Agenda Item

1

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	Delays in Discharge from Hospital to a Community Setting Update
Reference Number:	CC-56-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

That the IJB notes the actions being taken by both Community Health and Social Care Services and Acute Services and comment on the progress made and on future plans for tackling the issues of delayed discharges.

High Level Summary:

This report summarises the actions being taken within Community Health and Social Care Services and Acute Services.

Corporate Priorities and Joint Working:

There is a national requirement to reduce delayed discharges, and health and social care partnerships are pivotal to this. Shetland's Joint (Commissioning) Plan 2016-19 is the Commissioning Strategy for Shetland's Health and Social Care Partnership, and this contains the detail of how services work to ensure a whole systems approach to caring for people in their own homes and as close to home as possible.

Key Issues:

The ongoing commissioning cycle and guidance on development of health and care plans requires that clients/patients and carers and third sector colleagues have full involvement. This includes a number of planning groups involving third sector providers and service user and carer representatives and the Public Partnership Forum.

There is no alternative to local acute hospital care other than off island facilities and if the local hospital has no spare bed capacity, then moving patients off island would be the only alternative. This risk is managed on a daily basis with twice daily bed statistics distributed widely to the whole health and care system.

Implications :

Service Users, Patients and	The actions from the Delays in Discharge reporting will help ensure monitoring and directing health and social care services;

Communities:	and ensure the best possible outcomes for service users, patients and the community.
Human Resources and Organisational Development:	Any change in the way services are delivered will involve engagement with affected staff. The Council and NHS have a range of policies that will apply to any staff affected by an organisational change. There is also regular consultation with Trade Unions through the consultative mechanisms in place in both organisations and through the Joint Staff Forum.
Equality, Diversity and Human Rights:	Shetlands Joint Strategic (Commissioning) Plan 2016-19 supports and promotes equalities, health and human rights.
Legal:	Under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the IJB is responsible for the strategic planning of the functions delegated to it by the Shetland Islands Council and NHS Shetland and for the preparation of the Strategic Plan. The Strategic Plan specifies the services to be delivered by the parties.
Finance:	Delays in discharging patients from hospital can lead to the IJB incurring additional unscheduled care bed costs. The cost of providing hospital beds is largely a fixed cost, so as overall bed capacity is not being exceeded, the cost for unscheduled care beds is currently being met from within the IJB Set-Aside budget. However, this is not the best use of IJB resources. Returning an individual to their own home and providing care in that setting can be delivered at a lower cost, freeing up bed space to allow for scheduled operations and other procedures to take place, which otherwise might not be possible.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The main risk is that of not developing and establishing new service provision models. We know that traditional models of care that rely on institutional settings are resource intensive and unsustainable. Good progress has been made in recent years to shift the balance of care. We must continue to promote new ways of working and provide flexible, responsive health and care services in the community that make fullest use of new technologies such as Technology Enabled Care. We must work in collaboration with Acute Services, with Third Sector partners and communities to promote prevention, early intervention and develop health improvement programmes.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has 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.
Previously considered by:	This report has not been presented to any other formal meeting.

Agenda Item

1

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	Delays in Discharge from Hospital to a Community Setting Update
Reference Number:	CC-56-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The purpose of this report is to inform the Integration Joint Board of the work that is being carried out between Acute and Community Health and Social Care Services to minimise the number of people whose discharge from hospital to a community setting is delayed.

1.2 This report summarises the actions being taken within Community Health and Social Care Services and Acute Services. The issue of delayed discharges has particular relevance to Winter Planning and ensuring that there is adequate capacity in acute services to admit patients who need inpatient care, and also that there are adequate hospital beds for elective care (including planned surgery).

2. Background

2.1 "A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge and who continues to occupy the bed beyond the ready for discharge date". (*Delayed Discharges Definitions and Data Recording Manual, 2012*).

2.2 The current Scottish Government target for reducing delayed discharges is to have no one waiting longer than 28 days to be discharged from hospital to a more appropriate care setting.

2.3 At the time of writing this report the situation is:

- 9 delayed discharges in total
- 5 delayed discharges over 14 days
- 0 delayed discharges coded 9/71X (Exemption)

2.4 Since the start of reporting at each business cycle to the Committee, the number of delayed discharges has averaged around 4 people at any given

time (this average is the measure for 2015), where the delay has been from one day and upwards. The average will continue to be measured within this financial year (see Appendix 1). This is an improvement compared to 2014/15 which averaged around 8 people. A number of initiatives have contributed to the improvements, including the decision in April 2015 to put additional social work to undertake the hospital liaison and duty social work roles. This resulted in a full time social worker taking on this role as opposed to different social workers each day. This has helped to improve communication between acute and community staff and also improve the assessment and planning process for people in hospital.

In addition to this two senior social care workers from Lerwick and Central have concentrated on the assessment and care coordination element, further improving communication, assessment and support planning. The success of this initiative will be made permanent. Further to this the Intermediate Care Team have provided reablement support to a number of people requiring input to facilitate them leaving hospital.

This additional and changed use of resource has had a positive effect on our number of delayed discharges.

2.5 During 2015 the number of bed-days used by patients who were delayed was 2313, with 86 patients contributing to this total.

2.6 The cohort of delayed discharges is almost entirely older people. The longest delayed discharges are usually people waiting for a residential care bed.

2.7 Both Community Health and Social Care Services and Acute Services recognise the imperative to reduce delayed discharges, as spending longer than necessary in hospital reduces the likelihood of maximising an individual's independence in the longer term. The issue of delayed discharges is recognised as an end to end pathway issue and both services are working together to reduce delays.

2.8 There are immediate and longer term actions to reduce delayed discharges. Immediate actions include ensuring that there is robust information available on capacity within the system and the progression of actions for each individual delayed person from the whole multi-disciplinary team. The Intermediate Care Team, funded through the Integrated Care Fund, is actively recruiting on a permanent basis to create a level of resilience. Another initiative within the Integrated Care Fund is a home from hospital service that has been procured from Royal Voluntary Service, a Third Sector partner. This supports individuals to return home in a timely manner, or to be supported as part of a package if hospital admission can be avoided. The Integrated Care Fund now forms part of the baseline funding for NHS Shetland.

2.9 The Information Services Division annual summary of occupied bed days and census figures (June 2016) cites Shetland as decreasing the total number of occupied bed days from delayed discharge at 56% (Scottish average 9%) which was the largest reduction for partnerships in Scotland.

2.10 Further actions are being developed over time, to put in place robust

mechanisms for reducing delayed discharges further and creating a sustainable process.

3. Conclusions

3.1 Minimising delayed discharges is important for a number of reasons. The primary reason is that when people stay in hospital for longer than necessary there is a loss of independence and this can adversely affect the longer term outcomes for individuals' rehabilitation.

3.2 It is important that the link between hospital discharges and the ability of the hospital to accept new patients is understood. There is no alternative to local acute hospital care other than off island facilities and if the local hospital has no spare bed capacity, then moving patients off island would be the only alternative.

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25 August 2016

Appendices
Appendix 1 – Monitoring of weekly reported delays

Background documents
Shetland's Joint Strategic (Commissioning) Plan 2016-19
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/DraftJointStrategicCommissioningPlan2015-16Version4.pdf

Delayed Discharges Definitions and Data Recording Manual
http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/delayed-discharges-manual-120613.pdf

ISD Publication
https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2016-06-28/2016-06-28-DelayedDischarges-Report.pdf?49715822936

Date	Total number of delayed patients	number of patients delayed > 2 weeks excluding code 9
05/04/2016	5	2
12/04/2016	3	1
19/04/2016	2	0
26/04/2016	0	0
03/05/2016	2	0
10/05/2016	0	0
17/05/2016	0	0
24/05/2016	0	0
31/05/2016	2	0
07/06/2016	2	0
14/06/2016	4	1
21/06/2016	5	0
28/06/2016	4	0
05/07/2016	4	0
12/07/2016	5	3
19/07/2016	6	3
26/07/2016	6	4
02/08/2016	7	5
09/08/2016	7	4
16/08/2016	9	5

Average number of patients delayed	4.1

Agenda Item

2

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	Primary Care Strategy Action Plan
Reference Number:	CC-54-16 F
Author / Job Title:	Lisa Watt / Service Manager Primary Care

Decisions / Action required:

That the Integration Joint Board (IJB) note the updated Primary Care Strategy Action Plan

High Level Summary:

The Strategy has been developed to give a direction of travel for Primary Care in Shetland, and an implementation plan is attached. It should be noted that at the same time as the Strategy is being implemented, it is anticipated that national guidance on a new Scottish GP contract will be released and this guidance will need to be incorporated into the detailed implementation plan once received. The action plan attached gives an update on the current position. As the work progresses further actions will be added.

