.
E8 Percentage of carers who feel supported to continue in their caring role.	41%		54%	Not measured for Quarters				Improvement of 13%, significantly higher than the national average.
E9 Percentage of adults supported at home who agree they felt safe	75%		79%	Not measured for Quarters				Improvement of 4% but still below national average.
E10 Percentage of staff who say they would recommend their workplace as a good place to work				Not measured for Quarters				Under development. To be included in NHS and LA Staff Surveys
E12 Rate of emergency admissions for adults per 100,000			10,665	Not measured for Quarters				Target still to be met - new data will be provided going forward
E13 Rate of emergency bed days for adults per 100,000			79,644	Not measured for Quarters				Under Development - available in 6-12 months

Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	
	Value	Value	Value	Value	Value	Value	Value	
E14 Readmissions to hospital within 28 days of discharge				Not measured for Quarters				Under Development - part of GP practice indicators data- to be available in Summer 2015
E15 Proportion of last 6 months of life spent at home or in community setting	92.5%	92.5%		Not measured for Quarters				Just below Scottish average. Managed Clinical Network for Palliative Care established in 2015
E16 Falls rate per 1,000 population in over 65s				Not measured for Quarters				Under Development - no specific timescales for completion
E17c Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Care & Support			92%	Not measured for Quarters				The majority of care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E17e Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Environment			100%	Not measured for Quarters				All care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E17s Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Staffing			92%	Not measured for Quarters				The majority of care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E17m Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections - Quality of Management and Leadership			72%	Not measured for Quarters				The majority of care settings have a 'Good' grading from Care Inspectorate among the domains assessed.
E19 Number of days people spend in hospital when they are ready to be discharged		184	1,545	538	226	381	400	Number of delays continues to fall, with focussed work to reduce length of stay.
E20 Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency				Not measured for Quarters				
E21 Percentage of people admitted from home to hospital during the year, who are discharged to a care home				Not measured for Quarters				Under development
E22 Percentage of people who are discharged from hospital within 72 hours of being ready				Not measured for Quarters				Under development - new collection methods required which will take up to 12 months
E23 Expenditure on end of life care				Not measured for Quarters				Under development - final definition still to be agreed
LDP001 People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support		67.5%	58.43%	46.5%	43.6%	43.6%	100%	We are continuing to promote the value of having this support to all patients at point of diagnosis but it is down to individual choice as to whether they take up the offer
LDP002 18 weeks referral to treatment for Psychological Therapies		57.7%	90.3%	87.5%	93.7%	85.6%	94.4%	The cCBT service introduced in September 2014 continues to have a positive impact on COMPLETED wait reporting. NB this positive results masks the long ONGOING waits for those needing face-to-face therapy. See LDP002a

Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	
	Value	Value	Value	Value	Value	Value	Value	
LDP002a 18 weeks referral to treatment for Psychological Therapies (percentage of ongoing waits less than 18 weeks)		57.7%	50.18%	50.5%	34.5%	57.9%	57.8%	Resources have been identified to recruit a local full-time Consultant Clinical Psychologist. This will help address the long waits.
LDP003a Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery			91.5%	86%	90%	100%	90%	Client missed target due to staff availability.
LDP003d Clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery		100%	94%	100%	93%	83%	100%	ISD have been contacted as it appears that DNAs have not been captured by the system.
CCR003 Percentage of people 65 and over receiving intensive care package (over 10 hours per week) in their own home rather than a care setting.		41%	42.25%	41%	41%	41%	46%	We are continuing to promote reablement programmes to enable people to remain at home
CCR007 Number of 65 and over receiving Personal Care at Home.		214	199	221	215	190	199	To enable people to remain at home we aim to increase independence which may result in less need for personal care at home
MH002 Admission rates to Psychiatric Hospitals			15	4	3	5	3	This will help us consider the effectiveness of our local service provision.
MH003 People with a diagnosis of dementia on the QOF dementia register			169.25	179	174	179	145	More people on the dementia register are dying or moving away than are being diagnosed. Plan in development to provide diagnostic training/awareness for relevant staff (e.g. GPs). Work continues to encourage people to seek earlier assessment and diagnosis. We are also intending to audit all people discharged from hospital with dementia indicated in the discharge summary to ensure that they are on the register so that no potential new diagnoses are missed.
AHP006 Increased number of people receiving home monitoring for health and social care (technology enabled care)			657	610	659	658	657	Latest national performance figures (2012/13) show Shetland ranked in top quartile of local authorities in Scotland for its telecare usage by care at home clients (Source- Draft Joint Inspection of Adult Services 2014/15).
CJ002 Percentage of offenders commencing supervision within 7 working days of being sentenced			94.65%	94.1%	84.5%	100%	100%	Service achieving target
AS002 Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills				Not measured for Quarters				Adults with learning disability, autistic spectrum disorder and/or complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted.
AS003 Number of incidents of emergency respite provided for adults with Learning Disability/Autistic Spectrum Disorder			1	1	0	0	0	An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays. Source: Newcraigielea The risk of unscheduled care will be reduced.

Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	
	Value	Value	Value	Value	Value	Value	Value	
CCR001 Delayed discharge from Hospital - no delays exceeding 14 days			2	2	3	2	2	Intense work with acute services to work out delays in systems and processes
CJ001 Percentage of court reports submitted on time	Not measured for Years	Not measured for Years	Not measured for Years	100%	100%	100%	100%	Service consistently meets target
CJ004 Risk and need assessment completed and case management plans in place within 20 days			100%	100%	100%	100%	100%	Service consistently meets target
CJ005 Percentage of individuals showing a decrease in assessed risk and need at end of order		37.5%		Not measured for Quarters				New risk assessment system in place which will provide more accurate data
AS005 Number of Social Care staff trained to implement Positive Behaviour Support.		4		Not measured for Quarters				The target of 6 staff trained in 2015/16 is on amber due to long term absence of the trainer. Training is now underway and will be completed in 2016. The 2016/17 intake will be slightly delayed however is anticipated to be completed within the 2016/17 monitoring period.
AHP001 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count)			7	8	6	20	7	To achieve the nationally agreed referral to assessment timescales we have initiated a number of initiatives including streamlining our referrals and screening processes, reviewing all processes, and reconfiguring the team into a north and a south team to gain staff efficiency
AHP002 Percentage Waiting Time from Referral to Treatment for Orthotics Services (18 weeks)			98.73%		98.1%	98.1%	100%	Each instance of missed target is analysed by line manager.
AHP003 Percentage Waiting Time from Referral to Treatment for Physiotherapy Services (18 weeks)			97.93%		97.7%	97%	99.1%	Service consistently meets target. Significant pressures due to long term sickness absence, and increased number of referrals.
AHP004 Percentage Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)			99.67%		99.5%	99.5%	100%	Each instance of missed target is analysed by line manager.
CCR005 Occupancy of care homes		88.7%	91.2%	91%	91%	91.7%	91%	Target now being met. Occupancy targets more challenging to meet as increased use of respite care.
CJ003 Unpaid Work commenced within 7 working days		84.2%	87.05%	90.9%	80%	85%	92.3%	Increase in offenders attending as instructed
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.0%	6.0%	5.8%	6.3%	5.4%	5.6%	5.8%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.
E01 FOISA responded to within 20 day limit - Health & Social Care Services	79%	91%	93.5%	100%	93%	85%	96%	Continue to strive to meet target.

Directorate Performance Report – Outcomes 1-9

Shetland Islands Council

Generated on: 27 May 2016

Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
DS001 Decay experience of children in P1: The mean dmft (decayed, missing or filled teeth per child) of children aged 5-6 years in P1 attending SIC primary schools			Not measured for Quarters				Not measured for Quarters	Source: NDIP data. Gives prevalence of dental decay in one age group of the total child population. Scotland dmft 1.27
ASW003 Percentage of outcomes for individuals are met	Not measured for Years							The new system for gathering this has been delayed until the start of April 2016 in order for training of all staff to be completed.
PC002 Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre			100%	100%	100%	100%	100%	Monthly data return from practices shows 100% compliance for those patients who need to speak to a healthcare professional on the day
PC004 Percentage access to a Primary Care health professional for an appointment within 48 hours at any Shetland Health Centre			100%	100%	100%	100%	100%	Monthly data return from practices shows 100% compliance for those patients who request an appointment within 48 hours

Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
CCR003 Percentage of people 65 and over receiving intensive care package (over 10 hours per week) in their own home rather than a care setting.	41%		41%	41%	41%	46%	30%	We are continuing to promote reablement programmes to enable people to remain at home
CCR007 Number of 65 and over receiving Personal Care at Home.	214	200	221	215	190	199	200	To enable people to remain at home we aim to increase independence which may result in less need for personal care at home
CN002 Number of early supported discharges with no readmission in 30 days by Intermediate Care Team		100%	95.5%	100%	100%	94%	100%	23 patients - 16 early supported discharge - no readmissions. 7 alternative to admission
MH002 Admission rates to Psychiatric Hospitals			4	3	5	3	6	This will help us consider the effectiveness of our local service provision.

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
MH003 People with a diagnosis of dementia on the QOF dementia register			179	174	179	145	184	More people on the dementia register are dying or moving away than are being diagnosed. Plan in development to provide diagnostic training/awareness for relevant staff (e.g. GPs). Work continues to encourage people to seek earlier assessment and diagnosis. We are also intending to audit all people discharged from hospital with dementia indicated in the discharge summary to ensure that they are on the register so that no potential new diagnoses are missed.
AHP006 Increased number of people receiving home monitoring for health and social care (technology enabled care)			610	659	658	657	599	Latest national performance figures (2012/13) show Shetland ranked in top quartile of local authorities in Scotland for its telecare usage by care at home clients (Source- Draft Joint Inspection of Adult Services 2014/15).

