Agenda Item

1

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Performance Overview - *Cover*
Reference Number:	CC-61-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

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

High Level Summary:

This report summarises the activity and performance within the functions delegated to the IJB. Key Performance Indicators for the set aside services will continue to be included through this year's reporting cycle.

Corporate Priorities and Joint Working:

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

Key Issues:

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

Key areas for the IJB to note are:

(1) Psychological Therapies – a Consultant Clinical Psychologist has been appointed and will commence employment in November 2016 which will help address the longest waits.
(2) Appendix D (page 11) shows that for the National Core Indicator E15 (proportion of last 6 months of life spent at home or in community setting) that Shetland is the best performing health and social care partnership in Scotland.
(3) Admission rates to Psychiatric Hospitals has increased over the last quarter. The

Risk Register for both the Directorate and IJB has been updated to reflect the absence of key staff in the Mental Health service.

(4) In Appendix B (page 3) a reduction in overtime hours has been managed by part-time and relief staff being utilised to cover additional hours.

(5) Appendix E Complaints show the number received from the health part of the directorate. For social care more robust recording of complaints is being addressed and future reports will show a more balanced view.

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

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In

	exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. The IJB is responsible for the operational oversight of service delivery of its delegated functions and through the Chief Officer will be responsible for the operational management of integrated services.
Previously 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:	26 September 2016
Report Title:	Performance Overview
Reference Number:	CC-61-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

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

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

2. Background

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

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

2.3 In Appendix C the Local Delivery Plan is the suite of indicators generated by NHSS that are relevant to the IJB.

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

2.6 In Appendix E the IJB can see complaints recorded to date. When there is a complaint which relates to a situation where the actions of both the NHS and the Council are involved, there is an agreed joint process for the investigation stage. Thereafter the Council is obliged to deal with complaints about its services in terms of the statutory social work complaints procedure. The appendix highlights health complaints. A project was undertaken to ensure that social care complaints received are recorded on the designated system and this is being progressed.

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

3. Conclusions

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

Contact Details:

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

16 May 2016

Appendices
Appendix A – Projects and Actions – Community Health & Social Care Services
Appendix B – Corporate Indicators
Appendix C – Local Delivery Plan
Appendix D – National Health & Wellbeing Performance Indicators - Quarterly
Appendix E – Complaints

Background documents
Community Health & Social Care Directorate Plan

Appendix A - Projects and Actions - Integrated Joint Board

Report Type: Actions Report

Generated on: 14 September 2016

Report Layout: IJB Simple Actions

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP017b Implement findings outlined within Mental Health review	Implement findings outlined within Mental Health review (2014)	Number of actions progressing. Updated Action Plan being taken to the IJB in October 2016	Planned Start	06-Jan-2015		A number of actions in progress but needing completion. Refreshed action plan drafted. Additional expertise brought in to accelerate completion of strands of work.	Community Health & Social Care Directorate
			Actual Start	06-Jan-2014	71%		
			Original Due Date	31-Mar-2015	Expected Success		
			Due Date	30-Sep-2016			
			Completed Date		Experiencing issues, risk of failure to meet target		

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP024 Develop Integrated Locality Service Plans	Develop Integrated Locality Service Plans	People are able to look after and improve their own health and wellbeing and live in good health for longer	Planned Start	07-Nov-2014		2016/17 Strategic Plan approved. Work for 2017/18 will continue to develop locality service plans.	Community Health & Social Care Directorate
			Actual Start	02-Nov-2015	50%		
			Original Due Date	31-Mar-2015	Expected Success		
			Due Date	31-Dec-2016			
			Completed Date		Likely to meet or exceed target		

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP025 Assist Shetland Partnership with implementing the redesign of community justice.	Assist Shetland Partnership with implementing the redesign of community justice.	Offenders within Shetland have the best opportunities to make positive changes to their lives and reduce the likelihood of reoffending.	Planned Start	07-Nov-2015		Transition phase is progressing well and we are on target to reach the deadlines for 2016.	Community Health & Social Care Directorate
			Actual Start	12-Nov-2015	80%		
			Original Due Date	31-Mar-2015	Expected Success		
			Due Date	31-Dec-2016			
			Completed Date		Likely to meet or exceed target		

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP026 Develop a joint Organisational Development and Workforce Strategy	Develop a joint Organisational Development and Workforce Development Strategy	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Planned Start	01-Apr-2015		Joint Strategy currently in draft form will be presented to the next Joint Staff Forum on 27 September 2016 with a view to presenting to the IJB in November 2016.	Community Health & Social Care Directorate
			Actual Start	11-Nov-2015	70%		
			Original Due Date	31-Mar-2016	Expected Success		
			Due Date	30-Sep-2016			
			Completed Date		Experiencing issues, risk of failure to meet target		

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP027 Development of Oral Health Strategy	Deveopment of Oral Health Strategy	People are able to look after and improve their own health and wellbeing and live in good health for longer	Planned Start	01-Apr-2015		Draft Strategy being consulted on by professional groups	Community Health & Social Care Directorate; Oral Health
			Actual Start	01-Jul-2015	80%		
			Original Due Date	31-Mar-2016	Expected Success		
			Due Date	30-Sep-2016			
			Completed Date				

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP031 Develop Anticipatory Care plans	Develop Anticipatory Care plans within localities that include all of the available assets	People using health and social care services are safe from harm	Planned Start	01-Apr-2015		Being monitored more frequently. Renewed focus with Chief Nurse (Community) leading project within Integrated Care Fund.	Community Health & Social Care Directorate
			Actual Start	12-Nov-2015	70%		
			Original Due Date	31-Mar-2016	Expected Success		
			Due Date	30-Dec-2016			
			Completed Date		Experiencing issues, risk of failure to meet target		

Appendix B - Council-wide Indicators - Community Health and Social Care compared with Whole Council

Shetland Islands Council

Generated on: 14 September 2016 15:48

Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	
	Value	Value	Value	Value	Value	Value	Value	
OPI-4A Staff Numbers (FTE) - Whole Council	2248	2191	2168	2143	2164	2168	2186	Managers continue to carefully manage staff numbers and associated costs and reflects recruitment pressures in some areas.
OPI-4A-E Staff Numbers (FTE) - Community Health & Social Care Directorate	530	517	493	481	494	493	494	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4A-E+NHS Staff Numbers (FTE) - Community Health & Social Care Directorate inc. NHS			676		682	676	681	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4C Sick %age - Whole Council	3.6%	4.2%	3.7%	3.2%	3.5%	4.0%	2.6%	A reduction from previous year reflects a greater focus in maximising attendance.
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.0%	6.0%	5.7%	5.4%	5.4%	5.7%	4.1%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.
OPI-4E Overtime Hours - Whole Council	56,552	64,738	79,071	16,270	21,383	17,404	16,403	Overtime and Overtime budgets are devolved to departmental level. Overtime is often the most cost effective way to utilise existing teams and ensure prompt service to our customers.
OPI-4E-E Overtime Hours - Community Health & Social Care Directorate	1,856	5,675	7,546	2,201	2,644	1,218	246	Q1 reduction due to part time/relief staff working additional hours rather than overtime being paid
E01 FOISA responded to within 20 day limit - Health & Social Care Services	79%	91%	93.5%	93%	85%	96%	92%	Continue to strive to meet target.

Appendix B (cont) - Sickness Absences - Community Health & Social Care Services

Shetland Islands Council

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

Generated on: 14 September 2016 15:48

	Previous Years			Last year Quarter 1	This year Quarter 1	
Code & Short Name	2012/13	2013/14	2014/15	Q1 2015/16	Q1 2016/17	(past) Performance & (future) Improvement Statements
	Value	Value	Value	Value	Value	
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	6.3%	4.1%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.

Appendix B (cont) - Sickness Absences - All Directorates (for comparison)

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

	Previous Years			Last year	This year
Short Name	2012/13	2013/14	2014/15	Q1 2015/16	Q1 2016/17
	Value	Value	Value	Value	Value
Sick %age - Whole Council	4.1%	3.6%	4.2%	4.1%	2.6%
Sick %age - Chief Executive's "Directorate"	3.6%	1.4%	2.4%	1.9%	0.5%
Sick %age - Children's Services Directorate	2.8%	2.8%	3.7%	3.1%	2.3%
Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	6.3%	4.1%
Sick %age - Corporate Services Directorate	3.0%	1.6%	2.4%	2.0%	0.8%
Sick %age - Development Directorate	3.7%	2.7%	4.2%	4.0%	2.2%
Sick %age - Infrastructure Directorate	4.0%	3.4%	4.0%	4.3%	2.5%

Appendix C - Directorate Performance Report – Local Delivery Plan

Shetland Islands Council

Generated on: 14 September 2016

Local Delivery Plan

Code & Short Name	Years				Quarters				(past) Performance & (future) Improvement Statements
	2014/15		2015/16		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Target	Value	Value	Value	Target	
LDP001 People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support	67.5%	50%	44.75%	50%	43.6%	45.3%	45.3%	50%	Note: this is an interim measure showing the percentage of people with newly diagnosed dementia who take up the offer of post diagnostic support (ie have an active link worker) as national data is not yet available. Due Oct 2016.
LDP002 18 weeks referral to treatment for Psychological Therapies	57.7%	90%	90.3%	90%	85.6%	94.4%	75.7%	90%	The cCBT service introduced in September 2014 continues to have a positive impact on COMPLETED wait reporting. NB this positive results masks the long ONGOING waits for those needing face-to-face therapy. See LDP002a
LDP003a Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery			91.5%	90%	100%	90%	75%	90%	Client missed target due to staff availability.
LDP003d Clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery	100%	90%	94%	90%	83%	100%	100%	90%	ISD have been contacted as it appears that DNAs have not been captured by the system.
LDP004 Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	763	420	976	657	295	360	41	63	We remain behind trajectory on this target. Health Improvement delivered the vast majority of ABIs on behalf of primary care, and staff reductions means smaller capacity. The actual number of ABIs recorded as being delivered in Primary Care remains low. Maternity are moving over to electronic system which will make data extraction much easier, and links are being developed with Community Pharmacy to capture the contribution that they make.
LDP005 48 hour access or advance booking to an appropriate member of the GP team	73.2%	90%	76.4%	90%	Not measured for Quarters		Not measured for Quarters	Not measured for Quarters	Practices run a mix of advanced booking, triage and on the day appointments through walk in clinics. Advance booking relates to the opportunity to have an appointment with a member of the clinical team, not a named GP. The largest practice currently has GP vacancies which is impacting on access, with several other practices also having vacancies. National data only produced every 2 years – next publication due in May 2018.
LDP006 4 hours from arrival to admission, discharge or transfer for A&E treatment			95.8%	98%	94.7%	96.6%	94.7%	98%	582 presentations out of 627 left A&E Department within four hours