Corporate Priorities and Joint Working:

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

Key Issues:

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

Implications :

Service Users, Patients and Communities:	Successful implementation of the Primary Care Strategy will improve recruitment and retention and contribute to improved outcomes for service users, patients and the community.

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

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

considered by:	

Primary Care Strategy – Action Plan

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

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

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

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

Lisa Watt
Service Manager Primary Care

Version 2 – 19/08/16
LMC – Local Medical Committee; DCHSC – Director of Community Health & Social Care; IT – IT department

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

Version 2 – 19/08/16

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

			no longer done face to face. Noted that most other Boards do not offer exit interviews to independent contractors.
Influence partner organisations such as Scottish Ambulance Service, Shetland Islands Council with regard to transport issues and Scottish Government on national policy that will affect local services	Medical Director/Head of Planning & Modernisation	March 2017	Other services to understand the impact of any service changes that they plan or make, and to put in mitigations where there is adverse impact for health services or for the health of local communities
Actively pursue schemes such as Remote & Rural Fellows Scheme	Medical Director		There were no applicants for the Remote & Rural Fellow Scheme in Shetland in 2016, a further advert will be placed for the 2017 scheme.
Increase the number of training practices in Shetland	Medical Director/LMC	Dec 2016	There is currently one training practice in Shetland, the Deanery have indicated that they would be interested in seeing another practice undertaking training accreditation
To increase the focus of Primary Care on the Board of NHS Shetland, it is proposed to have a specified non-executive director with a remit for Primary Care issues	Medical Director/Chief Executive	Sept 2016	Proposal to be developed which sets an outcomes approach for the role.
The development of a locality primary care team to include GP roles as envisaged in the new GP contract, pharmacy, and health improvement practitioner time, working with community nursing, social care and other professionals such as OT to develop a more integrated model of health and social care, as part of integrated locality working	Community Health & Social Care operational team	Oct 2016	Discussions regarding locality service models underway; detail on the new GP contract is not yet known and will be incorporated into this action plan once this is available
Develop a Primary Care Workforce Plan	Primary Care Manager/All GP Practices	Dec 2016	This should include an understanding of core skills required to deliver services effectively including prevention and anticipatory care, and the amount of time required to do this well
Provide skills development and training	Medical Director/LMC/Staff	Mar 2017	This should include a structure which provides guidance on roles and responsibilities, including specifically 'end of life'

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

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

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

supported remote access, and one single electronic record			

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	Effective Prescribing in Shetland
Reference Number:	CC-60-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

It is recommended that the IJB approve the actions proposed to control prescribing costs, including:

1. The development of the Pharmacy team within Health and Social Care.
2. Understanding local variation compared to better performing partnerships across Scotland.
3. Using Orkney practice data as a benchmarking comparator to Shetland practices, Orkney has a similar sized population and geography.
4. Reducing wastage of medicines from non usage and hoarding.
5. Supporting the development of work to ensure effective prescribing within the Primary Care Quality Cluster.

High Level Summary:

The cost of medicines prescribed by General Practitioners to Shetland patients continue to rise. As the population becomes older so the prevalence of long term conditions increases. New and innovative medicines are being made available to treat a range of conditions. These factors drive up costs. Traditionally cost pressures were managed through switching to less expensive medicines, however the savings from these approaches are diminishing. A strategic approach which is person-centred, rather than centred on targets and conditions, is now being implemented. Prescribing which is effective and safe will ultimately be cost effective too. Prescribing costs are rising faster than some partnership areas of Scotland, and our local intelligence shows some wide variation in prescribing which is driving the cost increases.

Corporate Priorities and Joint Working:

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

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

Key Issues:
The overall cost of medicines in Shetland continues to rise, and is rising at a faster rate than some other partnership areas in Scotland. Benchmarking data raises questions about prescribing cost anomalies within Shetland. Traditionally methods of managing spend can no longer be relied on to produce savings. Shetland prescribing is generally of a high standard although there is significant variation between practices, and Shetland has some higher prescribing costs compared to similar populations elsewhere.

Implications :	
Service Users, Patients and Communities:	Ensuring that prescribing resources are utilised effectively will maximise the benefits from medicines and reduce the potential for harm. Reducing unnecessary costs will allow other services to be sustainable.
Human Resources and Organisational Development:	There is a need to invest in pharmacy staffing to ensure that the work to ensure efficient prescribing continues.
Equality, Diversity and Human Rights:	There are no specific implications arising from this report.
Legal:	There are no specific implications arising from this report.
Finance:	Increases in the amount of resources required to be spent on prescribing jeopardises the ability of the IJB to direct resources to other services. The result of increased expenditure on prescribing is that more efficiency will need to be found in other parts of the service.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Pharmacy has put in place a number of monitoring indicators to flag where variation is occurring. The capacity of pharmacy is not adequate to investigate at a patient level, and the reliance is on the co-operation and engagement of the clinicians who are the prescribers.

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.
Previously considered by:	This report is drawn from a discussion paper presented to the Area Drug and Therapeutics Committee on 28 July 2016 and the IJB Audit Committee 26 August 2016.

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	Effective Prescribing in Shetland
Reference Number:	CC-60-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The purpose of this report is to inform the Integration Joint Board of a particular topic that the IJB Audit Committee has decided to escalate to the IJB through the Chief Officer. There are a raft of work streams being led by the Director of Pharmacy, which are designed to reduce variation and therefore costs. The national and local data indicates that the prescribing costs for both primary and secondary care are escalating faster than the Scottish average, and when benchmarked against similar populations there is greater variation between practices in Shetland.

1.2 The risks are twofold. Firstly, if prescribing costs continue to rise there is a real risk that the expected efficiencies pharmacy are tasked to find this year will not be realised. Secondly, if costs continue to rise then an over spend in-year is likely.

2. Background

2.1 Appendix 1 contains the full set of papers that were presented to the IJB Audit Committee by the Director of Pharmacy on 26 August 2016. The papers set out the issues and challenges for primary care prescribing, which forms a significant part of the IJB budget.

2.2 There is a wealth of data available both nationally and locally which shows the patterns of prescribing in Shetland and how local prescribing compares to the rest of Scotland, at a patient cost level and by particular medications. While Shetland generally compares favourably there are some therapeutic areas where costs are higher. When compared to a similar population such as Orkney, Shetland appears to have higher costs. It is that variation that provides an opportunity not only for cost control in-year, but also to find potentially significant savings.

2.3 An overspend on the prescribing budgets will put pressure on other services to generate further savings. Not capitalising on potential further recurrent efficiencies from prescribing will result in the burden to find savings being put on other services at a time when there is already a shortfall in efficiencies being generated in the health part of the IJB budget.

2.4 Nationally wastage of medicines runs in any given area at between 5 to 20 percent. Garnering public support and clinical engagement to tackle medicines wastage is vital. Local campaigns have run in the past, alongside national drives to reduce wastage, however evidence including anecdote indicates that there is still significant wastage of medicines in Shetland, where there is non-usage and hoarding.

2.5 There is a national requirement to develop Quality Clusters in primary care, and Shetland has one cluster that is forming. A quality lead has been identified in each practice, and the Cluster has agreed to include prescribing as part of their quality work.

2.6 The Director of Pharmacy also fulfils the same role for NHS Orkney. There is value in extending the benchmarking between practices to include Shetland and Orkney. The addition of the Orkney practice prescribing information will provide a larger cohort of practices to compare with, and opportunities for shared learning.