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
CJ002 Percentage of offenders commencing supervision within 7 working days of being sentenced			94.1%	84.5%	100%	100%	100%	Service achieving target
ASW001 Percentage of assessments completed on time			92%	100%	100%	100%	100%	Each instance of missed target analysed by line manager
ASW002 Percentage of reviews completed on time			92%	96.9%	89%	95.6%		Each instance of missed target analysed by line manager. Acceptable reason for each missed review
ASW004 How satisfied are residents with local social care/ social work services?	85%	80%	Not measured for Quarters				Not measured for Quarters	Significantly higher than national average (55%)

Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
DS004 Number of people who are waiting to register with Public Dental Service (PDS) for ongoing Care			1,120	973	930	635		Source: Local data. Despite waiting, all these people are able to access NHS dental care elsewhere.

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
AS002 Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills		35	Not measured for Quarters				Not measured for Quarters	Adults with learning disability, autistic spectrum disorder and/or complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted.
CN001 Number of Anticipatory Care Plans in Place			699	757	837	831	700	Data shows 27 new entries in February but overall reduction in total eKIS numbers reflects more deaths than new summaries put in place

Outcome 5 - Health and social care services contribute to reducing health inequalities

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
DS003a The percentage of the adult populations who are registered with Shetland dentists for NHS dental care	78.35%		Not measured for Quarters				Not measured for Quarters	Target is to see a net rise in registration figures. Registration brings with it the responsibility to provide on-going care, for which the PDS alone does not have sufficient capacity. Larger rises are therefore dependent on an independent NHS practice opening alongside the Public Dental Service to increase capacity.
DS003c The percentage of the child populations who are registered with Shetland dentists for NHS dental care	91.85%		Not measured for Quarters				Not measured for Quarters	Target is to see a net rise in registration figures. Registration brings with it the responsibility to provide on-going care, for which the PDS alone does not have sufficient capacity. Larger rises are therefore dependent on an independent NHS practice opening alongside the Public Dental Service to increase capacity.

Outcome 6 - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
AS003 Number of incidents of emergency respite provided for adults with Learning Disability/Autistic Spectrum Disorder			1	0	0	0	0	An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays. Source: Newcraigielea The risk of unscheduled care will be reduced.

Outcome 7 - People who use health and social care services are safe from harm

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
CCR001 Delayed discharge from Hospital - no delays exceeding 14 days			2	3	2	2	2	Intense work with acute services to work out delays in systems and processes
CJ001 Percentage of court reports submitted on time	Not measured for Years		100%	100%	100%	100%	100%	Service consistently meets target
CJ004 Risk and need assessment completed and case management plans in place within 20 days			100%	100%	100%	100%	100%	Service consistently meets target
CJ005 Percentage of individuals showing a decrease in assessed risk and need at end of order	37.5%	75%	Not measured for Quarters				Not measured for Quarters	New risk assessment system in place which will provide more accurate data
PPS002 Percentage rate of antibiotic prescribing in relation to Scottish average			100.29%	113.3%	99.05%	114%	100%	In general we are expecting less antibiotics to be prescribed in Shetland than in the Scottish population
PPS003 Number of polypharmacy reviews completed			35	22	19	22	30	Polypharmacy reviews bring about better outcomes for patients and often significantly reduce costs
PPS004 Number of discharge prescriptions dispensed out of hours by nursing staff	114	98	75	82	166	112	147	Good discharge planning should reduce the need for nurses to dispense medicines out of hours. Dispensing by pharmacy always more appropriate
CN003 Percentage of Catheter Associated Infections in individuals with an indwelling urinary catheter				0%	0%	0%	0%	No CAUTIs identified out of 9 catheters inserted

Outcome 8 - People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
AS005 Number of Social Care staff trained to implement Positive Behaviour Support.	4		Not measured for Quarters				Not measured for Quarters	The target of 6 staff trained in 2015/16 is on amber due to long term absence of the trainer. Training is now underway and will be completed in 2016. The 2016/17 intake will be slightly delayed however is anticipated to be completed within the 2016/17 monitoring period.

Outcome 9 - Resources are used effectively in the provision of health and social care services, without waste

	Years	Quarters					
		Q1	Q2	Q3	Q4	Q4	(past) Performance & (future) Improvement Statements