Appendix D - Directorate Performance Report – Outcomes 1-9 - Quarterly Measures

Shetland Islands Council

Generated on: 14 September 2016

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

	Years		Quarters					
Code & Short Name	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Value	Value	Value	Target	
ASW003 Percentage of outcomes for individuals are met	Not measured for Years							The new system for gathering this has been delayed until the start of April 2016 in order for training of all staff to be completed.
PC002 Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre			100%	100%	100%	100%	100%	Monthly data return from practices shows 100% compliance for those patients who need to speak to a healthcare professional on the day
PC004 Percentage access to a Primary Care health professional for an appointment within 48 hours at any Shetland Health Centre			100%	100%	100%	100%	100%	Monthly data return from practices shows 100% compliance for those patients who request an appointment within 48 hours

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

	Years		Quarters					
Code & Short Name	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Value	Value	Value	Target	
CCR003 Percentage of people 65 and over receiving intensive care package (over 10 hours per week) in their own home rather than a care setting.	41%		41%	41%	46%	47%	30%	We are continuing to promote reablement programmes and personalised support to enable people to remain at home.
CCR007 Number of 65 and over receiving Personal Care at Home.	214	200	215	190	199	195	200	Personal care is offered to individuals with assessed need when they have no alternative suport systems in place. We are working closely with the Intermediate Care Team to reduce the need for personal care.
CN002 Number of early supported discharges with no readmission in 30 days by Intermediate Care Team		100%	100%	100%	94%	100%	100%	16 Intermediate care patients - 14 Early Supported Discharge, 2 Admission avoidance.
MH002 Admission rates to Psychiatric Hospitals			3	5	3	6	6	This will help us consider the effectiveness of our local service provision. Increase in number due to unavailability of Consultant Psychiatrist

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
MH003 People with a diagnosis of dementia on the QOF dementia register			179	179	170	169	184	More people on the dementia register are dying or moving away than are being diagnosed. Plan in development to provide diagnostic training/awareness for relevant staff (e.g. GPs). Work continues to encourage people to seek earlier assessment and diagnosis. We are also intending to audit all people discharged from hospital with dementia indicated in the discharge summary to ensure that they are on the register so that no potential new diagnoses are missed.
AHP006 Increased number of people receiving home monitoring for health and social care (technology enabled care)			659	658	657	670	599	Latest national performance figures (2012/13) show Shetland ranked in top quartile of local authorities in Scotland for its telecare usage by care at home clients (Source- Draft Joint Inspection of Adult Services 2014/15).

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
CJ002 Percentage of offenders (supervision) seen within 5 working days of the order being made			84.5%	100%	100%	100%	100%	Target being met.
ASW001 Percentage of assessments completed on time			100%	100%	100%	100%	100%	Each instance of missed target analysed by line manager
ASW002 Percentage of reviews completed on time			96.9%	89%	95.6%	91%	100%	The data provided is a measure of 6 monthly reviews. Those that didn't meet this target were due to either a service user, family member or professional not being available on the date set. The reviews were held as soon after the original date as possible. In no case did we exceed the statutory minimum of holding a review within 12 months.

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
DS004 Number of people who are waiting to register with Public Dental Service (PDS) for ongoing Care			973	930	635	753	500	Source: Local data. Despite waiting, all these people are able to access NHS dental care elsewhere.

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
CN001 Number of Anticipatory Care Plans in Place			757	837	831	917	700	Data shows 27 new entries in February but overall reduction in total eKIS numbers reflects more deaths than new summaries put in place

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
AS003 Number of incidents of emergency respite provided for adults with Learning Disability/Autistic Spectrum Disorder			0	0	0	0	0	An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays. Source: Newcraigielea The risk of unscheduled care will be reduced.

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
CCR001 Delayed discharge from Hospital - no delays exceeding 14 days			3	2	2	0	2	Intense work with acute services to work out delays in systems and processes
CJ001 Percentage of court reports submitted on time			100%	100%	100%	100%	100%	Service consistently meets target
CJ004 Risk and need assessment completed and case management plans in place within 20 days			100%	100%	100%	100%	100%	Service consistently meets target
PPS002 Percentage rate of antibiotic prescribing in relation to Scottish average			113.3%	99.05%	114%	98.8%	100%	In general we are expecting less antibiotics to be prescribed in Shetland than in the Scottish population
PPS003 Number of polypharmacy reviews completed			22	19	22	58	30	Polypharmacy reviews bring about better outcomes for patients and often significantly reduce costs
PPS004 Number of discharge prescriptions dispensed out of hours by nursing staff	114	98	82	166	112	47	48	Good discharge planning should reduce the need for nurses to dispense medicines out of hours. Dispensing by pharmacy always more appropriate
CN003 Percentage of Catheter Associated Infections in individuals with an indwelling urinary catheter			0%	0%	0%	0%	0%	No catheter associated infections in the last audit. As this is the 3rd audit in a row to show no infections, we have now moved to 6 monthly audit with the next scheduled audit due in November 2016.

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q1 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
DS002 The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland	3,013		2,230	2,032	1,703	2,167	1,670	Sources: Local wte data and ONS population data. The greater the wte of dentists, the greater the available capacity for the resident population to receive NHS dental care. (Scotland ratio 1:1670)
AHP001 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count)			6	20	7	6	10	To achieve the nationally agreed referral to assessment timescales we have initiated a number of initiatives including streamlining our referrals and screening processes, reviewing all processes, and reconfiguring the team into a north and a south team to gain staff efficiency
AHP002 Percentage Waiting Time from Referral to Treatment for Orthotics Services (18 weeks)			98.1%	98.1%	100%	100%	90%	Each instance of missed target is analysed by line manager.
AHP003 Percentage Waiting Time from Referral to Treatment for Physiotherapy Services (18 weeks)		90%	97.7%	97%	99.1%	99.2%	90%	Service consistently meets target. Significant pressures due to long term sickness absence, and increased number of referrals.
AHP004 Percentage Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)			99.5%	99.5%	100%	99.2%	90%	Each instance of missed target is analysed by line manager.
CCR005 Occupancy of care homes	88.7%	90%	91%	91.7%	91%	88%	90%	Target now being met. The increased use of respite care will result in lost days during change over periods.
CJ003 Unpaid Work commenced within 7 working days	84.2%	100%	80%	85%	92.3%	63.6%	100%	Target not reached due to some individuals not attending placements due to employment and other reasons.
PPS001 Percentage spend for Shetland on GP Prescribing compared to the national average			109.9%	96%	98%	98.1%	99%	Shetland has traditionally spent less on medicines per patient. The costs per patient are increasing, this highlighting the need to undertake additional prescribing efficiency work

Appendix D (cont) - Directorate Performance Report – Outcomes 1-9 - Annual Measures

Shetland Islands Council

Generated on: 14 September 2016

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

Code & Short Name	Previous Years						This Year		(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2015/16	2016/17	
	Value	Target	Value	Target	Value	Target	Target	Target	
E15 Proportion of last 6 months of life spent at home or in community setting	92.1%	90.8%	92.3%	90.8%					Best performing partnership in Scotland. Managed Clinical Network for Palliative Care established in 2015
DS001 Decay experience of children in P1: Percentage of children with no obvious caries in deciduous teeth (children aged 5-6 years in P1 attending SIC primary schools)	80.9%	75%							Source: NDIP data. Gives prevalence of dental decay in one age group (P1 or P7) of the total child population. Scotland P1 dmft 1.27.

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

Code & Short Name	Previous Years						This Year		(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2015/16	2016/17	
	Value	Target	Value	Target	Value	Target	Target	Target	
ASW004 How satisfied are residents with local social care/ social work services?	81%	80%	85%	80%					Significantly higher than national average (55%)

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

Code & Short Name	Previous Years						This Year		(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2015/16	2016/17	
	Value	Target	Value	Target	Value	Target	Target	Target	
AS002 Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills				35					Adults with learning disability, autistic spectrum disorder and/or complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted.

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

Code & Short Name	Previous Years						This Year		(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2015/16	2016/17	
	Value	Target	Value	Target	Value	Target	Target	Target	

Code & Short Name	Previous Years						This Year		(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2015/16	2016/17	
	Value	Target	Value	Target	Value	Target	Target	Target	
DS003a The percentage of the adult populations who are registered with Shetland dentists for NHS dental care			78.35%		84%				Target is to see a net rise in registration figures. Registration brings with it the responsibility to provide on-going care, for which the PDS alone does not have sufficient capacity. Larger rises are therefore dependent on an independent NHS practice opening alongside the Public Dental Service to increase capacity.
DS003c The percentage of the child populations who are registered with Shetland dentists for NHS dental care			91.85%		94%				Target is to see a net rise in registration figures. Registration brings with it the responsibility to provide on-going care, for which the PDS alone does not have sufficient capacity. Larger rises are therefore dependent on an independent NHS practice opening alongside the Public Dental Service to increase capacity.

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

Code & Short Name	Previous Years						This Year		(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2015/16	2016/17	
	Value	Target	Value	Target	Value	Target	Target	Target	
CJ005 Percentage of individuals showing a decrease in assessed risk and need at end of order			37.5%	75%	65.4%	75%	75%		New risk assessment system in place which will provide more accurate data for 2016/17

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

Code & Short Name	Previous Years						This Year		(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2015/16	2016/17	
	Value	Target	Value	Target	Value	Target	Target	Target	
AS005 Number of Social Care staff trained to implement Positive Behaviour Support.			4			6	6		The target of 6 staff trained in 2015/16 is on amber due to long term absence of the trainer. Training is now underway and will be completed in 2016. The 2016/17 intake will be slightly delayed however is anticipated to be completed within the 2016/17 monitoring period.