3. Conclusions

3.1 There is significant variation in prescribing costs. The level of variation indicates that there is value in investing further time and effort in this area. There are further steps that can be taken to understand variation and reduce wastage. None of this can happen without the full engagement of the prescribers.

3.2 The implications of not seeking to make efficiencies from prescribing is that efficiencies will have to be found elsewhere. If the opportunity is missed, the effect will be seen in a reduction of provision in other services.

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26 August 2016

Appendices
Appendix 1 – IJB Audit Committee Report – Effective Prescribing in Shetland

Background Documents
Quality Clusters http://www.sehd.scot.nhs.uk/pca/PCA2016(M)07.pdf

APPENDIX 1

COVER

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board Audit Committee
Date:	26 August 2016
Report Title:	Effective prescribing in Shetland
Reference Number:	CC-52-16
Author / Job Title:	Chris Nicolson / Director of Pharmacy

Decisions / Action required:

It is recommended that the IJB Audit Committee note the strategic approach being planned to ensure effective prescribing in Shetland.

To avail themselves of the opportunity to discuss the impact of prescribing on costs and make suggestions on how the Committee might wish to be assured hereafter on the value of actions taken to ensure cost effective prescribing.

High Level Summary:

The cost of medicines prescribed by General Practitioners to Shetland patients continue to rise. As the population becomes older so the prevalence of long term conditions increases. New and innovative medicines are being made available to treat a range of conditions. These factors drive up costs. Traditionally cost pressures were managed through switching to less expensive medicines. However the savings from these approaches are diminishing. A strategic approach which is person centred, rather than centred on targets and conditions, is now being implemented. Prescribing which is effective and safe will ultimately be cost effective too.

Corporate Priorities and Joint Working:

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

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

Key Issues:

The overall cost of medicines prescribed by General Practitioners to Shetland patients continue to rise.

Traditionally methods of managing spend can no longer be relied on to produce savings. Shetland prescribing is generally of a high standard although variation between practices can cause concern.

A strategic approach to medicines management is being implemented; although this is has its own challenges.

Implications :	
Service Users, Patients and Communities:	Ensuring that prescribing resources are utilised effectively will maximise the benefits from medicines and reduce the potential for harm.
Human Resources and Organisational Development:	There is a continuing need to invest in pharmacy staffing.
Equality, Diversity and Human Rights:	There are no specific implications arising from this report.
Legal:	There are no specific implications arising from this report.
Finance:	Prescribing costs generated by General Practitioners (GPs) form part of the IJB budgets. Due to expected increased costs per patient, it is estimated this budget may overspend by £92k. Efficiency savings are required within Pharmacy and Prescribing budgets- overall of £200k. It is anticipated that up to £192k may be required from the GPs Prescribing budget.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Any risks to the Integration Joint Board arising from this paper are acknowledged and the purpose of the paper is to describe arrangements being put in place to mitigate the risks.

Policy and Delegated Authority:	This particular report is presented to the IJB Audit Committee in terms of its responsibility for operational oversight of integrated services. The Director of Pharmacy (DoP) is responsible for the operational management of pharmacy services and prescribing support, all of which sits within the IJB. The DoP is the Accountable Officer for certain legal aspects of prescribing and prescribing governance for NHS Shetland.
Previously considered by:	This report is drawn from a discussion paper presented to the Area Drug and Therapeutics Committee on 28 July 2016.

APPENDIX 1

REPORT

Shetland Islands Council

Meeting:	Integration Joint Board Audit Committee
Date:	26 August 2016
Report Title:	Effective Prescribing in Shetland
Reference Number:	CC-52-16
Author / Job Title:	Chris Nicolson / Director of Pharmacy

1.0 Introduction

1.1 Effective prescribing is achieved when medicines are started appropriately, where effects are monitored appropriately and when treatments are stopped at the right time. Cost effective prescribing is much more than choosing the correct medicine for a particular condition it is also around understanding the limitations around the use of medicines for individual patients.

2.0 The GP Prescribing Budget

2.1 Costs associated with medicines are generally met from Health Board allocations, some costs such as the costs of dispensing are met centrally by the Scottish Government Health Department, through what is known as non-cash limited funds. Next to staffing costs, medicines costs represent the biggest area of spend for NHS Shetland, in total this is around £6M.

2.2 The cost of medicines relate to the cost of care, delivered by both social care and health staff. For example, moving to more expensive once daily dosing can reduce the cost of visiting carers, and the expensive new “biological” medicines to treat rheumatology patients, often allow patients to have independence rather than being wholly dependent on carers.

2.3 The General Practice (GP) prescribing budget which is part of the overall Pharmacy budget, is spent within the IJB. The budget this year (2016-2017) is £4.478M. Last year (2015-16) the spend was £4.311M. With prescribing costs per patient currently growing at 6%, spend could be as high £4.570M i.e. an overspend of £92,000. Prescribers therefore will have difficulty in staying within their budget allocation.

2.4 Additionally the savings challenge for prescribing is £200,000. Half of this saving, around £100,000 will be applied to the GP prescribing budget as the year progresses, so the total savings required in the GP prescribing budget could be as high as £192,000.

3.0 Finding savings

3.1 In year savings are increasingly difficult to find in the GP prescribing budget and every effort is being made to release short term savings. However, in

line with other areas in Scotland, there is a move towards a longer term strategic approach which can only be delivered through multidisciplinary working, in particular strengthening the working relationships between GPs and pharmacists.

3.2 Each year over the last 15 years in Shetland, various programmes to reduce prescribing costs through switching, generic substitution and implementing savings through the Quality Outcomes Framework (where GPs were paid to make therapeutic changes) have been successful. However the return from these programmes is diminishing. Scriptswitch® (see Appendix) largely replaces the manual effort associated with switching from one product to another.

3.3 The Quality Outcomes Framework (QOF) has been removed. QOF was always designed as a quality tool but its failing was that it contributed to the addition of medicines to treat a specific illness rather than encouraging prescribers to consider the whole person. As such QOF has contributed to the polypharmacy situation we face today. The expectation of benefits from conventional medicines, particularly where several medicines are used for multiple conditions over long periods of time is reducing.

3.4 Generic prescribing is now at the highest attainable level, yet in some situations, particularly around inhaler use, there are various recommendations to prescribe by proprietary brand, as this is deemed more cost effective and much better from a clinical perspective.

3.5 A longer term approach which concentrates on the quality of treatments rather than the cost of treatment is now much more likely to realise savings.

3.6 With modern medicines and the introduction of increasingly targeted treatments it is now recognised and there will be a gradual move to these targeted, and more expensive treatments, with higher expectation of benefit- see the National Clinical Strategy. So although there are potential savings in conventional treatments, more investment will be needed for new medicines. A considered approach is required.

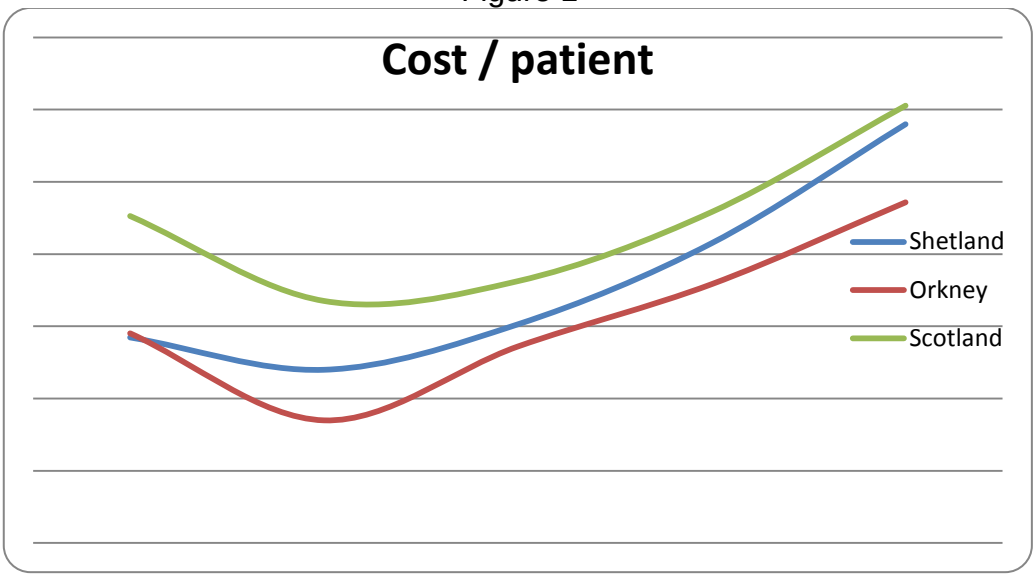
4.0 Medicines Management

4.1 Medicines management, where all the medicines a patient is taking are considered together in a rational way, supports better and more cost-effective prescribing in primary care and helps patients to manage their own medications better. Good medicines management can help to reduce the likelihood of medication errors and potential patient harm. Mindful and efficient prescribing is part of this, and treatment costs can be reduced (which includes GP time and other treatment costs, as well as the actual cost of the medicine) while increasing the benefits for patients. The National Clinical Strategy articulates a desire to facilitate a clinically led, patient-centred approach in reducing harm and waste from unnecessary intervention and treatments.