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Value	Target	
DS002 The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland	3,013		2,230	2,230	2,032	1,703	1,670	Sources: Local wte data and ONS population data. The greater the wte of dentists, the greater the available capacity for the resident population to receive NHS dental care. (Scotland ratio 1:1670)
AHP001 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count)			8	6	20	7	10	To achieve the nationally agreed referral to assessment timescales we have initiated a number of initiatives including streamlining our referrals and screening processes, reviewing all processes, and reconfiguring the team into a north and a south team to gain staff efficiency
AHP002 Percentage Waiting Time from Referral to Treatment for Orthotics Services (18 weeks)				98.1%	98.1%	100%	90%	Each instance of missed target is analysed by line manager.
AHP003 Percentage Waiting Time from Referral to Treatment for Physiotherapy Services (18 weeks)		90%		97.7%	97%	99.1%	90%	Service consistently meets target. Significant pressures due to long term sickness absence, and increased number of referrals.
AHP004 Percentage Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)				99.5%	99.5%	100%	90%	Each instance of missed target is analysed by line manager.
CCR005 Occupancy of care homes	88.7%	90%	91%	91%	91.7%	91%	90%	Target now being met. Occupancy targets more challenging to meet as increased use of respite care.
CJ003 Unpaid Work commenced within 7 working days	84.2%	100%	90.9%	80%	85%	92.3%	100%	Increase in offenders attending as instructed
PPS001 Percentage spend for Shetland on GP Prescribing compared to the national average			112.9%	109.9%	96%	98%	99%	Shetland has traditionally spent less on medicines per patient. The costs per patient are increasing, this highlighting the need to undertake additional prescribing efficiency work

Directorate Performance Report – Local Delivery Plan

Shetland Islands Council

Generated on: 27 May 2016

Local Delivery Plan

Code & Short Name	Years		Quarters			Date Range 3	(past) Performance & (future) Improvement Statements
	2014/15		Q4 2014/15	Q1 2015/16	Q2 2015/16	Q4 2015/16	
	Value	Target	Value	Value	Value	Target	
LDP001 People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support	67.5%	50%	75%	46.5%	43.6%	50%	We are continuing to promote the value of having this support to all patients at point of diagnosis but it is down to individual choice as to whether they take up the offer
LDP002 18 weeks referral to treatment for Psychological Therapies	57.7%		62.5%	87.5%	93.7%	90%	The cCBT service introduced in September 2014 continues to have a positive impact on COMPLETED wait reporting. NB this positive results masks the long ONGOING waits for those needing face-to-face therapy. See LDP002a
LDP003a Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery			100%	86%	90%	100%	Client missed target due to staff availability.
LDP003d Clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery	100%	100%	100%	100%	93%	100%	ISD have been contacted as it appears that DNAs have not been captured by the system.
LDP004 Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	201	522	133	180	221		All areas have contributed to improving performance and are increasing intervention rates
LDP005 48 hour access or advance booking to an appropriate member of the GP team	73.2%	90%	Not measured for Quarters	Not measured for Quarters		Not measured for Quarters	Practices run a mix of advanced booking, triage and on the day appointments through walk in clinics. Advance booking relates to the opportunity to have an appointment with a member of the clinical team, not a named GP.
LDP006 4 hours from arrival to admission, discharge or transfer for A&E treatment			96.2%	94.1%	97.8%	98%	582 presentations out of 627 left A&E Department within four hours
LDP007 At least 60 per cent of 3 and 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year.	75%	60%	Not measured for Quarters	Not measured for Quarters		Not measured for Quarters	Highest rate in Scotland and one of only 2 Boards to meet the 60% target. The aim is to maintain and improve present levels through continuing investment in targeted Childsmile activities

Agenda Item

6

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	Joint Staff Forum Terms of Reference
Reference Number:	CC-37-16 F
Author / Job Title:	Christine Ferguson, Director Corporate Services

Decisions / Action required:

1. That the IJB:
   a) consider the TOR attached as Appendix 1, the key issues identified in this report, the recommendations of the EJCC to the Council and those of the APF to the Health Board in this regard and agree any changes required to the TOR;
   b) recommend the TOR to the Council and the Health Board for approval; and
   c) support the nominations for membership of the JSF made by EJCC and APF.

High Level Summary:

The Integration Scheme approved by the Health Board and Council at meetings on 11 and 18 February 2015 respectively (Min Ref SIC 07/15), states that "*The Parties will ensure that there is an effective Joint Staff Forum where staffing issues, professional issues and concerns relevant to joint working can be raised and discussed, where difficulties can be explored and resolved and where shared routes forward can be agreed.*"

The IJB was formally constituted in June 2015 and assumed its full role and responsibilities under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 on 20 November 2015 (Min. Ref IJB 11/15).

The Terms of Reference of the Joint Staff Forum has been revised to reflect the establishment of the IJB and subsequent discussions at meetings of the JSF.

Corporate Priorities and Joint Working:

The JSF was established in March 2002 as part of the governance arrangements for partnership working between the Council and the Health Board locally under the Joint Future framework.

Since 2002 a range of protocols have been prepared and agreed to support integrated staffing arrangements for jointly managed services across the Council and the Health Board. These protocols underpin existing management arrangements including a single management structure for IJB business reporting to the Director of Community Health and Social Care in his role as Chief Officer for the IJB.

The JSF was reinvigorated in early 2012 to support work on closer integration of health and social care functions of the Council and the Health Board as part of the work to implement the Public Bodies (Joint Working) (Scotland) Act 2014.