Summary of complaints for community services in 2016/17

A summary of formal complaint activity for NHS Shetland from 1 April 2016 to 9 September 2016 is set out below. Further detail, including the actions taken as a result of each formal complaint relating to community health in 2016/17 is provided.

From 1 April 2016 to 9 September 2016 the Board received a total of 32 formal complaints. Complaints and feedback staff have also handled 47 patient feedback contacts. Of the 32 formal complaints received in year to date, 21 relate to the community health and social care directorate and two span both community and acute directorates.

Please note that the summary does not include independent contractor General Practices, who are responsible for their own local resolution of complaints following national guidance. Complaints against other Health Boards or Special Health Boards, e.g. the Scottish Ambulance Service, are also excluded.

2016/17	**Quarter 1**	**Quarter 2 (to date)**	**Quarter 3**	**Quarter 4**	**Total**
	1.4.16 – 30.06.16	**01.07.16 – 09.09.16**	**01.10.16 – 31.12.16**	**01.01.17 – 31.03.17**	
Directorate of Acute and Specialist Services	6	2			8
Directorate of Community Health and Social Care	10	11			21
Acute & Community	1	1			2
Board HQ Services	1	0			1
Other	0	0			0
Withdrawn	0	0			0
Total	**18**	**14**			**32**
Outcome	Upheld: 5 Partly upheld: 8 Not upheld: 5	Upheld: 5 Partly upheld: 3 Not upheld: 0 Open: 6			

Community Health and Social Care Directorate Complaints received 1 April 2016 to 9 September 2016

	Summary	Staff Group(s)	<= 20 wkg days	If not, why	Outcome	Actions
Quarter 1						
1	Poor treatment and no follow up plan	CMHS	N	Slight delay in final sign off	Upheld	• Medical reasoning confirmed as appropriate, however unmet need re psychological therapy support. Future resources explained. • Recommendation of contact with CPN to further support self management
2	Complaint handling	Board HQ/ CMHS	Y		Upheld	• Apology given and explanation of why a previous complaint had not been handled satisfactorily. Commitment given to address this as quickly as possible and assurances sought from service about ability to respond appropriately
3	Delay in receiving prescription medicines	LHC/ Pharmacy	Y		Upheld	• Reasons for delay explained, however the prescription was issued on the day as requested • Process audited to try and determine what had happened to the original prescription
4	Physiotherapy referral	Physio	Y		Not upheld	• Satisfied referral was triaged appropriately
5	Communication and diagnosis	CMHS	N	Unplanned staff absence	Part upheld	• Staff asked to reassure patients their notes had already been reviewed prior to consultation • Staff asked to consider whether patients have access to PCs when proposing particular therapeutic interventions • Apology given for misunderstanding about the reasoning for a question asked
6	Medication concern, communication and diagnosis	CMHS	N	Unplanned staff absence	Part upheld	• Apology given if proposal to review medication for safety purposes had not been fully understood by patient • Communication process already under review and improvements in place

7	GP on call did not visit after advised they would by NHS24	OOH GP	Y		Partly upheld	• Apology offered that GP had spoken with relative rather than patient (which would have been possible had they made a home visit), however at the point the decision was made there was no additional clinical information to warrant a home visit (condition had been assessed the previous day)
8	Poor care and failure to x-ray and diagnose fracture	LHC	Y		Not upheld	• Clinical advice and decision making found to be reasonable over period in question • Treatment would not differ despite the later confirmation of a fracture
9	Change to diagnosis, lack of support available	CMHS	Y		Part upheld	• Department to review process for allocating a temporary CPN during unexpected or extended leave, and for flagging repeat phone calls on different occasions • Clinicians to be clear to service users that they can opt out of copy letters to GPs if and when they choose
10	No dental provision in Yell	Dental	Y		Upheld	• Current situation explained, and apology given that the situation was unlikely to improve in the short term
Quarter 2						
11	Dissatisfaction with diagnosis	CMHT	N	Investigation was revisited following additional information provided	Part upheld	• Diagnosis found to be arrived at through robust process, however part upheld as there was an unmet need for the individual
12	Dissatisfaction with diagnosis and staff attitude	GP	N	Additional details required to be checked at latter stage of investigation	Part upheld	• Diagnosis error understandable but GP reminded to listen to patient and check further back in medical records if needs be • Communication issues considered and some suggestions made about how to improve for future consultations
13	Staff attitude and inconsistency of information	Dental	Y		Upheld	• Information clarified to complainant and staff • Communication issues reviewed with dentist in question • Future treatment plan proposed

14	Actions/attitude towards dying relative	Community nursing	N	Complexity of investigation and delay in speaking with key staff member	Upheld	• Apology given that communication and some care aspects fell short of expectation • Additional training for staff member • Palliative and end of life care refresher training for all community nursing staff by the MacMillan team • SBAR approach implemented for end of life patients where there will be a change in staff cover • A debrief/clinical supervision session to be held following the death of all palliative patients • Written information identified which may prove useful for families
15	Access to GP appointments	LHC	Y		Upheld	• Apology provided and explanation that GP staffing shortages were being experienced both in Shetland and nationally • Explanation provided about six week appointment booking periods • Options identified for onward referral, including telephone consultation • Staffing shortages for reception staff explained – practice manager post now out to advert • Asked if interested in joining a Patient Participation Group for LHC
16	Inflexibility re speaking to GP and staff attitude	LHC	Y		Upheld	• Error with result reporting flagged to NHS Grampian. Situation to be monitored moving forwards • Telephone call options and restrictions explained. Potential to write to people when a call does not prove possible, although this would be a case by case decision • Recommendation to consider whether a standalone system for recording calls would be helpful, both to callers and staff in such situations • Apology given about miscommunication in this case
17	Examination without chaperone, communication	GP	Y		Part upheld	• GP asked to ensure chaperones are present as appropriate • Suggestions made re communication challenges
18	Poor dental service for Northern Isles	Dental	Y		Upheld	• Cuts in dental funding provision explained and apology given • Appointments offered at either Brae or Lerwick to complete required work

19	Discharge without pain relief, lack of dignity in death	Acute and community	N		Open	
20	Poor dental service for Northern Isles	Dental			Open	
21	Allergic reaction to prescribed drug, staff attitude	LHC			Open	
22	Inclusion of inappropriate comment in partner's assessment	CMHS			Open	

Agenda Item

2

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Strategic Commissioning Plan – Process of Update
Reference Number:	CC-66-16
Author / Job Title:	Hazel Sutherland / Head of Planning and Modernisation

Decisions / Action required:

That the Integration Joint Board considers the requirements for undertaking the annual update of the Strategic Commissioning Plan and RESOLVES to approve the process outlined in Appendix 1.

High Level Summary:

The Strategic Commissioning Plan was approved by the IJB on 24 November 2015 with a 3 year timeframe. The Scottish Government Guidance indicates that the Plan should be updated on an annual basis. The Integration Joint Board should set the scene at the start of the refresh process to give direction to the various consultation groups as to any key issues and constraints which need to be considered. The proposal is to align the needs assessment and future service planning process with the budgeting process from the start of the exercise. There then follows a series of consultation and negotiation processes, with the objective of having a draft plan and budget presented to the IJB in December 2016.

Corporate Priorities and Strategic Aims:

The Strategic Commissioning Plan describes how health and care services can be delivered jointly across the services described in the Integration Scheme. This describes how key priorities, as well as day to day operational services, will be delivered.

The Plan is a significant part of public sector delivery in Shetland and supports the Shetland Community Partnership's Local Outcome Improvement Plan, Shetland Islands Council's Corporate Plan, NHS Shetland's 2020 Vision and Local Delivery Plan.

Delivery of the Strategic Commissioning Plan relies on partnership working between Shetland Islands Council, NHS Shetland, other regional and national organisations (such as the Scottish Ambulance Service and NHS Grampian and other specialist Health Boards) and voluntary sector providers.

Key Issues:

It will be extremely challenging to live within the resources allocated in the 3 Year Plan and significant changes to the current models of delivery are expected. The focus of the preparation of the Strategic Commissioning Plan needs to accommodate an accelerating

'modernisation' agenda to improve outcomes (where necessary). The process described in Appendix 1 is an iterative consultative process where clear communication and managed timescales will be key to successfully updating the plan on robust evidence of need with clear priorities for change.

Implications :	
Service Users, Patients and Communities:	The Strategic Commissioning Plan sets out the services to be delivered over the next 3 years. Any significant changes to that plan will be of interest to services users, patients and communities, particularly in respect of accessibility and availability.
Human Resources and Organisational Development:	At this stage, there are no direct impacts on Human Resources and Organisational Development. However, any significant changes to existing service models and methods of delivery may, in time, affect staffing – both in terms of the number of staff and the skills mix required – in order that service costs can be accommodated within the total budget allocation.
Equality, Diversity and Human Rights:	The Plan as a whole is subject to an Integrated Impact Assessment, which will be reported to a future meeting.
Partnership Working	The Integration Joint Board is a strategic partnership which supports the work of the Shetland Partnership. Delivery of the Plan is conditional upon the partnerships working successfully to integrate services around the needs of individuals, carers, their families and communities.
Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 require Boards to produce a strategic commissioning plan and update it annually.
Finance:	There are potentially significant financial implications associated with the update of the Strategic Commissioning Plan. The current plan required to be supported by a Recovery Plan for NHS Shetland. The aim of the update is to prepare a plan which minimises, or ideally eliminates, the need for a Recovery Plan in 2017-18. This may mean that the Plan needs to include details of significant change projects required to operate within the financial limits set. However, having the planning and budgeting process aligned will give confidence to the Board that the services described within the Plan can be delivered for the available funding.
Assets and Property:	At this stage, there are no implications for Assets and Property. However, any significant changes to existing service models and methods of delivery may, in time, affect the overall estate in order that service costs can be accommodated within the total budget allocation.
Environmental:	There are no specific environmental issues arising from this Report.