4.2 The evidence around the benefits of good medicine management is clear with numerous studies and trials all pointing to similar conclusions. Nationally there is a considerable body of evidence from the point of view of patient safety, service efficiency and cost that strongly suggests medicines management needs to be improved. And although prescribing in Shetland appears to be as efficient and clinically effective as prescribing in other areas

of Scotland pilot studies have shown that there is much that can be done in Shetland as well.

Figure 1



4.3 It is increasingly clear that as the population ages, the tendency will be for the cost per patient in Shetland to approach the Scottish Average (this is illustrated in figure 1). This small change in gradient (already detectable) if unchecked, will have a profound effect on spend and largely negate any opportunity for savings.

5.0 Variation across Shetland

5.1 It is also known that there is however considerable variation between practices (see Appendix 1) and there is work to be done in actively improving medicine management in all areas of prescribing in Shetland.

5.2 NHS Shetland has always encouraged prescribers to adopt change - employing pharmacists to target 'outlying' practices through the provision of practical support, dissemination of information and prescribing feedback. Prescribing advisers have aimed to facilitate a non-confrontational approach in achieving this.

5.3 Historical data suggests that this work has been achieved successfully in most practices with a positive influence on prescribing behaviours. In more recent years pharmacists appear to be working effectively in a hands on way with most practices and achieving measurable gains, while GPs generally view them positively as facilitators of prescribing behaviour change. The introduction of a pharmacist into the Lerwick Health centre is particularly valued.

5.4 It is suggested however, that most Shetland prescribers do not assimilate information on drug costs and price changes and are often unaware of prices or price changes. This is not surprising as price fluctuations, particularly in the generic market are relentless. Prescribers may have little reason to be aware of absolute drug costs although Scriptswitch®, when utilised, increases the awareness of relative drug costs.

5.5 In Shetland there has been a general willingness to undertake simple cost-minimisation prescribing strategies, e.g. generic and lower cost, therapeutically equivalent substitution. Not surprisingly prescribers in Shetland have not been willing to trade quality and effectiveness for cost. By

contrast, there is some evidence of willingness to trade cost for patient convenience, and also a willingness to trade cost for quality of evidence within a drug class (e.g. to use atorvastatin instead of simvastatin).

5.6 Little attention has been paid in Shetland to health economic concepts such as cost effectiveness and cost utility, however it is generally believed, and there is some evidence to support this, that prescribing in Shetland is considered cost-effective as well as cost-efficient.

6.0 External Influences

6.1 The Grampian Formulary is shared with and used by NHS Shetland. The influence of NHS Grampian, and more recently Shetland's hospital consultants on GP prescribing is profound, with GPs generally being unwilling to change therapies recommended by specialists. One of the difficulties most commonly articulated is that specialists tend to treat a single condition, which results in GPs having to manage an increasing medicine burden for an individual patient. As with Scotland as a whole, it may be fair comment that the patients view on this increasing polypharmacy is not always sought.

7.0 Assessment of where we are

7.1 It is an observation, that while prescribing budgets have been carefully calculated and faithfully set each year, these are seen by some GP's as largely irrelevant and simply indicative. Perhaps unsurprisingly, many GPs seem not overly concerned by budget overspends, whether at practice or Health Board level. A view sometimes expressed is that *"it is up to the Scottish Government/Health Board to provide an adequate budget to meet needs"*. There is little evidence of any services which have been lost because of overspends, which adds credibility to this view.

7.2 Despite this, prescribing data produced by the Information and Statistics Division (ISD) indicate that prescribing in Shetland, in most therapeutic areas is cost effective. In recent years, the opportunities for savings have reduced. GP practices have largely concentrated on making savings agreed with the prescribing advisor, as part of QOF. Pharmacists have provided assistance in meeting the targets.

7.3 Scriptswitch® has been invaluable. The opportunities to make savings in-year are now diminishing. There is considerable expertise involved in analysing data and introducing savings initiatives, and Shetland is fortunate in having these skills both in the past and currently which has contributed in no small way to the enviable position that existed until now.

7.4 The end of QOF, the diminishing effectiveness of switching and the relentless increase in conditions such as diabetes with a move to higher cost more effective medicines, suggest that a more strategic approach to medicine management needs to be implemented, this is particularly challenging in Shetland with a relatively large number of small practices and single handed specialists relative to the population size.

7.5 Increasingly the Director of Pharmacy is working regionally and with the National programmes to ensure the opportunities to share work with colleagues in other Boards can result in a reduction in spend in Shetland and across Scotland. There are strong network arrangements across the north of Scotland at which pharmacists share good practice and innovative ideas.

8.0 Recommendations

8.1 The underlying recommendation of this report is that the approach to prescribing savings should be driven as a quality programme with a longer term strategic approach – short term savings initiatives are of diminishing effectiveness. To this end a Prescribing Action Plan has been drafted, which considers quality as well as purely cost driven actions, and envisages closer working between GPs and pharmacists.

8.2 Short term savings have always been required. This year savings of £192,000 may be required from the GP prescribing budget alone. It is clear that while efforts need to continue, any gains from switches and other short term measures are likely to be short lived. Importantly, this means that additional effort is required year on year simply to maintain savings already made, as well as developing new saving initiatives. All this has to take place against a background of an increasingly older population with and an associated increased incidence of, long term conditions treated by more effective, more expensive therapeutic agents.

8.3 The strategic approach required, is one which has a focus on quality and effective medicines management. This is now widely recognised as the key approach in reducing costs. The Kings Fund suggests that focus needs to be increasingly centred on the individual, and their views on treatment, rather than simply treating a condition. Professionals, particularly GPs, pharmacists and non-medical prescribers will have to work together with a common purpose and aim. Multidisciplinary working will increasingly be the norm and pharmacists and technicians will be required to work to the "top of their licence" working directly with patients in clinics and in their place of residence.

Some progress has been made in Shetland.

8.4 Strengthening of the pharmacy team, through a remote and rural fellowship will help ensure that Shetland is able to recruit and retain pharmacists developing their skills in career level posts. There is ongoing need for training, and work is underway to scope this requirement.

8.5 Some national resource has been made available to increase staffing numbers, which although still significantly below Scottish average levels, is improving the effectiveness of the pharmacy workforce. The pharmacy leadership has been realigned ensuring that the service can best fit an integrated model. In the future there may be a need for investment in both pharmacy technicians and pharmacists.

8.6 Work done in the Lerwick practice and innovative pilots across Shetland could be rolled out to help reduce variation and improve safety as well as cost effectiveness. The pharmacy team should increasingly be integrated into practices and social care settings.

8.7 Refocusing on quality, on patients, and on a commitment to multidisciplinary working is resulting in the emergence of a set of multidisciplinary actions. These are necessary and should be supported by a commitment to training, recruitment and potentially investment. This will be difficult, but if it can be done anywhere, it can be done in Shetland. These actions are organised into a five year Prescribing Actions Plan.