The revised TOR presented at Appendix 1 supports closer joint working arrangements across all Council and Health Board business reflecting the decisions of the Council and the Health Board in November 2014, *" that the committees, sub-committees and governance groups that are needed for the Body Corporate should all be joint, looking at all the business of the Council and the [Health] Board unless there is a specific reason why this cannot be done e.g. legal impediment"* (Min. Ref SIC 78/14).

Key Issues:

The Council and the Health Board remain accountable for the functions delegated to the IJB and therefore must make sure that appropriate governance arrangements are in place for the IJB as set out in the Integration Scheme.

The proposals in this report support the "Workforce" section in the Integration Scheme, which is included in the revised TOR.

Current members of the JSF, when discussing the revised TOR, were of the view that in terms of membership, substitutes should not be allowed. However, more recently it has not been possible to find a date over the next 3 months when the JSF could meet and be quorate. In light of this, the TOR put forward at Appendix 1 to this report includes the ability for substitutes to attend meetings of the JSF with the agreement of the joint chairs.

The frequency of meetings is expected to be six weekly with meeting dates set a year in advance however, it has been normal practice over the years for formal meetings of the JSF to be convened more frequently as required in order to facilitate timely progress with service redesign and other initiatives affecting the workforce and it is expected that this practice will continue into the future.

Previously, membership of the JSF has been drawn from the members of the Council's EJCC and the APF of the Health Board however, staff representatives have asked that staff representatives need not be on EJCC or APF in order to make sure that the people on the JSF from the staff side are those best placed to take part in wide ranging discussions on all joint and integration staffing matters. This request has been accommodated in the revised TOR at Appendix 1.

Implications :	
Service Users, Patients and Communities:	The IJB has a Participation and Engagement Strategy to ensure the views of service, users, patients and communities are heard and taken into account in developing services. Information in this regard will be available to the JSF as appropriate.
Human Resources and Organisational Development:	Working with staff is a key aspect of Health and Social Care Integration. The Integration Scheme includes a section on "Workforce" which states that there will be "*an effective Joint Staff Forum where staffing issues, professional issues and concerns*

	relevant to joint working can be raised and discussed, where difficulties can be explored and resolved and where shared routes forward can be agreed". The Integration Scheme requires the development of a Workforce Development Strategy, an Organisational Development Action Plan and a Training Plan and part of the role of the JSF will be to keep these key documents under review. The JSF has an important role in making sure the expertise of the workforce is available to the Council, the Health Board and the IJB to ensure decisions are made in light of their knowledge and experience.
Equality, Diversity and Human Rights:	Quality assurance on Equalities, Diversity and Human Rights is an integral part of the activities of the Council and the Health Board. The recommendations in this report do not require an Equalities Impact Assessment.
Legal:	The proposals in this report support the work of the Council, the Health Board and the IJB required under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the associated Regulations and Guidance and Shetland's Integration Scheme.
Finance:	Any expenses and costs associated with the activities of the JSF including backfill for its members will be met from within existing budgets of the Council and the Health Board. The costs will be recorded and monitored to inform future budget setting processes.
Assets and Property:	There are no implications for major assets and property. All meetings of the JSF 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 JSF has operated successfully for many years supporting the Council and the Health Board through significant organisational change as the integration agenda has developed. If the JSF is to continue to fulfil this role, it is important that the TOR are updated and membership renewed so that meetings can take place as required to support this critical area of work for both the Council and the Health Board. Currently, a failure of the governance arrangements as such is not identified as a risk for the Council, the Health Board or the IJB however, failure to deliver the outcomes expected of integration is identified as a risk and an effective JSF is an important factor in mitigating against this risk.

Policy and Delegated Authority:	The requirement for the JSF is set out in Shetland's Health and Social Care Partnership Integration Scheme 2015. The remit and membership require decisions of the Parties to

	the Integration Scheme (the Council and the Health Board). This report seeks the support of the IJB for the recommendations that will be made to the Council and the Health Board to approve the revised TOR for the JSF.
Previously considered by:	The JSF at meetings on 10 September 2015 and 5 November 2015.

NHS Shetland

Shetland Islands Council

JOINT STAFF FORUM

TERMS OF REFERENCE
Revised April 2016

1. Background

1.1 The Joint Staff Forum (JSF) was established in July 2002 in line with Scottish Executive Guidance on the Joint Future initiative to ensure that joint management arrangements, joint resourcing, joint training and organisational development would be delivered in consultation with staff representatives of the partner agencies, namely Shetland NHS Board (the Health Board) and Shetland Islands Council (the Council).

1.2 On 27 June 2015, Shetland's Health and Social Care Partnership Integration Joint Board (IJB) was formally constituted as a public body under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) and on 20 November 2015, the IJB approved its first Strategic Plan and assumed responsibility for the functions delegated to it under the terms of the Act.