Risk Management:	There are significant risks associated with the failure to deliver the Strategic Commissioning Plan, which are recorded and reported separately on the Risk Register.

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. Establishing the process of updating the Strategic Commissioning Plan provides clarity and decision points for officers to work within and the IJB has the authority to do so.

Agenda Item

2

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Strategic Commissioning Plan – Process for Annual Update
Reference Number:	CC-66-16
Author / Job Title:	Hazel Sutherland / Head of Planning and Modernisation

1. Introduction

1.1 The purpose of this report is to present the IJB with the outline timetable and process for updating the Strategic Commissioning Plan.

2. Background

2.1 The IJB is responsible for the preparation of the Strategic Commissioning Plan. The Plan is prepared on a 3-Year basis but is required to be updated on an annual basis.

2.2 An extract from the Scottish Government Guidance states:

"Each Integration Authority must produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over the medium term, using the integrated budgets under their control. Stakeholders must be fully engaged in the preparation, publication and review of the strategic commissioning plan, in order to establish a meaningful co-productive approach, to enable Integration Authorities to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration:

- to improve the quality and consistency of services for patients, carers, service users and their families;

- to provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- to ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

Services cannot continue to be planned and delivered in the same way; the current situation is neither desirable in terms of optimising wellbeing, nor financially viable. With the full involvement of all stakeholders and the creation of a single system for strategic commissioning of services, Integration Authorities can now think innovatively about how support services might be provided in the future.

The focus should be less about how it is done now and more about how it should be done in future. This might mean, through a robust option appraisal process, that the Integration Authority makes decisions about disinvesting in current provision of services in order to reinvest in other services and supports that are required to meet on-going and changing demand.

3. Process of Refresh

3.1 The IJB should, at the start of the process, set the direction and constraints within which it wishes the Strategic Commissioning Plan to be updated.

3.2 The process which will be followed is set out in diagrammatical form in Appendix 1.

3.3 Four of the IJB's Committees will be key to generating ideas and critically appraising the process, namely:
- the Strategic Planning Group
- the Joint Staff Forum
- the Care, Clinical and Professional Governance Committee; and
- the Local Partnership Finance Team

3.4 The IJB has a number of supporting policy statements to assist them in their work, including:
- the Communication Plan and
- the Participation and Engagement Strategy.

3.5 Each organisation will also have its own internal processes of consultation and development to help shape the refreshed plan to make sure it is strategic in nature, robust, evidence based and forward focused.

- The idea is that we build an iterative process of developing ideas and themes, within the budgetary constraints of the 3 Year Financial Plan, which draws together into a draft Plan for consideration by December 2016. The Budgetary process will be aligned to this timetable and there is an aspiration to complete the exercise to significantly reduce, or ideally eliminate, the need for a Financial Recovery Plan in 2017-18.

3.7 A presentation has been developed to kick-start the refresh of the needs assessment/gap analysis and forward planning process. The presentation is attached at Appendix 2.

3.8 The IJB will be faced with a scenario that the cost of running the existing service delivery models is higher than the total amount allocated in the 3 Year Financial Plan. The IJB may therefore wish to start considering what prioritisation mechanism it may wish to use when considering changes to the current service delivery models and cost structures.

3.9 A separate paper sets out the key strategic themes and a high level summary of moving towards a sustainable integrated health and care service for Shetland by 2020.

4. Conclusions

4.1 During September, October and November, detailed work will be done to refresh the Strategic Commissioning Plan, with a view to getting a draft update to the IJB meeting on 9 December 2016.

4.6 The Strategic Commissioning Plan updates will be aligned with the budgeting process.

Contact Details:
Hazel Sutherland
Head of Planning and Modernisation, NHS Shetland
Email: hazelsutherland1@nhs.net
6 September 2016

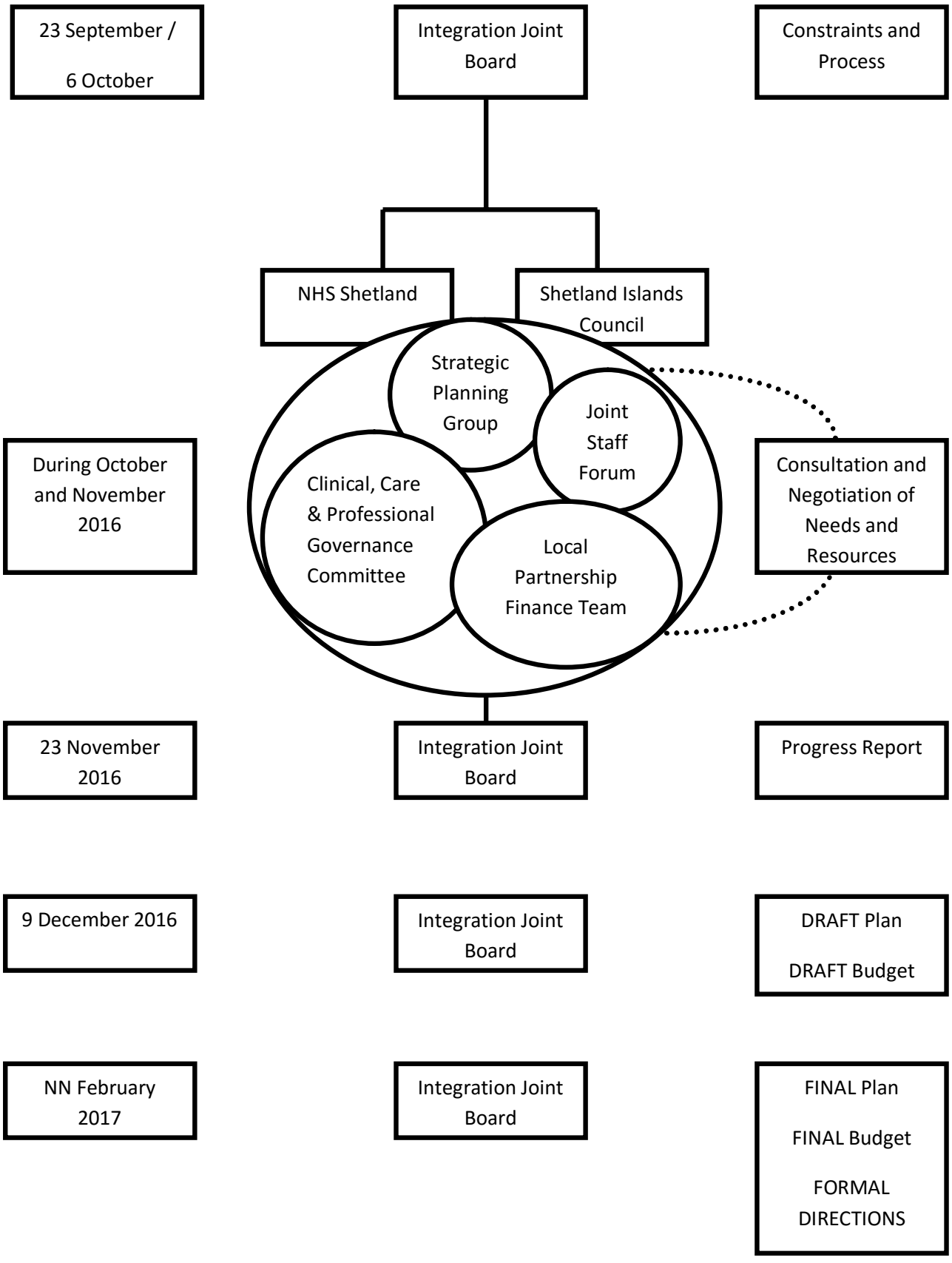
Appendices:
Appendix 1 Diagram of Planning and Budgeting Cycle
Appendix 2 Powerpoint presentation on Refreshing the Strategic Commissioning Plan

Background Documents:

Health and Social Care Integration, Public Bodies (Joint Working) (Scotland) Act 2014, Strategic Commissioning Plans Guidance http://www.gov.scot/Resource/0046/00466819.pdf

Joint Strategic (Commissioning) Plan 2016-19, Version 7 – June 2016
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/Strategicplan2016-19.pdf

Integration Joint Board - Planning and Budgeting Cycle



Integration Joint Board – Strategic Planning Group

Refreshing the Strategic Commissioning Plan

Purpose of Integration

"...We want to ensure that:

- adult health and social care services are firmly integrated around the needs of individuals, their carers and other family members;
- that the providers of those services are held to account jointly and effectively for improved deliver;

Purpose of Integration

- That services are underpinned by flexible, sustainable financial mechanism that give priority to the needs of the people they serve rather than the needs of the organisations through which they are delivered; and
- That those arrangements are characterised by strong and consistent clinical and professional leadership”

Nicola Sturgeon, December 2011

The ‘Strategic Commissioning Process’

- Assessing and forecasting needs
- Linking investment to agreed outcomes
- Considering options
- Planning the nature, range and quality of future services
- Working in partnership to put these in place

Purpose of the ‘Refresh’

- refresh our Strategic Commissioning Plan every year (3 year but annual update);
- align with the budget setting and savings agenda;
- agree the ‘transformational change’ projects to work towards the health and wellbeing outcomes

Forward Looking

- “Services cannot continue to be planned and delivered in the same way; the current situation is neither desirable in terms of optimising wellbeing, nor financially viable.”

- “The focus should be less about how it is done now and more about how it should be done in future”.