8.7.1 Prescribing Action Plan

The Prescribing Action Plan being drafted a strategic 5 year plan which majors on therapeutic improvements through better medicine management. Some examples of these planned actions will describe how:

- Tackling polypharmacy is key, accompanied by additional support to patients, in particular the frail elderly.
- Improving respiratory prescribing can help patients get the benefit from the medicines prescribed.
- The diabetes service will be supported to deliver increasingly effective prescribing as numbers grow.
- GPs are freed up to more effectively deliver their clinical role by removing many medicine related tasks, better done by pharmacists and technicians.
- Managing the interface and discharge for patients leaving hospital can contribute to more effective and efficient prescribing in Shetland.

The plan needs to be underpinned by:

- A commitment to develop pharmacy as an effective workforce so that pharmacists and technicians are properly equipped to undertake the tasks.
- Information that is used more effectively to support the ongoing education of prescribers while creating a better understanding of prescribing and medicine related issues.

8.8 The Prescribing Action Plan will be a key strategic document which should be considered alongside service plans and action plans emerging from the Primary Care Strategy.

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9 August 2016

Appendices

Appendix 1- Prescribing Dashboard

Background Documents

A National Clinical Strategy for Scotland
http://www.gov.scot/Resource/0049/00494144.pdf

The Kings Fund – Effective Medicines Management
http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/medicines-management

Prescribing Dashboard Jan-March 2016

Quality Measure	Practice										NHS Shetland	NHS Orkney	Scotland
	1	2	3	4	5	6	7	8	9	10			
No of items/1000 patients [1]	4985	5335	6675	8296	5311	5505	3819	4255	4828	7131	5443	4247	4441
Cost/item[2] **(£)**	6.68	7.52	8.25	6.87	8.66	8.22	11.30	10.04	9.79	7.84	8.87	10.85	11.12
Cost/patient[3] **(£)**	33.31	40.11	55.07	56.95	45.99	45.27	43.14	42.74	47.26	55.88	48.26	46.08	49.37
NSAID use[4]													Measure compares to Scotland
PPI performance[5]													Measure compares to Scotland
Use of strong analgesics[6]													Measure compares to Scotland
Antibiotics (total Items)[7]													Measure compares to Scotland
Year to March 16. Percentage over/under budget[8]	-8.20	10.11	44.49	16.30	9.18	3.73	19.61	11.45	-7.74	20.86	7.48	unavailable	
Scriptswitch acceptance rate as a percentage of offers[9]	16.7	5.7	29.6	22.2	37.3	Nil data	62.3	29.4	33.3	48.5		unavailable	
% Generic [10] **Prescribing rate**	84.23	86.71	80.16	84.83	86.56	84.78	84.22	82.00	88.33	86.93	84.81	unavailable	82.99

Explanatory Notes

This dashboard can indicate where prescribing variation across Shetland exists and can indicate where issues not related to the prevalence of clinical conditions exist. This data is build from a number of sources in pharmacy but similar data, identifying the practices is already in the public domain and similar dashboards are being tested.

1. Number of prescription items written in the quarter, should be viewed with caution as some practices prescribe monthly others two monthly.
2. Cost per item, might indicate which practices are prescribing expensive medicines-but more likely to be related to number of tablets prescribed.
3. Cost per patient, a more accurate measure, but this figure can be skewed by practice size, just one or two expensive patients can have an impact when the practice is small- by national standards nine of our ten practices are small.
4. While disease prevalence and number of people with various conditions as well as their age and gender can have an effect on spend, the spend on some medicines should be low in all practices, an example would be the use of anti-inflammatory medicines (the NSAIDS) such as ibuprofen.
5. Similarly the use of PPIs- medicines which reduce stomach acid- is not closely related to clinical conditions, these medicines should often be time limited, and patients should move to maintenance doses.
6. The high use of some analgesics is not supported by treatment guidelines.
7. The use of antibiotics should always be minimised.
8. The practice budget is based on the weighted (for age sex and deprivation) practice population.
9. Scriptswitch® is a computer programme that uses the Grampian/Shetland formulary as its database. The system links to the GP practice system, so that when the GP attempts to prescribe a medicine, a more cost effective alternative may be proposed. The measure used is the number of switches offered which are accepted.
10. The generic prescribing rate was the gold standard prescribing indicator. However for some conditions it is now more clinically effective and cost effective to use branded products. During 2016-17 a fall in generic prescribing will be a proxy measure of success as the new respiratory guidelines are implemented.

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	Financial Monitoring Report to 30 June 2016
Reference Number:	CC-57-16 F
Author / Job Title:	Karl Williamson / IJB Chief Financial Officer

Decisions / Action required:

The IJB is asked to note:

The Management Accounts for the 2016/17 year as at the end of the first quarter.

High Level Summary:

The purpose of this report is to enable the Integration Joint Board (IJB) to monitor the financial performance of the delegated budgets contained in the Joint Strategic Commissioning Plan 2016-19. This report outlines the projected outturn position for 2016/17 as at the end of the first quarter. The IJB may also consider issuing further directions to SIC and NHSS to address any forecast overspends.

At the end of the first quarter the consolidated year-end outturn forecast, at 31st March 2017, for the Partnership as a whole is an overall adverse variance of £1,255k.

There are significant recurring underspends in staffing costs which are highlighted in the main report and there is ongoing work led by Finance to better understand how these underspends are being generated.

Corporate Priorities and Strategic Aims:

The IJB's vision, aims and strategic objectives are set out in the Integration Scheme and the Strategic Plan 2016-19.

The quarterly Financial Monitoring Reports are to enable the IJB to manage in-year financial performance of the integrated budget and to monitor performance against the Strategic Commissioning Plan

Key Issues:

The projected outturn position is an adverse variance of £1,255k for the partnership as a whole. This position highlights the financial challenge we are facing over the next few years and beyond. It is crucial that services are redesigned in a manner that continues to deliver quality health care but at lower cost. As the Strategic Commissioning Plan, and associated budgets, is revised for 2017/18 the IJB must play a key role in redesigning the future of health and social care in Shetland.

Implications :	
Service Users, Patients and Communities:	May be affected should services be redesigned. However appropriate consultation procedures will be followed should any changes have an impact on this group.
Human Resources and Organisational Development:	May be affected should services be changed. However appropriate consultation procedures will be followed should any changes have an impact on this group.
Equality, Diversity and Human Rights:	None
Partnership Working	Partnership working is at the very core of IJB principles.
Legal:	None
Finance:	The NHS arm of the budget is currently projected to be overspent at the year-end A Recovery Plan has been presented to a previous meeting and continues to be developed. The full savings target is currently not expected to be met on a recurrent basis from the NHS patient services. Any shortfall in savings will mean a carry forward to the next financial year, increasing the challenge for the IJB.
Assets and Property:	None
Environmental:	None
Risk Management:	There are numerous financial risks involved in the delivery of services and the awareness of these risks is critical to successful financial management. From a financial perspective, risks are an integral part of planning for the future as assumptions are required to be made. These assumptions can be affected by many internal and external factors, such as supply and demand, which may have a detrimental financial impact.

Policy and Delegated Authority:	The IJB has delegated authority for the budgets specified in the Joint Strategic Commissioning Plan 2016-19 from SIC and NHSS. The services detailed in this report are under the control of the IJB.
Previously considered by:	The proposals in this report have not been presented to any other committee or organisation.

Agenda Item

4

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	07 September 2016
Report Title:	Financial Monitoring Report to 30 June 2016
Reference Number:	CC-57-16 F
Author / Job Title:	Karl Williamson / IJB Chief Financial Officer

1. Introduction

1.1 The purpose of this report is to enable the Integration Joint Board (IJB) to monitor the financial performance of the delegated budgets contained in the Joint Strategic Commissioning Plan 2016-19. This report outlines the projected outturn position for 2016/17 as at the end of the first quarter.

2. Background

2.1 The 2016/17 IJB budget was agreed as part of the Joint Strategic Commissioning Plan 2016-19 on 28th June 2016.

2.2 The Integration Scheme requires for management accounts to be presented to the IJB at least quarterly.

2.3 This report represents the management accounts as at the end of the first quarter of 2016/17.

3. Executive Summary

3.1 The management accounts at 30 June 2016 have been compiled following financial analysis and budget monitoring at SIC and NHSS.