1.3 The Integration Scheme "sets out the detail as to how the Council and the Health Board will integrate services" under the terms of the Act and section 7 of the Integration Scheme on Workforce is included below.

> ***7. Workforce***
>
> *The Parties will ensure that there is an effective Joint Staff Forum where staffing issues, professional issues and concerns relevant to joint working can be raised and discussed, where difficulties can be explored and resolved and where shared routes forward can be agreed.*
> *The Membership and Terms of Reference of the Joint Staff Forum are set out in the Supplementary Documentation.*
>
> ***Workforce Development Strategy***
>
> *A Workforce Development Strategy and Action Plan developed by the Parties (the Health Board and the Council) will be agreed by the Parties with the IJB and maintained by the staff supporting the HR Strategic Management of the integrated service delivery that is under the direction of the Chief Officer including services delivered through localities.*
> *The Workforce Development Strategy will be agreed and put in place by*

April 2016 or at an earlier date as agreed by the IJB with the Parties and refreshed annually thereafter.

Organisational Development Action Plan

An Organisational Development Action Plan will be agreed by the Parties with the IJB setting out the work on organisational development and HR issues. The Organisational Development Action Plan will be maintained by the staff supporting the HR Strategic Management of integrated service delivery that is under the direction of the Chief Officer including services delivered in localities.
The Organisational Development Action Plan will be agreed and put into place by April 2016 or at an earlier date as agreed by the IJB with the Parties and refreshed annually thereafter.

Training Plan

A Training Plan agreed by the Parties and agreed with the IJB will be maintained as part of the Supplementary Documentation to the Integration Scheme. Training support functions will be provided by the Parties to the integrated services managed by the Chief Officer.
The Training Plan will be agreed and put into place by April 2016 or at an earlier date as agreed by the IJB with the Parties and refreshed annually thereafter.[1]

1.4 In November 2014, the Council and the Health Board agreed:
" that the committees, sub-committees and governance groups that are needed for the Body Corporate should all be joint, looking at all the business of the Council and the [Health] Board unless there is a specific reason why this cannot be done e.g. legal impediment".
The Council's Executive Manager HR and the Health Board's Director of HR and Support Services are working together to ensure that as far as possible, one combined set of policies and procedures is developed over time to support all the staff of both organisations. Therefore, although the work on integrated health and social care services has been the main driver in the past, increasingly it is expected that the JSF will consider matters affecting all staff of the Council and the Health Board.

[1] Shetland Islands Health and Social Care Partnership Integration Scheme 2015

2. REMIT OF THE JOINT STAFF FORUM

2.1 To provide a joint environment "*where staffing issues, professional issues and concerns can be raised and discussed; difficulties can be explored and resolved and shared routes forward can be agreed*"[2].

2.2 To provide a forum for dialogue encouraging the development of an open, trusting and supportive culture which recognises and explores solutions to the challenges presented by differing approaches to human resource management within the Health Board and the Council.

2.3 To ensure that engagement, consultation and involvement of all stakeholder parties are transparent, timely and meaningful.

2.4 To support effective leadership as core and central to leading a changing environment and that leaders are particularly responsive to the move to a more joined up service in order to develop the Health and Social Care Integration agenda and to develop closer partnership working between the Council and the Health Board generally.

2.5 To discuss agreements/recommendations proposed within the Council and the Health Board that impact on staff involved in joint working. Where particular implementation issues for staff involved in joint working arrangements are identified, the JSF may make recommendations to be raised with the author of the report, and through the Staff Governance Committee (SGC) or EJCC, depending on the detail of the proposal.

2.6 To monitor progress on the work set out in the Organisational Development Action Plan, the Workforce Development Strategy and Action Plan and the Training Plan.

2.6 The JSF does not replace or usurp the role and remit of either SGC or EJCC where staffing issues will continue to be discussed in line with the published constitutions.

[2] Shetland Islands Health and Social Care Partnership Integration Scheme, June 2015

3. COMPOSITION

JSF Membership

3.1 JSF membership comprises:

- 4 Representatives (from 6 representatives) nominated by the Health Board Area Partnership Forum (APF)
- 4 Representatives (from 6 representatives) nominated by the Council's Employees Joint Consultative Committee (EJCC)

Staff representatives will comprise 50% of the membership from each of the Parties and will include the staff representatives appointed by the Council and the Health Board to the IJB.

Non-staff representatives will include at least one representative from among those appointed by each of the Parties to serve on the IJB.

JSF Joint Chairs

3.2 The Council and the Health Board will each appoint a Joint Chair from their respective members at 3.1 above, who will chair each meeting in rotation.