Strategic Commissioning Plan Guidance

Drivers for Change

- a desire for improved outcomes
- quality services, at local, regional and national level
- less funding for public sector
- difficulties in recruiting to certain posts and in some areas of Shetland
- addressing the population changes
- rebalancing care to local communities
- more complex health needs
- a persistent (and possibly worsening) inequality gap

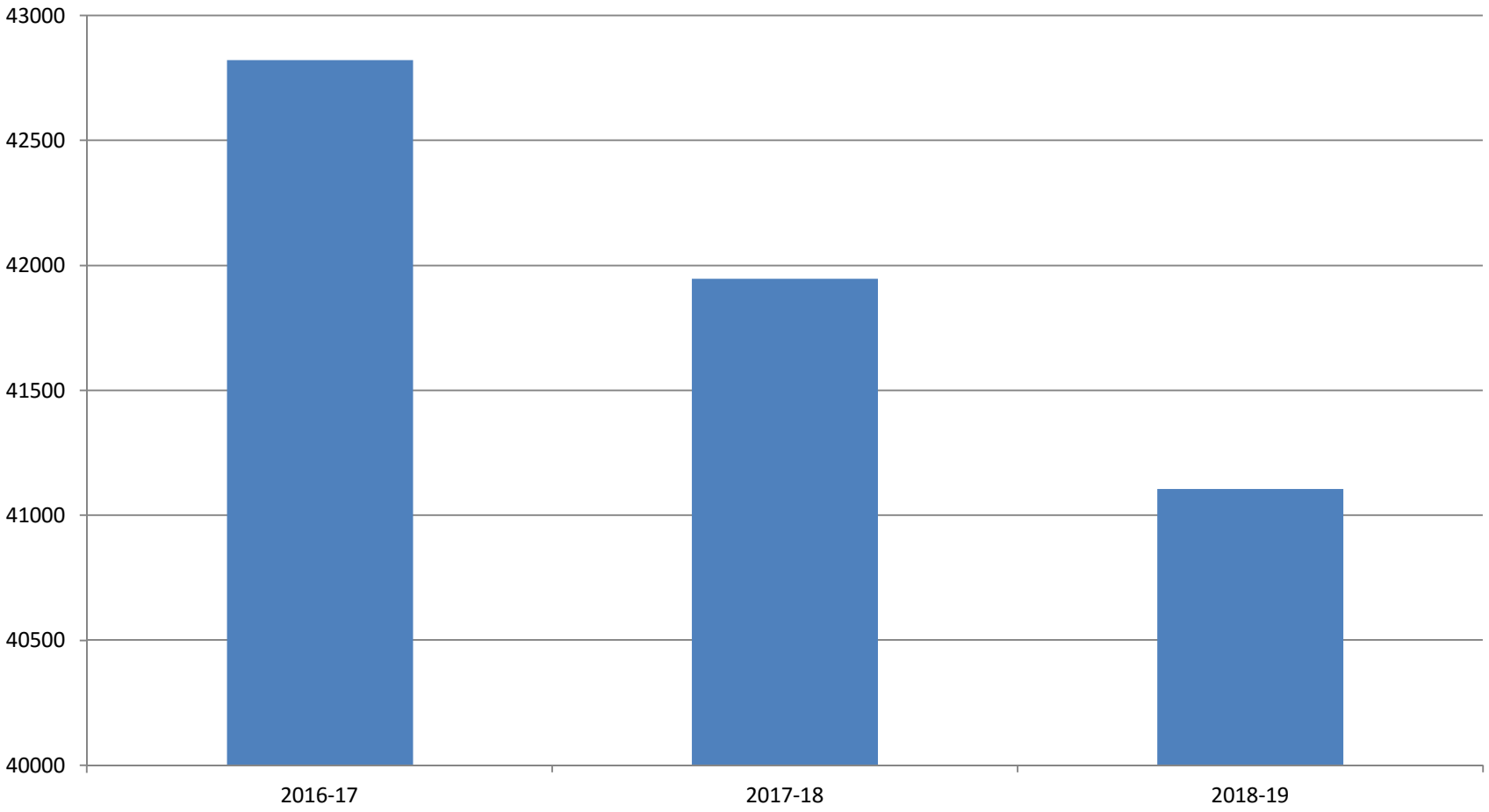
Themes of the Modernising Agenda

- early intervention, focused on children and young people
- tackling inequality, with a focus on health inequality
- anticipate needs and prevent them happening
- self care and management
- services designed with users, not done to them
- services integrated from the point of view of service users
- services planned around localities and community needs, this is not limited to health and care services
- opportunities to redesign services using e'health solutions
- generating efficiencies, reducing costs and releasing savings
- building organisational capacity

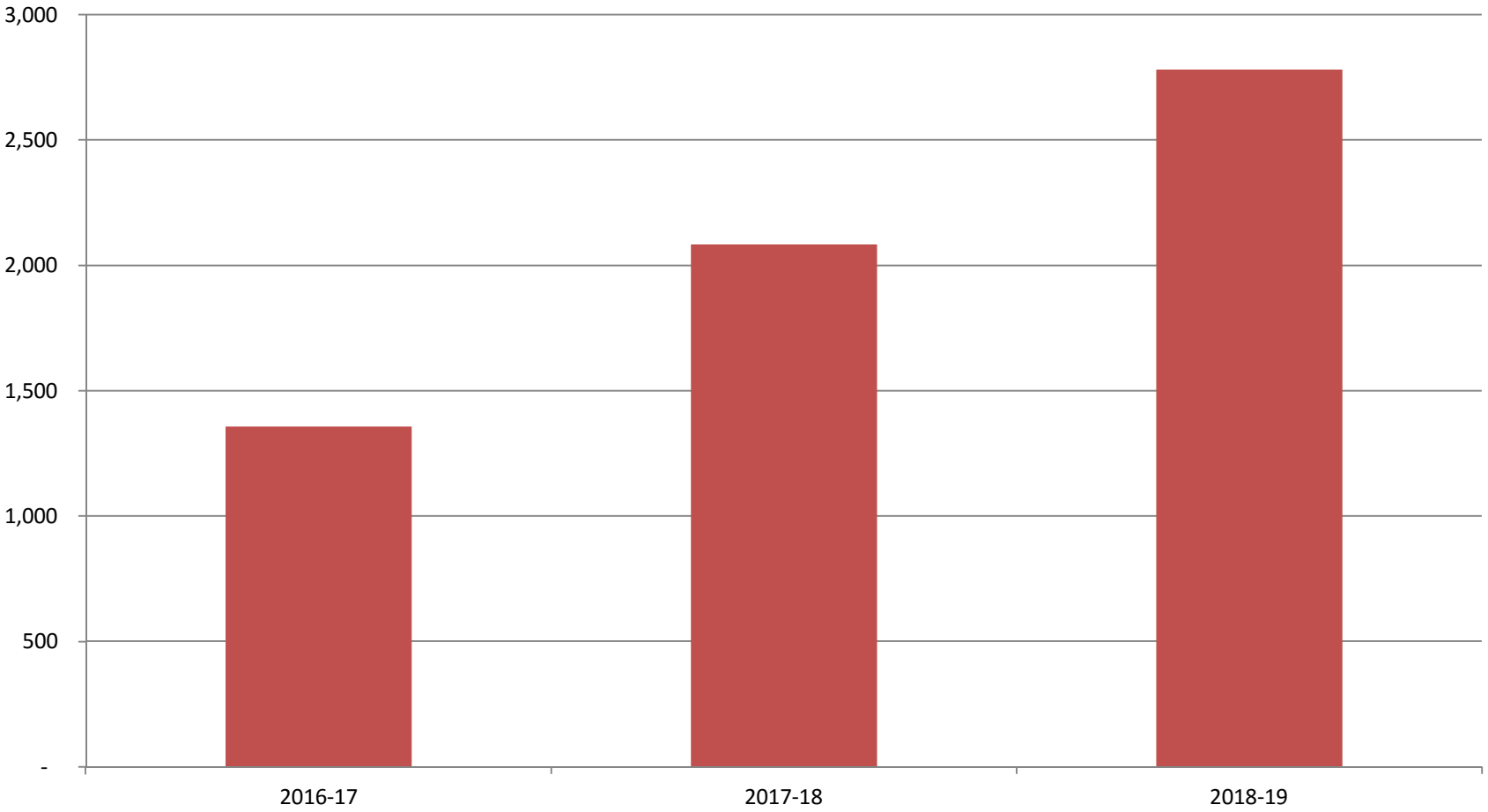
The IJB 3 Year Financial Plan

Year	IJB Total Budget	IJB NHS Efficiency Target
	£000	**£000**
2016-17	42,820	1,357
2017-18	41,945	2,083
2018-19	41,105	2,780

Integrated Joint Board Total Budget £000



Integrated Joint Board NHS Efficiencies Target £000



What is Strategic Commissioning?

- “Traditionally the starting point for forward planning for many of us is to consider what we’ve already got and then look at how to preserve, sustain or increase it. Strategic commissioning...expects us to ....ask a different set of questions:
- What exactly are we trying to achieve, and for whom?
- How successful have we been?
- What do we need to do differently for a better result, and how are we going to resource that?

Scottish Government Guidance

Members Roles

Strategic commissioning is crucially about establishing a mature relationship between different partners from across the public, third and independent sectors in a way which will help to achieve the best services for the population. Providers themselves will bring knowledge and experience of their services and the outcomes they are delivering. Every partner has a role to play in strategic commissioning, and that is why it is important that local arrangements promote mature relationships and constructive dialogue. Members will be expected to:

- represent their sector or professional area (community of interest);
- ensure the interests of the agreed localities are represented;
- develop and maintain the necessary links and networks with groups and individuals in their community of interest to enable views to be sought and represented over the development, review and renewal of the Strategic Commissioning Plan;
- take an active role in the development of the initial draft of the Strategic Commissioning Plan (as well as the subsequent drafts);
- help ensure the Strategic Commissioning Plan reflects the needs and expectations (and that there has been an adequate assessment of those needs and expectations) both across Shetland and in the localities.

Terms of Reference

Health and Wellbeing Outcomes

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

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

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

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

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

Health and Wellbeing Outcomes

- **Outcome 6:** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

- **Outcome 7:** People using health and social care services are safe from harm

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

- **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services

Current Strategic Commissioning Plan

- By Service Area – 39 individual service plans
- 148 Individual Actions
- Mixture of operational practice and strategic change

What Do We Know Already?

- Population trends, centralisation
- Age trends, older population
- Health and Care Needs changing
- Health inequalities, potentially widening gap
- Deprivation
- Locality Profiles

What are we Finding Out?