3.2 These accounts are based on projected outturn position which is consistent with SIC financial reporting. NHSS favours year to date reporting but for the

purposes of IJB reporting it has been decided to adopt the outturn approach. However as with all forecasting of future events, members should interpret with caution this forecast as it is almost certain the actual yearend outturn position will not match these projections.

3.3 Appendix 1 details the consolidated year-end outturn forecast for the IJB as a whole. Current projected outturn to the end of March 2017 is an adverse variance of £1,255k.

3.4 Appendix 2 details the annual budgets by organisation as per the Joint Strategic Commissioning Plan 2016-19.

4. Financial Commentary

4.1 Mental Health - projected outturn overspend of (£63k) (2.6%)
Off island Service Level Agreement overspend due to patient who required treatment outside the Grampian area. This ceased in July so no further overspend in this area forecast (£50k)

Small projected overspend in car allowance/mileage due to high value package of care being delivered at present which is expected to continue during the year (£13k).

4.2 Substance Misuse - projected outturn breakeven
This service area is expected to be on budget.

4.3 Oral Health - projected outturn overspend (£83k) (2.6%)
Allocation has been reduced by £103k (3.5%) from 2015/16. As well as the reduction in allocation, there has been increase in pay costs due to on cost increase (National insurance and pension), inflationary rise and incremental drift. This has led to a total savings requirement of £138k. Dental management has identified £50k in pay savings through a change in skill mix but £88k is yet to be identified.

4.4 Pharmacy & Prescribing - projected outturn breakeven
This service area is expected to be on budget.

4.5 Primary Care - projected outturn overspend of (£195k) (4.3%)
GP locum costs incurred in Yell until GP recruited in June 2016 (£19k). Continued locum requirements in Lerwick to cover 1.97 WTE vacancy until the end of September 2016 (£53k). Hildasay Medical Practice is also outperforming its contract on enhanced services and the Board is liable for its non recurring maternity cover (£72k).

4.6 Community Nursing - projected outturn breakeven
This service area is expected to be on budget.

4.7 Directorate - projected underspend of £4k (0.65%)
There are no significant variances in this service area.

4.8 Pensioners - projected outturn breakeven
This service area is expected to be on budget.

4.9 Sexual Health - projected outturn breakeven
This service area is expected to be on budget.

4.10 Adult Services – projected outturn underspend of £141k (2.7%)
The projected underspend mainly relates to:

- Various vacant posts at the Eric Gray Resource Centre, including a vacant Senior Social Care worker which has taken several months to fill, £59k;
- Vacant Deputy Manager post in Supported Living and Outreach for first few months, with the Team Leader post in this area currently vacant, combined with less use of relief staff and some staff being paid at a lower pay grade than budgeted, £77k.

4.11 Adult Social Work – projected outturn overspend of (£462k) (26.4%)
The projected overspend mainly relates to:

- Increased demand for care services to be provided from Self-Directed Support packages. This projection is based on the current level of packages being provided, (£438k). This is offset by additional funding agreed by the IJB to be used for this purpose, £348k;
- A projected overspend in Off-Island Placements (£372k) for which contingency budget is available if the costs cannot be met from overall underspends in Council budgets during the year.

4.12 Community Care Resources – projected outturn underspend £580k (5.7%)
The projected underspend is mainly due to:

- A projected underspend on employee costs across the service, most notably in Care at Home Central, where a review of staffing rotas is currently being undertaken, alongside work to assess the impact of movement by service users from Care at Home Service provision to Self-Directed Support packages, £369k;
- The remainder of the projected underspend in employee costs relates to rolling vacancies across the service which may take several months to fill, some difficulty in recruiting to Care at Home posts in specific areas, a reduction in actual Care at Home hours delivered against budget, as the level of care packages can fluctuate during the year depending on demand, coupled with less use of relief staff to cover annual leave than budgeted for, £268k;
- Expected over-achievement of income from charging for board and accommodation and other non-residential charges. This can vary significantly from budget due to changing customer base and it is dependent on the financial circumstances of those receiving care, £185k;

- There is a projected overspend on Independent Sector Placements of (£155k) for which contingency budget is available if the costs cannot be met from underspends in Council budgets during the year.

4.13 Criminal Justice – projected outturn underspend of £11k (38.0%)
There are no significant variances in this service area.

4.14 Speech & Language Therapy - projected outturn breakeven
This service area is expected to be on budget.

4.15 Dietetics - projected outturn breakeven
This service area is expected to be on budget.

4.16 Podiatry - projected outturn breakeven
This service area is expected to be on budget.

4.17 Orthotics - projected outturn breakeven
This service area is expected to be on budget.

4.18 Physiotherapy - projected outturn breakeven
This service area is expected to be on budget.

4.19 Occupational Therapy - projected outturn underspend £29k (1.8%)
There are no significant variances in this area.

4.20 Health Improvement - projected outturn breakeven
This service area is expected to be on budget.

4.21 Unscheduled Care - projected outturn overspend (£249k) (7.8%)
Ward 3 overspend on pay costs due to fixed term contracts which were only budgeted for in 2015/16 running into 2016/17 due to delays in recruitment. Bank costs being incurred as these posts come to an end (£111k).

Cost pressures in Accident & Emergency (£40k) and in Ronas Ward (£11k) due to sickness cover.

Overspend of (£87k) in relation to locums required to cover a part year vacancy for a consultant in general medicine and to cover junior doctor rotas.

4.22 Renal - projected outturn breakeven
This service area is expected to be on budget.

4.23 Scottish Government Additionality Funding - projected outturn underspend £43k, (8.4%)
The proposed use of the Additionality funding is set out in Appendix 4 and was approved by the IJB on 28th June 2016.

The recruitment for the two posts required for the Re-ablement Programme to Support Care Homes has only begun in August 2016. Therefore it is likely this £86k budget will underspend by £43k. The IJB is permitted to carry reserves so this ring fenced underspend will be carried forward into 2017/18.

4.24 Integrated Care Funding - projected outturn breakeven

The plan for use of the Integrated Care Fund this year was developed alongside the development of the Joint Strategic (Commissioning) Plan for 2016-19. The proposed spend is shown in Appendix 3.

Shetland's Joint Strategic (Commissioning) Plan 2016-19 is Shetland's plan for how services for all adults including older people will meet the outcomes of the 9 National Health and Wellbeing Outcomes. The Integrated Care Fund Plan is also aligned to meeting those outcomes.

Shetland's share of the £100m national resource for the Integrated Care Fund amounts to £0.410m for 2016/17, and this allocation is based on the national allocation formula for the distribution of funding to health boards (the funding comes through NHS Shetland).

Integrated Care Fund expenditure will accelerate later in the year. Any slippage on spend will be reported to the IJB, and would carry forward to 2017/18 with a clear plan on expenditure for that year.

For 2016/17, working closely with Acute and Specialist Services, the proposed spend of the Integrated Care Fund is to continue building the capabilities to shift the balance of care further to community settings. Supporting people to maintain and enhance independence is key to enhancing people's lives, whilst maintaining service provision for those that most need it in the face of diminishing resources.

4.25 Efficiency Target - projected outturn overspend (£1.011m) (59.2%)

The efficiency target represents the NHS unidentified savings gap which existed when the 2016/17 budgets were agreed. Since then a recovery plan has been developed and was presented to the IJB on 28th June 2016. The recovery plan is shown in Appendix 5, covering current projects only and current projections indicate that £698k will be achieved recurrently in year. Non recurrent plans will allow the gap to be reduced to the outturn forecast. This represents £497k achieved in directly managed services and a notional 26% of the set aside projection of £773k.

This still leaves a year-end shortfall of £1.011m which will have to be underwritten by the Health Board. NHS Shetland has a statutory duty to break even each year and has plans in place to achieve this position in 2016/17. The shortfall will however be carried forward and will be added to the new 2017/18 efficiency target for the IJB. The 2017/18 budget and associated efficiency target will be determined as we work through the budget setting cycle from July 2016 to February 2017.