In attendance

3.3 The following personnel will be expected to attend each meeting of the JSF. Such attendance is not intended to give a right to be elected to Joint Chair, except where the individual is also a member under 3.1 above:

- Executive Manager Human Resources Shetland Islands Council
- Director of Human Resources Shetland NHS Board
- Director of Community Health and Social Care
- Director of Nursing and Acute Services, Shetland NHS Board
- Head of Planning and Modernisation, Shetland NHS Board
- Director of Corporate Services, Shetland Islands Council
- Director of Children's Services, Shetland Islands Council

Members and staff of the Council and the Health Board and of the trades unions will be allowed to sit in or observe with the agreement of the Joint Chairs.

JSF Joint Lead Officers

3.4 The Executive Manager Human Resources for the Council and the Director of Human Resources and Support Services for the Health Board will be the joint lead officers for the JSF.

4. REPORTING MECHANISMS

4.1 The minutes of each meeting of the JSF will be made available for information to SGC, APF, EJCC, the Council's Human Resources Planning Group (HRPG) and the Integration Joint Board (IJB) having been confirmed for accuracy by the Joint Chairs.
Responsibility for this will be assigned to the minute taker.

4.2 Responsibility for cascading the information to staff as appropriate will rest with the managers who are listed as in attendance at meetings of the JSF.

4.3 Each consultative body will also take responsibility for ensuring that information is disseminated to all staff as appropriate.

5. ADMINISTRATION ARRANGEMENTS

5.1 The Joint Staff Forum will meet six weekly or as agreed by the JSF. The dates will be set a year in advance.

5.2 Additional meetings will be arranged as required following discussion with the Joint Chairs.

5.3 The Joint Staff Forum will be serviced by the Council's Committee Services. In this context servicing means booking a room, sending out a notice of the meeting along with the agenda and supporting papers, taking minutes and maintaining the business programme.

5.4 Requests for items to be included on the agenda should be made through the Council's Committee Services.

5.5 A notice calling the meeting will be issued with the agenda and supporting papers not less than seven calendar days before the date of the meeting. These will be issued by e-mail to agreed e-mail addresses unless paper copies are requested to meet the needs of any member of the JSF.

5.6 The JSF will not consider any item which has been submitted after the agreed clearance date, unless prior agreement has been received from the Joint Chairs.

6. QUORUM

6.1 The quorum for a meeting will be 4 members being 2 JSF members from the Council and 2 JSF members from the Health Board. Substitutes will be allowed by agreement with the joint chairs.

7. RESOLUTION OF CONFLICT

7.1 The discussion of agenda items will be carried out with the aim of reaching consensus. Where consensus is not reached, the Chair will identify the area of disagreement and this will be noted in the minute. Such areas of disagreement and any unresolved issues will be brought to the attention of the SGC, EJCC, APF, HRPG and the IJB through the minute and a joint report prepared by the lead officers as appropriate.

ENDS

Agenda Item

7

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	IJB Business Programme 2016/17
Reference Number:	CC-36-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

The Integration Joint Board consider its business planned for the financial year to 31 March 2017, and RESOLVES to approve any changes or additions to the Business programme.

High Level Summary:

The purpose of this report is to inform the IJB of the planned business to be presented to the Board over the financial year to 31 March 2017, and discuss with Officers any changes or additions required to that programme.

Corporate Priorities and Joint Working:

Work of the IJB is essential in ensuring the efficient and effective performance of Shetland's Health and Social Care Partnership in order to deliver the outcomes set out in the Integration Scheme.

In order to fulfil the statutory duties with regard to the functions delegated to the IJB by the Shetland Islands Council (the Council) and Shetland NHS Board (the Health Board), and in order to meet public governance principles, the IJB must make sure its Business Programme supports its role in the planning and direction of services to meet the needs of some of the most vulnerable people in our community, and to set its business in accordance with local and national reporting frameworks.

Key Issues:

The IJB's governance documents contain the legislative requirements and matters of best practice and standards, and the Business Programme enhances these by publicising the plans for decision making and other public reporting requirements, in keeping with the principles of good governance.

Implications :

Service Users,	The Business Programme provides the community and other

Patients and Communities:	stakeholders with important information, along with the Strategic Commission Plans, as to the planned business for the coming year.
Human Resources and Organisational Development:	There are no direct impacts on staffing or organisational development matters with regard to approval of the Business Programme. However approval of the Business Programme will give direction and assurances to staff with regard to the timing and requirements for decisions and public reporting that the IJB has agreed. It has been agreed that support for the Business Programme function for the IJB will be co-ordinated by the Council's Corporate Services Department as part of the corporate services support for the IJB. This will be achieved within existing resources.
Equality, Diversity and Human Rights:	There are no direct impacts on equality, diversity or human rights with regard to approval of the Business Programme, although individual items will have to have regard to those in terms of any outcomes and associated risks. The recommendation in this report does not require an Equalities Impact Assessment.
Legal:	The IJB is advised to establish a Business Programme, but there are no legal requirements to do so. There are no direct legal impacts with regard to approval of the Business Programme, although individual reports will have to have regard to current and impending legislation and the impact on the IJB, and the services which the NHS and SIC deliver, in terms of outcomes and legal risks.
Finance:	The there are no direct financial implications by approving the Business Programme, but indirect costs may be avoided by optimising time spent by officers and members of the IJB at scheduled meetings. Regular financial and performance reporting will ensure that the IJB fulfils the terms of the Integration Scheme. Any costs associated with the development and maintenance of the IJB Business Programme will be met from within existing budgets of the Council and the Health Board.
Assets and Property:	There are no implications for major assets and property. It is proposed that all meetings of the IJB will be held in either the premises of the Council or the Health Board and that the costs will be covered accordingly by the Council and the Health Board.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The risks associated with setting the Business Programme are around the challenges for officers meeting the timescales