- National Services Scotland :
  - Using data to support integration; a national resource that it available to us
- National Indicators
  - Combining health and care indicators and costs
- What others are doing eg
  - ‘High Resource Individuals’ – a small % of the population costs a significant % of the overall resources – why? Can we prevent it?

Shaping the ‘Refresh’

- Gap Analysis / Future Planning – by service
- Self assessment – what do we need to do now to achieve the Health and Wellbeing Outcomes?
- National Shared Services data on costs and performance comparisons to highlight areas to do specific studies

Using your knowledge and experience...

- What do you think about the process of updating the Strategic Commissioning Plan? Is there anything else we'd need to consider?
- What would be your priorities for themes and issues to address in the 2017-18 Strategic Commissioning Plan Refresh?

Agenda Item

3

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Strategic Commissioning Plan – Key Strategic Drivers - *Cover*
Reference Number:	CC-65-16
Author / Job Title:	Hazel Sutherland / Head of Planning and Modernisation

Decisions / Action required:

That the Integration Joint Board considers the key strategic drivers which will influence the annual update of the Strategic Commissioning Plan and RESOLVES to approve that the plan be prepared on the following basis:

- securing savings and efficiencies on an ongoing and recurring basis;
- shifting the balance of care (a) from Grampian to Shetland and (b) from hospital to home/community settings;
- tackling health inequality, promoting self care and self management; and
- working towards redesigning services to achieve the national health and wellbeing outcomes.

High Level Summary:

The Strategic Commissioning Plan was approved by the IJB on 24 November 2015 with a 3 year timeframe. The Scottish Government Guidance indicates that the Plan should be updated on an annual basis. The IJB should set the scene at the start of the refresh process to give direction to the various consultation groups as to any key issues and constraints which need to be considered. The proposal is to align the needs assessment and future service planning process with the budgeting process from the start of the exercise. There then follows a series of consultation and negotiation processes, with the objective of having a draft plan and budget presented to the IJB in December 2016.

Corporate Priorities and Strategic Aims:

The Strategic Commissioning Plan describes how health and care services can be delivered jointly across the services described in the Integration Scheme. This describes how key priorities, as well as day to day operational services, will be delivered.

The Plan is a significant part of public sector delivery in Shetland and supports the Shetland Community Partnership's Local Outcome Improvement Plan, Shetland Islands Council's Corporate Plan, NHS Shetland's 2020 Vision and Local Delivery Plan.

Delivery of the Strategic Commissioning Plan relies on partnership working between Shetland Islands Council, NHS Shetland, other regional and national organisations (such

as the Scottish Ambulance Service and NHS Grampian and other specialist Health Boards) and voluntary sector providers.
Key Issues:
It will be extremely challenging to live within the resources allocated in the 3 Year Plan and significant changes to the current models of delivery are expected. The focus of the preparation of the Strategic Commissioning Plan needs to accommodate an accelerating 'modernisation' agenda to improve outcomes (where necessary).

Implications :	
Service Users, Patients and Communities:	The Strategic Commissioning Plan sets out the services to be delivered over the next 3 years. Any significant changes to that plan will be of interest to services users, patients and communities, particularly in respect of accessibility and availability.
Human Resources and Organisational Development:	At this stage, there are no direct impacts on Human Resources and Organisational Development. However, any significant changes to existing service models and methods of delivery may, in time, affect staffing – both in terms of the number of staff and the skills mix required – in order that service costs can be accommodated within the total budget allocation.
Equality, Diversity and Human Rights:	The Plan as a whole is subject to an Integrated Impact Assessment, which will be reported to a future meeting.
Partnership Working	The IJB is a strategic partnership which supports the work of the Shetland Partnership. Delivery of the Plan is conditional upon the partnerships working successfully to integrate services around the needs of individuals, carers, their families and communities.
Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 require Boards to produce a strategic commissioning plan and update it annually.
Finance:	There are potentially significant financial implications associated with the update of the Strategic Commissioning Plan. The current plan required to be supported by a Recovery Plan for NHS Shetland. The aim of the update is to prepare a plan which minimises, or ideally eliminates, the need for a Recovery Plan in 2017-18. This may mean that the Plan needs to include details of significant change projects required to operate within the financial limits set. However, having the planning and budgeting process aligned will give confidence to the Board that the services described within the Plan can be delivered for the available funding.
Assets and Property:	At this stage, there are no implications for Assets and Property. However, any significant changes to existing service models and methods of delivery may, in time, affect the overall estate in order that service costs can be accommodated within the total

	budget allocation.
Environmental:	There are no specific environmental issues arising from this Report.
Risk Management:	There are significant risks associated with the failure to deliver the Strategic Commissioning Plan, which are recorded and reported separately on the Risk Register.

Policy and Delegated Authority:	Shetland's Integration Joint Board was formally constituted on 27 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. Establishing the key strategic drivers to influence the annual update of the Strategic Commissioning Plan sets the direction for officers to work within and the IJB has the authority to do so.

Agenda Item

3

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Strategic Commissioning Plan – Key Strategic Drivers
Reference Number:	CC-65-16
Author / Job Title:	Hazel Sutherland / Head of Planning and Modernisation

1. Introduction

1.1 The purpose of this Report is to present the IJB with some initial themes and issues to consider in updating the Strategic Commissioning Plan.

2. Background

2.1 The IJB is responsible for the preparation of the Strategic Commissioning Plan. The Plan is prepared on a 3-Year basis but is required to be updated on an annual basis.

3. Key Strategic Drivers - Emerging Themes and Issues

3.1 The IJB should, at the start of the process, set the direction and constraints within which it wishes the Strategic Commissioning Plan to be updated. The process which will be followed is set out in the companion report on today's agenda. An update of the 3-Year Financial Plan is also provided to help shape the planning process over the next few months.

3.2 The overall purpose of the annual update of the Strategic Commissioning Plan for 2017-18 is:

- to align the strategic planning, service planning and budgeting processes; and
- to change the Plan away from detailed service plans to focus on service improvement and strategic change projects.

3.3 It will be useful at the start of the exercise for the IJB to give direction to managers to assist in the preparation of their service plans.

3.4 The IJB will be faced with a scenario that the cost of running the existing service delivery model is higher than the total amount allocated in the 3-Year Financial Plan.

3.5 The Local Outcomes Improvement Plan recognises that Shetland:

- is a good place to live; and
- the 'majority' of people experience a good quality of life

but that there exists challenges around:

- inequality;
- vulnerable children and young people;
- mental health; and
- harm caused by alcohol.

3.6 From a health and care perspective, there are specific issues around:

- Population changes and demographic issues
- Rebalancing care from hospital to community
- More complex health and care needs
- Long term conditions
- A persistent (and possibly worsening) inequality gap
- Diseconomies of scale for services (not reflected in funding settlement)
- Remote and rural setting; logistics and transport
- Recruitment and retention and ensuring a sustainable workforce

3.7 There is a separate report on the agenda which addresses the specific financial challenges as set out in the IJB's 3-Year Plan.

3.8 An early indication has been given to managers that the service plans should be prepared on the following basis, and this can be refined as the IJB develops its strategic direction:

- securing savings and efficiencies on an ongoing and recurring basis;
- shifting the balance of care (a) from Grampian to Shetland and (b) from hospital to home / community settings;
- tackling health inequality, promoting self care and self management; and
- working towards redesigning services to achieve the national health and wellbeing outcomes.

3.9 Some of the emerging themes and key strategic issues to explore will be around:

- An understanding of the inter-connectedness of all elements of the health and care system (between specialist services, hospital and community, and on and off island medium and longer term placements)
- A clear understanding of the fixed costs associated with the Gilbert Bain Hospital and the current care centre structure;
- Maximising the utilisation of existing assets and spaces;
- Making sure that patients/clients and service users are cared for in the right location (out with Shetland; Gilbert Bain Hospital or within a community setting);
- Getting the right staffing ratios and skills mix across the various health and care systems and enable staff to work to their full skills and capacity;
- Maximise the ability of eHealth technology to support change;
- Actively promoting self help, self management and preventative services.

3.10 Most of the themes are supported through the change projects, such as:

- Repatriation of services from Grampian;
- Rebalancing care to the community
- Staffing Reviews
- Primary Care and Oral Health Action Plans

4. Conclusions

4.1 Over the next few months, detailed work will be done to refresh the Strategic Commissioning Plan, with a view to getting a draft update to the IJB meeting on 9 December 2016.

4.2 The IJB is invited to consider the strategic context within which it

operates and provide a focus upon which the updated plan can be developed.

Contact Details:
Hazel Sutherland
Head of Planning and Modernisation, NHS Shetland
Email: hazelsutherland1@nhs.net
6 September 2016

Background Documents:
Health and Social Care Integration, Public Bodies (Joint Working) (Scotland) Act 2014, Strategic Commissioning Plans Guidance http://www.gov.scot/Resource/0046/00466819.pdf

Joint Strategic (Commissioning) Plan 2016-19, Version 7 – June 2016
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/Strategicplan2016-19.pdf

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	A Proposal to develop an extended intermediate care and community rehabilitation team
Reference Number:	CC-64-16 F
Author / Job Title:	Kathleen Carolan, Director of Nursing & Acute Services/ Simon Bokor-Ingram, Director Community Health & Social Care

Decisions / Action required:

The IJB is asked to:

- Agree the strategic shift in service delivery that supports the aims and objectives as set out in the Joint Strategic Plan 2016/17-19;
- Direct Shetland Islands Council and NHS Shetland Board to enact the operational delivery required, as set out in the proposal;
- Require the Chief Officer to enact these changes in Community Health and Social Care

High Level Summary:

During 2016, we have been undertaking an engagement exercise to ask practitioners, patients, carers and the public how best to deliver the balance of specialist and community based services in Shetland – taking into account various factors including:

1. Demographic changes/challenges (e.g. increasing activity, frailty, patient complexity);
2. Service sustainability and workforce challenges (across health and social care);
3. Challenges that affect us uniquely in a remote and rural setting (e.g. diseconomies of scale, geographical and logistical issues);
4. National, regional and local priorities;
5. The financial outlook/forecast over the next 5 years

We agreed through a table top exercise to review the options available, that the redesign that would yield most benefit and presented least risk was the enhancement of the existing intermediate care team (ICT) so that more services could be provided in a community based setting – including non acute rehabilitation which is currently delivered in the Rehabilitation Unit on Ronas Ward.