5. Overall Year-end Projection

5.1 Current projected outturn to the end of March 2017 for the IJB is an overall adverse variance of £1,255k which represents an under spend in the SIC arm of the budget of £376k and an over spend in NHSS arm of £1,631k. However, the SIC under spend will be returned to the council leaving the IJB with the NHSS over spend of £1,631k. NHSS overall recovery plan for 2016/17 will then underwrite the shortfall in IJB funding to result in a break even position for the IJB.

6. Conclusions

6.1 The projected outturn position is an adverse variance of £1,255k for the IJB as a whole. This position highlights the financial challenge we are facing over the next few years and beyond. It is crucial that services are redesigned in a manner that continues to deliver quality health care but at lower cost. As the Strategic Commissioning Plan, and associated budgets, is revised for 2017/18 the IJB must play a key role in redesigning the future of health and social care in Shetland.

6.2 This report is based on assumptions at the end of the first quarter of 2016/17. There are many internal and external factors which may affect these assumptions but as we progress through the year the accuracy of our forecasts will improve as more actual expenditure data becomes available.

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18 August 2016

Appendices:

Appendix 1 Consolidated Financial Monitoring Report – Year-end outturn forecast
Appendix 2 Annual Budget by Organisation
Appendix 3 2016/17 Integrated Care Fund
Appendix 4 2016/17 Scottish Government Additionality Funding
Appendix 5 2016/17 IJB Recovery Plan

Appendix 1

Consolidated Financial Monitoring Report
Year-end outturn forecast

Service	**2016/17 Revised Annual Budget £000s**	**Projected Outturn at Quarter 1 £000s**	**Budget v Proj. Outturn Variance (Adv)/ Pos £000s**
Mental Health	2,412	2,475	(63)
Substance Misuse	661	661	0
Oral Health	3,167	3,250	(83)
Pharmacy & Prescribing	6,219	6,219	0
Primary Care	4,570	4,765	(195)
Community Nursing	2,330	2,330	0
Directorate	615	611	4
Pensioners	78	78	0
Sexual Health	38	38	0
Adult Services	5,202	5,061	141
Adult Social Work	1,747	2,209	(462)
Community Care Resources	10,176	9,596	580
Criminal Justice	29	18	11
Speech & Language Therapy	83	83	0
Dietetics	112	112	0
Podiatry	216	216	0
Orthotics	143	143	0
Physiotherapy	595	595	0
Occupational Therapy	1,593	1,564	29
Health Improvement	252	252	0
Unscheduled Care	3,210	3,459	(249)
Renal	144	144	0
Scottish Gov Additionality	512	469	43
Integrated Care Funding	410	410	0
Efficiency Target	(1,709)	698	(1,011)
Total	**42,806**	**45,456**	**(1,255)**

Appendix 2

Annual Budget by Organisation

Service	NHS £000	SIC £000s	Set Aside	Total
Mental Health	1,354	1,058	0	2,412
Substance Misuse	402	259	0	661
Oral Health	3,167	0	0	3,167
Pharmacy & Prescribing	5,750	0	468	6,219
Primary Care	4,570	0	0	4,570
Community Nursing	2,330	0	0	2,330
Directorate	94	521	0	615
Pensioners	0	78	0	78
Sexual Health	0	0	38	38
Adult Services	59	5,143	0	5,202
Adult Social Work	0	1,747	0	1,747
Community Care Resources	0	10,176	0	10,176
Criminal Justice	0	29	0	29
Speech & Language Therapy	83	0	0	83
Dietetics	112	0	0	112
Podiatry	216	0	0	216
Orthotics	143	0	0	143
Physiotherapy	595	0	0	595
Occupational Therapy	185	1,408	0	1,593
Health Improvement	0	0	252	252
Unscheduled Care	0	0	3,210	3,210
Renal	0	0	144	144
Scottish Gov Additionality	0	512	0	512
Integrated Care Funding	410	0	0	410
Efficiency Target	(1,289)	0	(420)	(1,709)
Total	**18,182**	**20,931**	**3,692**	**42,806**

Appendix 3

2016/17 Integrated Care Fund

Product	2016/17 Integrated Care Fund Allocation	Comments	Detail	Aligning to National Health and Wellbeing Outcomes
Proactive Care and Support				
- Intermediate Care Service	443,247	Estimated cost for a full year = £476,970; slippage on recruitment so have part funded.	Staffing costs 13.18FTE : includes 1FTE Team Leader; 7FTE Healthcare Support Workers; 2.67FTE Physiotherapist; 1.11FTE Occupational Therapist; 1.4FTE Patient Flow and 5% recharge for Management costs. Operational costs include training, transport, recruitment and running costs for reablement property.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonbale practicable, independantly and at home or in a homely setting in their community.
- Medical input and clinical expertise to support community initiatives including Intermediate Care and Anticipatory Care Planning.	30,000	Will fund consultant time that focuses on community activities.	Funds consultant programmed activities= time.	
- Identifying unmet need for long-term neurological conditions using a neurophysiotherapist to work with primary care and voluntary sector.	16,906	1 year appointment started in Aug'15. Balance of funding carried into 2016/17 to meet the 1 year contract.	1FTE Physio for 4.5 months - remainder of 1 year contract.	People are able to look after and improve their own health and wellbeing and live in good health for longer.
	490,153			
Preventative and Anticipatory Care				
- Accelerated rate of anticipatory care plan development across primary care, housing and social care.	15,627	Balance of funding from 2015/16 carried forward into 2016/17 for ongoing ACP development	Funds backfill for focusing on ACP developments.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonbale practicable, independantly and at home or in a homely setting in their community.
- Provision of hearing impairment training to community staff so they can better support clients.	16,000	Provision of hearing impairment training and support to community care staff.	Increase of 0.4FTE in Audiology Support Assistant hours to full time for 12 months and additional resources to provide training.	Public services contribute to reducing health inequalities.
	31,627			
Supportive Enablers				
- Third sector provided Independent Living Support at Home across seven localities to provide ongoing reablement and social engagement.	30,000	Require balance of 2015/16 contract funding £12,408 to be carried into 2016/17 to cover remainder of 1 yr contract. 2016/17 allocation to cover to end of financial year.	12 months at current RVS contract price = £29,778.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonbale practicable, independantly and at home or in a homely setting in their community.
- Contingency to fund priorities that emerge from Strategic Planning process.	30,000	Funding that IJB can direct to particular area/s	Uncommitted resource that can be directed by the IJB to a particular area where there is need identified.	Resources are used effectively and efficiently.
	60,000			
TOTAL : Integrated Care Fund 2016/17 Planned Spend	**581,780**			
Less Total Integrated Care Fund Allocation for 2016/17	**581,780**			
Balance of 2016/17 Funding Remaining	**0**			

Note:
2015/16 Integrated Care Fund = £410,000 - balance of £171,780 to be carried forward into 2016'17
2016/17 Integrated Care Fund = £410,000
TOTAL 2016/17 Allocation = £581,780

Appendix 4

2016/17 Additionality Funding Held by IJB for Adult Social Care

Proposed Draw on Additionality Funding	2016/17	Comments	Detail	Aligning to National Health and Wellbeing Outcomes
Social Work - hospital discharge liaison	78,330	Specifically to focus expediting timely hospital patient discharges, co-ordinating all agencies to ensure that rehabilitation is prioritised.	1FTE Social Worker at K2 plus mileage/phone allowance; 1FTE Admin at G2.	People, including those with disablities or long term conditions or who are frail are able to live, as far as reasonable practicable, independantly and at home or in a homely setting in their community.
Reablement Programme Support to Care Centres	86,100	To focus primarily on Montfield Support Services and develop the rehabilitation model further.	1FTE Physio at Band 6; 1FTE OT at Band 6 plus recruitment and mileage costs.	
Self-Directed Support Packages	347,570	Increase in uptake of Option 1 of Self Directed Support (full estimated cost at 31/05/16 is £354,485).	Costing based on current self-directed support packages at 31/05/16 for the remainder of 2016/17; takes into account increased hourly direct payment rates approved by Council for 2016/17. Increase in uptake of packages - October 2015 = 30 packages. June 2016= 37 packages.	Public services, particularly Health and Social Care services, are centered on helping to maintain or improve the quality of life of people who use them.
TOTAL : 2016/17 Additionality Funding Proposals Received	**512,000**			
2016/17 Additionality Funding	**512,000**			
Balance Remaining	**0**			

Note:

2016/17 Scottish Government announced additional £250M for Adult Social Care Outcomes - indicative allocation for NHS Shetland was £1.024M.
Following Scottish Government guidelines for use of this funding - £512,000 was allocated to support the cost of current service delivery with the remaining £512,000 held by the IJB for the delivery of additional Adult Social Care services and outcomes in order to address the rising demand for services from an ageing population.