	required, and any part of the Business Programme slipping and causing reputational damage to the IJB, the Council or the NHS. Equally, not applying the Business Programme would result in decision making being unplanned and haphazard and aligning the IJB's Business Programme with the objectives and actions contained in its Strategic Plans could mitigate against those risks.
Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB assumed responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting on 24 November 2015. Maintaining a Business Programme will ensure the effectiveness of the IJB's reporting framework, and its planning and performance management, by monitoring and reviewing the achievement of key outcomes and objectives as set out in its Strategic Plans, . The IJB has the authority to approve the IJB Business programme 2016/17 as set out in this report.
Previously considered by:	The Business Programme for 2016/17 was considered by the IJB at its meeting on 27 April 2016.

END

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	8 June 2016
Report Title:	IJB Business Programme 2016/17
Reference Number:	CC-36-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 This report presents a draft IJB Business Programme 2016/17 for the Integration Joint Board (IJB). The draft IJB Business Programme is attached at Appendix 1.

2. Background

2.1 The purpose of this report is to inform the IJB of the planned business to be presented to the IJB for the financial year to 31 March 2017 for the IJB to consider and advise regarding any changes or additions required to that programme.

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

3. Establishing the IJB Business Programme for 2016/17

3.1 The IJB should have an effective business programme in place to support its activities. The IJB is responsible for:

3.1.1 Strategic planning for health and social care services as specified in the Integration Scheme, developing and maintaining a three year Strategic Plan;

3.1.2 Directing service delivery by the Council and the Health Board in line with the Strategic Plan; and

3.1.3 Operational oversight, performance monitoring and reporting on integrated health and social care services through the Chief Officer.

3.2 The manner in which meetings have been scheduled is described below.

- Ordinary meetings – where there is no scheduled business within 2 weeks of the meeting, the meeting will be cancelled.

- Special meetings may be called on specific dates for some items – other agenda items can be added, if time permits.

- In consultation with the Chair, Vice Chair and relevant Officers, and if required according to the circumstances, the time, date, venue and location of any meeting may be changed, or special meetings added.

Recommendations

3.3 It is recommended that the IJB considers its business planned for the remaining quarters of the current financial year to 31 March 2017, and RESOLVES to approve any changes or additions to the Business programme.

4. Conclusions

4.1 The presentation of the IJB Business Programme for 2016/17 at each meeting provides a focussed approach to the business of the IJB and allows senior officers an opportunity to update the IJB with regard to any changes and / or additions required to the Business Programme in a planned and measured way.

Contact Details:
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23 May 2016

Appendices

Appendix 1: IJB Business Programme for 2016/17

Background Documents

H&SCI Integration Scheme Integration Scheme

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 Monday, 30 May 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.	• Performance Report (CC34) • Audit Commission report on health and social care integration (CC28) • Risk Registers – IJB and Directorate (CC35) • Shetland Local Outcomes Improvement Plan 2016-20 (CC33) • Joint Staff Forum Terms of Reference (CC37) • 2016/17 Business Programme (CC36)
	Tuesday 28 June 2016 at 11 a.m.	This date moved 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 2016/17-20 • Budget 2016/17(in light of LDP submitted 31 May and NHS Board approving 21 June) • Recovery Plan 2016/17 • Integrated Care Fund 2016/17 • Shifting the Balance of Care • SADP – Revised Terms of Reference
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 • Mental Health Action Plan Update • 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	• Budget 2017/18

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 Monday, 30 May 2016

	2016 at 2 p.m.	
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 2017 at 2 p.m.	• Q3 Financial Accounts

Planned business still to be scheduled - as at Monday, 30 May 2016
None
END OF BUSINESS PROGRAMME as at Monday, 30 May 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 (CC28) • Changing Models of Health & Social Care (CC29) • 2016-17 Internal Audit Plan (CC31) • Community Care Resources - Internal Audit Plan Update (CC27) • Annual Audit Report 2015-16 (CC30)
	Tuesday 28 June 2016 at 11 a.m.	This date moved because of the EU Referendum on 23 June and unavailability of committee services staff to administer the meeting. • Draft 2015/16 Accounts • Inspection Action Plan
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 Monday, 30 May 2016
None
END OF BUSINESS PROGRAMME as at Monday, 30 May 2016