On the basis that the local evidence pointed towards this being a safe shift in service provision into the community, a proposal has been developed setting out how we could deliver a wider range of support in the community through the extension of the existing ICT. Once this service is established, this would reduce our reliance on the beds in the Rehabilitation Unit and we would stop admitting into these beds (the space will be reused).

In terms of stakeholder engagement, through August and September 2016, the proposals have been shared with a wide range of professional advisory groups, patient groups, the third sector, at IJB seminars and with staff involved in delivering these services (now and in the future) to shape the final content of the proposal (which is enclosed).

Corporate Priorities and Joint Working:

Older people are major users of health and social care services and there are nationally predicted rises in the likely demand for mental health, long term conditions and acute health care as well as community based services.

Given this context of demographic change and the increasingly complex heath and care needs identified, we will need to continue to look at how we can shape local services in order to meet these service demand predictions. Our strategic plans must also include ways of supporting people with more complex needs in the community setting in a safe and sustainable way. This will include services to support recovery and rehabilitation in the community (e.g. leading to better health outcomes and shorter lengths of admission following illness or surgery) and effective preventative services (e.g. helping people to restore their ability to perform their usual activities in life).

This paper sets out a proposal to enhance the existing intermediate care model to support the need to grow and safely deliver community based rehabilitation, in line with the strategic plans approved by the Integration Joint Board (IJB) for 2016/17-19.

Key Issues:

We have carefully considered the impact on individuals who need a programme of rehabilitation and recovery following an acute illness. We have developed a model that removes some of the barriers that providing care in a hospital setting present (e.g. flexibility of staffing across hospital and community settings).

The proposal has been developed by a multi-agency team that will be responsible for the delivery of the community based service – demonstrating that there is ownership of the plan to provide an enhanced level of care in peoples own homes and specific residential care facilities such as Montfield Support Services.

There is consensus from the professional advisory groups that this proposal is evidence based and supports both the aims of the national clinical strategy and local strategic plans; to build services around ‘people’ rather than disease pathways and where it is safe to do so, deliver services as locally as possible.

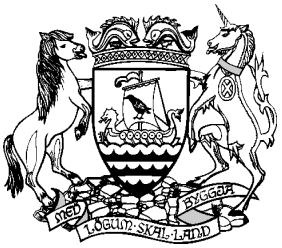
Similar feedback has been noted from other stakeholder groups that this proposal represents a continuation of the work we have undertaken jointly to develop community based services across the Health and Social Care Partnership – some of the successes are noted in the proposal which includes the reduction in the length of time that older people are spending in hospital.

The indicative savings associated with this change in the service model are aligned to the £2.8M ‘set aside’ budget that is part of the IJBs strategic commissioning arrangements. The full year effect of the savings will be approximately £475,000 (recurrently) and the saving is attributed to the reduction in the running costs of the Rehabilitation Unit. The funding released from the closure of these beds has already been re-invested in community health and care services locally, through funding of cost pressures in community health services. (for example Increasing the pharmacy budget, increased pay costs etc). The investment within the community to support this

shift is funded by investment from the Integrated Care fund and the "additionality" funding that has been passed to Social care from the National Health allocation of the Scottish Government. We do not, therefore, expect this change to generate any cost pressures in Community Care Resources. Staff who work on the Rehabilitation Unit will have the opportunity to work as part of the new ICT or take roles elsewhere in the hospital or community – there is a policy of no voluntary redundancy across the NHS.	
Implications :	
Service Users, Patients and Communities:	An Equality Impact Assessment is enclosed as part of the proposal.
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 2016/17-19 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 (in which this proposal is positioned) specifies the services to be delivered by the parties.
Finance:	Any impact will be in a reduction in the opportunity to shift resources to community services. The Integrated Care Fund is a recurrent allocation which is supporting the investment in community services. This along with the use of the Additionality Funding has already been agreed by the IJB at its meeting of the 28 June 2016.
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 and flexible, multi-disciplinary models of 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.

NHS Shetland



Shetland Islands Council

A Proposal to develop an extended intermediate care and community rehabilitation team

Developing an extended intermediate care and community rehabilitation team

1. Introduction

Older people are major users of health and social care services and there are nationally predicted rises in the likely demand for mental health, long term conditions and acute health care as well as community based services[1]. In regard to the demographic changes predicted for Shetland, the number of people over the age of 75 years will increase from 1,657 in 2010, to 3807 by 2035.

Given this context of demographic change and the increasingly complex heath and care needs identified, we will need to continue to look at how we can shape local services in order to meet these service demand predictions. Our strategic plans must also include ways of supporting people with more complex needs in the community setting in a safe and sustainable way. This will include services to support recovery and rehabilitation in the community (e.g. leading to better health outcomes and shorter lengths of admission following illness or surgery) and effective preventative services (e.g. helping people to restore their ability to perform their usual activities in life).

This paper sets out a proposal to enhance the existing intermediate care model to support the need to grow and safely deliver community based rehabilitation, in line with the strategic plans approved by the Integrated Joint Board (IJB) for 2016-19[2].

2. Existing model for rehabilitation and reablement

The Rehabilitation Unit which is situated on Ronas Ward[3] was established in the Gilbert Bain Hospital in 2014. The Unit has six beds, is open 24/7 and admits patients from the hospital and the community who meet the criteria for 'non acute rehabilitation'[4]. Patients are then supported through a programme of time limited rehabilitation typically for 4-6 weeks but programmes can be longer and some are delivered over 6-12 weeks.

The Rehabilitation Unit includes a team of Nurses, Healthcare Support Workers (HCSWs), Physiotherapists, Occupational Therapists, Therapy Assistants, Clinical Pharmacists and a Consultant Physician.

The Intermediate Care Team (ICT) was also established in 2014 and includes a similar range of health and social care professionals to those working in the hospital setting -

[1] A National Clinical Strategy for Scotland (2016) http://www.gov.scot/Publications/2016/02/8699

[2] Joint Strategic Commissioning Plan (2016-19)
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/Strategicplan2016-19.pdf

[3] Ronas Ward was relocated to the Gilbert Bain Hospital site in 2008, in 2014 when the Rehabilitation Unit was established then the remaining space was re-purposed to provide a Chemotherapy Unit and winter capacity planning beds. If the proposal was accepted, then the services which are currently situated on Ronas Ward will remain insitu and are not subject to change.

[4] A glossary of definitions is shown in the document appendices, taken from the Intermediate Care Framework for Scotland, Scottish Government (2012), http://www.gov.scot/resource/0039/00396826.pdf

but this team has a current focus on re-ablement and early supported discharge from hospital in the community and is available as an extended 'day time' service.

3. Impact of changes to older peoples care over the last 2 years

As a result of establishing these services and other interventions we have seen a decrease in the length of stay that older people experience in hospital and an increase in the number of people who can be cared for in the community as an alternative to hospital.

Recently published reports show that we are the best performing health and social care partnership in Scotland, as measured against a reduction during 2015-16, in the number of people who are medically fit but delayed in hospital waiting for a care package[5] (56% reduction against the national average of 9%) AND in the provision of palliative care available in the community[6] (92.3% of people spent the last 6 months of their lives at home/in the community).

In line with the increasing success of the development of community services, we have seen a reduction in hospital bed occupancy – in 2015 and 2016 the average bed occupancy for the hospital as a whole was at 80% or less, whilst at the same time the hospital teams managed more people that were increasingly frail and complex. The chart on the following page shows the bed occupancy for the hospital in 2015 and the downward trend in length of stay.

4. If the current services are working well – why change them?

Notwithstanding our successes, the current model is not optimal and some of the challenges associated with the existing model are summarised below:

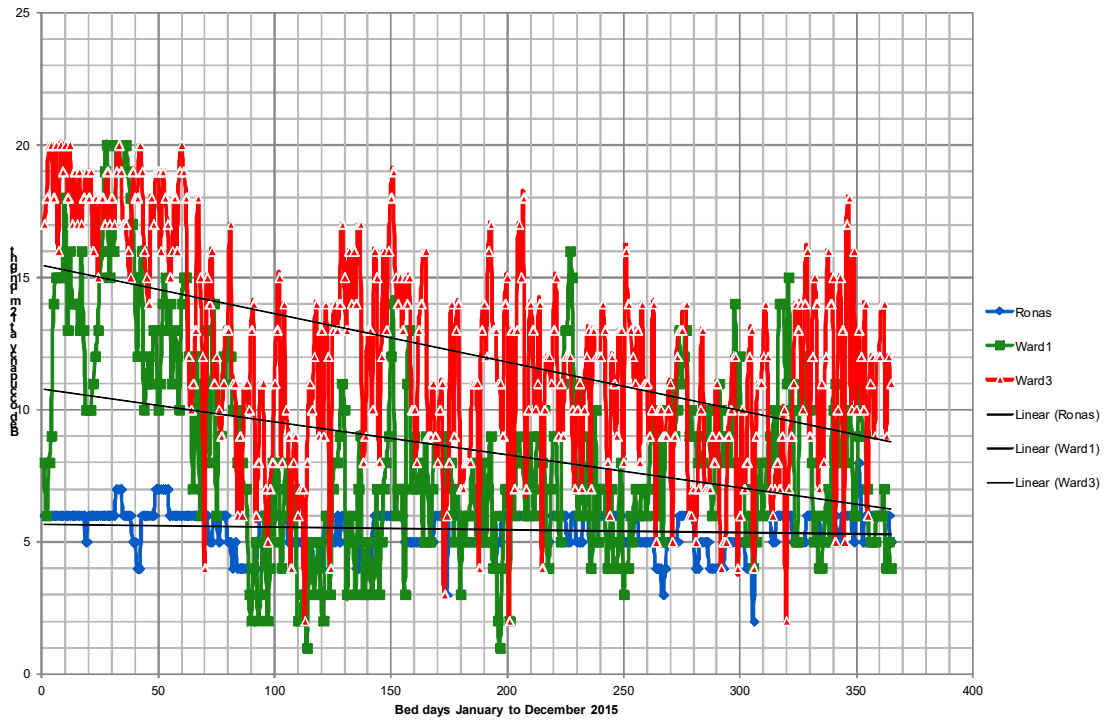
- Intensive, non acute rehabilitation is only available via Ronas Ward and there are times when patients would meet the criteria but there isn't capacity in the Unit to admit them – this can lead to longer lengths of stay in hospital;
- Conversely, there are times when the Rehabilitation Unit has lower occupancy, but because of the constraints of delivering a service in a 'building' it is difficult to flex staffing up or down in response to patient needs;
- The ICT operates between 8am and 10pm on weekdays – so there are times when we cannot provide early intervention and that means that some individuals are admitted to hospital or residential care as there wasn't an alternative available to provide the support they needed at home;