Recovery Plan

Appendix 5

DIRECTLY MANAGED SERVICES

Community Health & Social Care

Project	Estimated Full Year Effect £	Achievable in 2016/17	By When	Detail	Risks
Primary Care Management Costs	25,000	12,500	Aug-16	Review of health centre management. Opportunity to incorporate clinical leadership into the management model. Reallocation of roles and responsibilities has potential efficiency saving.	Reduction in capacity. Arrangement will need careful monitoring to ensure effiacacy.
Lerwick Health Centre costs	75,000	37,500	Aug-17	The ANP model is now in place. Patient list number has fallen. Activity and capacity being reviewed with potential for efficiency. Focus on promoting self-management to support demand management. Dedicated Pharmacist time supporting the practice.	Demand for service continues at current rate, or increases. Continued confidence in ANP model.
OOH Vehicle configuration	10,000	9,000	Apr-16	2nd out of hours vehicle in place to reduce need for moving single asset to next on call clinician.	2nd vehicle in place and efficiency being generated.
Community Nursing capacity to match demand	240,000	63,000	Mar-17	Full review of capacity and demand across Shetland of the Community Nursing Service. Will include options for extending out of hours provision and advanced practice. Support to communities to build capacity through initiatives including First Responder scheme promoted by Scottish Ambulance Service.	Communities not engaging with plans for future service delivery.
Pharmacy Challenge	200,000	200,000	Mar-17	Prescribing initiatives commenced. Pharmacists supporting practices with efficient prescribing. Number of work streams initiated. Local benchmarking programme in place.	Prescribing costs continue to increase, and above national trends. Pharmacists unable to engage clinicians in programmes.
Primary Care Redesign	200,000	30,000	Mar-17	Implementation of Primary Care Strategy. Options need to be developed to create resilience and sustainability. Project support for primary care being sought.	Unable to engage local clinicians. Communities not engaging with plans for future service delivery.
Off Island Mental Health Activity	44,630	44,630	Apr-16	More responsive local service that results in less people having to go off-island for in-patient mental health provision. Local service developing out of hours crises response.	Local service's ability to meet complex needs. Ability to respond out of hours to acute presentations.
Non recurrent savings	100,000	100,000	Mar-17	Seeking all opportunities to create efficiency, through pay and non pay budgets. Continuing to seek opportunities for redesign of services, through national benchmarking and work-streams.	Prolonged vacancy factor could affect capacity of services. Reducing non pay expenditure may build pressure for future years.
TOTAL	**894,630**	**496,630**			

ACUTE & SPECIALIST SERVICES

Acute & Specialist Services

Projects	Estimated Full Year Effect £	Achievable in 2016/17	By When	Detail	Risks
Acute services redesign	475,000	203,000	Mar-17	Match hospital capacity to demand for bed base. Incorporate factors including shifting balance of care; reduced delayed discharges and shortening lengths of stay.	Ability of community services to build capacity. Maintaining low rates of delayed discharges.
Increasing the use of telehealth and redesigning patient pathways	250,000	250,000	Mar-17	Repatriation of services to Shetland, resulting in less spend on off island activity and less spend on patient travel.	Ability to engage NHS Grampian in shifting care to Shetland. Confidence of clinicians to utilise and increase technology enabled care provision.
Hospital management team restructuring	20,000	20,000	Mar-17	Redesigning job roles and aligning capacity to service need.	Ability to recruit to posts.
Non recurrent savings	300,000	300,000	Mar-17	Seeking all opportunities to create efficiency, through pay and non pay budgets.	Prolonged vacancy factor could affect capacity of services. Reducing non pay expenditure may build pressure for future years.
TOTAL	**1,045,000**	**773,000**			

26% of acute budget assigned to IJB Set Aside

Agenda Item

5

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	IJB Business Programme 2016/17
Reference Number:	CC-59-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

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

	around the challenges for officers meeting the timescales required, and any part of the Business Programme slipping and causing reputational damage to the IJB, the Council or the NHS. Equally, not applying the Business Programme would result in decision making being unplanned and haphazard and aligning the IJB's Business Programme with the objectives and actions contained in its Strategic Plans could mitigate against those risks.
Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB assumed responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting on 24 November 2015. Maintaining a Business Programme will ensure the effectiveness of the IJB's reporting framework, and its planning and performance management, by monitoring and reviewing the achievement of key outcomes and objectives as set out in its Strategic Plans, . The IJB has the authority to approve the IJB Business programme 2016/17 as set out in this report.
Previously considered by:	The Business Programme for 2016/17 was considered by the IJB at its meeting on 8 June 2016.

END

Agenda Item

5

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	7 September 2016
Report Title:	IJB Business Programme 2016/17
Reference Number:	CC-59-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

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

2. Background

2.1 The purpose of this report is to inform the IJB of the planned business to be presented to the IJB for the remainder of 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.

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18 August 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 Thursday, 01 September 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 (CC47) • Oral Health Strategy (CC48) • Strategic Commissioning Plan 2016-19 (CC41) • Budget 2016/17(in light of LDP submitted 31 May and NHS Board approving 21 June) (CC46) • Recovery Plan 2016/17 (CC42) • Integrated Care Fund 2016/17 and Additional Funding 2016/17 (CC43) • SADP – Revised Terms of Reference • Choosing a Care Home Policy (CC44) • Draft Hospital Based Complex Clinical Care Policy (CC45)
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 (CC56) • Q1 Financial Accounts (CC57) • Primary Care Strategy Action Plan (CC54) • Effective Prescribing in Shetland (CC60) • 2016/17 Business Programme (CC59)
	Monday 26 September 2016 at 3 p.m.	This date moved because of the Chair and Vice Chair being unavailable on 23 September 2016. • Final 2015/16 Accounts • Performance Report Q1 • Risk Registers – IJB and Directorate • Health & Social Care Survey • Shifting the Balance of Care • APC Constitution • 2017/18 Budget Setting • Joint Strategic Commissioning Plan Refresh Process
Quarter 3 -	Wednesday 23	• Winter Plan

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 Thursday, 01 September 2016

1 October to 31 December 2016	November at 2 p.m.	• Public Health Annual Report • Q2 Financial Accounts • Directorate Plan 2017-18 • Workforce & Organisational Policy • Shetland Autism Strategy Action Plan • Families Affected By • Carers Strategy • 2016/17 Business Programme
	Friday 9 December 2016 at 2 p.m.	• Budget 2017/18
Quarter 4 1 January 2017 to 31 March 2017	Wednesday 25 January 2017 at 2 p.m.	• Delays in Discharge from Hospital to Community Setting • Audit Scotland Care Inspectorate Reports • 2016/17 Business Programme
	Wednesday 15 March 2017 at 2 p.m.	• Q3 Financial Accounts • Update EGRC

Planned business still to be scheduled - as at Thursday, 01 September 2016
None
END OF BUSINESS PROGRAMME as at Thursday, 01 September 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 (CC40)
Quarter 2 – 1 July 2016 to 30 September 2016	Friday 26 August 2016 at 10 a.m.	• Care Inspectorate and Healthcare Improvement Scotland Joint Inspection of health and social work services for older people in Shetland • External Audit Reports - Care Inspectorate • Effective Prescribing in Shetland
	Monday 26 September 2016 at 2 p.m..	This date moved to align with IJB Committee • Final 2015/16 Accounts • Internal Audit Review
Quarter 3 -	Friday 11 November	

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 Thursday, 01 September 2016

1 October to 31 December 2016	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 Thursday, 01 September 2016

None

END OF BUSINESS PROGRAMME as at Thursday, 01 September 2016