[5] Delayed Discharges in NHSScotland Annual summary of occupied bed days and census figures. Figures up to March 2016 https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2016-06-28/2016-06-28-DelayedDischarges-Report.pdf?26258486510

[6] Percentage of End of Life Spent at Home or in a Community Setting. Financial years ending 31st March 2010 to 2015 https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2016-08-30/2016-08-30-End-of-Life-Report.pdf?71296328307

- Medical leadership for the ICT is a vital part of older peoples care, to ensure that there is a clear oversight and a holistic plan to support people when they have multiple health needs. This means that the communication between primary, secondary and specialist medical services must be robust and responsive. Particularly if an individual has complex cognitive, physical and psychiatric conditions where a number of specialist are involved in providing medical input.

Chart 1 A chart to denote bed utilisation at the Gilbert Bain Hospital in 2015-16



5. The proposal – to extend the intermediate care teams remit to include community rehabilitation

The proposal is to extend the remit and staffing in the ICT, so that we can provide intensive, non acute rehabilitation in the community instead of the hospital, which will further reduce the length of stay in hospital for a number of patients. If someone needs intensive, non acute rehabilitation and they are medically stable, then the ICT will support them either at Montfield Support Services (if they continue to need 24/7 care) or in their own home. Based on the analysis of older people's care needs this data shows that community care capacity is sufficient to meet the requirements set out by this model. Whilst there will be a requirement for some short term social care support, there should, as a result, also be less demand from those on reablement pathways for longer term support, and where long term support needs do continue then the size of a package of care is likely to be less. In the long term this is therefore intended to reduce the overall demand on community care resources.

Patients will stay on the acute wards for the same amount of time that they do currently, and once they are ready for intensive rehabilitation then the hospital and community teams will work together, in collaboration with the patient and their family, to agree how rehabilitation or reablement support should be best provided.

Once this service is established, this would reduce our reliance on the beds in the Rehabilitation Unit and we would stop admitting into these beds (the space will be reused).

An example of how the pathway would work from a patient's perspective is shown in Appendix A.

6. Aims for the model of extended intermediate care and community rehabilitation

A specific driver for the extension of the intermediate care team approach is the opportunity to maximise the use of resources to support early assessment, provide an early response and early intervention – by bringing together the skills of the hospital based and community based multi-disciplinary teams.

The specific aims of the extended ICT are:

- To promote an assets based approach to wellness, independence and living with long term conditions;
- To promote goal setting, person centred care and self management;
- To increase opportunities for early intervention and anticipatory care;
- To enhance community service provision and deliver more care in the community setting, where it is safe to do so;
- To make best use of the resources (skills and expertise) across health and social care teams to deliver effective interventions to support older people living with long term conditions

The aims of the proposal address the challenges identified in respect of the current model by:

- Creating a team that can respond to the individual needs of a person in a way that is not so constrained by 'buildings and beds' – the ICT will be able to support people as appropriate in their own homes or in residential care whilst they participate in their programme of 'non acute rehabilitation';

- The ICT will be supported by other overnight services – so there is greater scope to provide additional input to an individual overnight and avoid admission to hospital or residential care, when minimal assistance is needed. Providing care as needed overnight may also support Carers and avoid the need for a crisis response;

- There is also scope for strengthening the arrangements with the Third Sector to provide home support services and linking the current arrangements with the proposal to extend the remit and resources available to the ICT;

- The ICT will include a senior Doctor (either a GP with a Special Interest in Older Peoples Care or a Consultant Physician) who will help to co-ordinate the medical input required to support the ongoing clinical needs of individuals who are receiving support with 'non acute rehabilitation' in the community setting. This Doctor will work closely with medical staff in the community e.g. the GP and Health Centre team, other clinicians in Shetland and specialist services off island for example, the Old Age Psychiatrists.

7. The scope and remit of the extended intermediate care team

The operational remit of the extended ICT is summarised below in terms of its core functions to provide:

- Time limited non acute rehabilitation (accepting admissions from the community or hospital);
- Time limited reablement support (in residential or home settings);
- Support for early discharge from hospital, where ongoing reablement is required;
- Anticipatory care plans (including falls and frailty assessments) for people at risk of increasing care needs/admission to hospital;
- A philosophy and use of assets based approaches e.g. person centred goal setting, health improvement and self management strategies across health and social care teams;
- Ongoing clinical assessment and supporting people with an acute illness in the community, thus avoiding hospital admission (under the direction of GPs in Primary Care and delivered by Nurses and Clinical Pharmacists as part of a 'virtual ward' approach)

The scope of this proposal is to develop a model that is focussed on providing non acute rehabilitation in the community for all individuals, irrespective of where their main residence is in Shetland.

Time limited reablement and early supported discharge will be delivered in the most appropriate setting for the individual (which might be residential care or at home).

In addition to this, the ICT will support people to return home as soon as possible by providing initial assessments in A&E and putting in place a rapid response care package, until a full needs assessment care be undertaken.

In this initial phase, resources will be focussed on establishing community based rehabilitation, rapid response, early discharge and assessment in A&E for individuals who live in the Lerwick and Central area[7]. Everyone who requires non acute rehabilitation in a residential setting (irrespective of where they live), will be able to access it from Montfield Support Services which is an enhanced residential care facility.

[7] Individual rehabilitation programmes may also be delivered in other settings e.g. another residential care centre or at home, as appropriate to that persons care needs (and the capacity available across the multi-disciplinary team).

The roll out of these services across Shetland will be subject to a second phase project and part of the wider work to develop locality based services.

The structure of the extended team and the list of services that will be provided are shown in Appendix B.

8. Engagement and developing the proposal

A joint project board was established in April 2016, with Executive Directors and Executive Managers representing Acute and Community based services who have worked together to oversee the development of the proposal. In addition to this, a project team was also established to bring together health and social care practitioners to form an expert group to develop the model. The proposal has been developed by the multi-disciplinary team that provides the existing services and if the proposal is supported, these practitioners will also be involved in the delivery of the future service.

The model has been developed using an abridged 'delphi technique' where a number of possible models/options have been proposed in order to identify aspects of these models that can either be adopted, rejected or adapted for inclusion in the final model. Feedback has been gathered from a range of sources including professional advisory groups such as the Area Clinical Forum (ACF) and the Area Medical Committee (AMC), community groups and the third sector (e.g. Carers Group) and patient forums (e.g. the Patient Participation Forum and the Patient Focus Public Involvement Steering Group). The proposals have also been reviewed by staff partnership fora e.g. the Area Partnership Forum and Joint Staff Forum.

Joint management teams have also had the opportunity to review the proposal to ensure that all risks to service delivery and sustainability are appropriately identified and quantified e.g. ensuring we have the capacity and resilience to manage winter pressures. A risk register identifying the high level risks is shown in Appendix D.

The feedback received has been incorporated into the various iterations of the draft proposal. An equality impact assessment has been developed to accompany the change plan that this proposal represents and is shown in Appendix E.

9. Expected demand for community based rehabilitation in 2016-2017

The number of patients admitted to hospital for rehabilitation assessments and/or intensive rehabilitation in 2015-16 was 42. The typical length of stay on the unit is 39 days. The average number of new patient referrals each month was 3-4, with a peak of 5 during June, July and October 2015. In addition to this, six patients were admitted to Ronas as part of the winter planning escalation arrangements and they were not on the ward for active rehabilitation and had a length of stay of less than 48 hours.

Table 1 Rehabilitation Unit Activity Data 2015-16	
Total No of Admissions	**48**
Patients Transferred to Ronas (winter pressures)	**6**
Patients Admitted for Rehabilitation	**42**
Total Average Length of Stay (LoS)	**54**

Adjusted Average LoS	**39**
No Patients Admitted for 90+ days	**4**
Table 2 Rehabilitation Unit Activity Data 2016-17	
Total No of Admissions (to date)	**30**
Patients Transferred to Ronas (winter pressures)	**0**
Patients Admitted for Rehabilitation	**30**
Total Average Length of Stay (LoS)	**32**
Adjusted Average LoS	**29**
No Patients Admitted for 90+ days	**1**

In terms of bed occupancy, this is equivalent to 3.6 beds (operating 24/7), so the Rehabilitation Unit was not running at full capacity in 2015-16 and that continues to be the case in 2016-17.

In addition to this, a number of these patients could have had early, supported discharge if the pathway for community rehabilitation been available at the time.

Therefore, there will not be a requirement to ring fence residential care resources to provide non acute rehabilitation and the proposed model is likely to reduce reliance on permanent residential care options and overall length of stay in residential care (through the increased potential for reassessment of care needs and ongoing access to therapists).

In order to understand the potential impact of early supported discharge and non acute, community based rehabilitation on community care services; a comprehensive case note review of 22 patient records was undertaken to understand the patient rehabilitation pathway and outcomes in detail. The case note review found that the care needs, recovery goals and levels of patient dependency are comparable with the existing care needs for individuals who are living in the community (with support from families or formal packages of care).

At discharge, 60% of the patients who had set rehabilitation recovery goals went home to the care of their family with minimal support and/or had time limited support from the Intermediate Care Team.

The nursing sensitive care requirements focussed on specialist input to manage: stoma care, pressure care, wound care, medicines management and continence. The nurses also made a significant contribution to the reinforcement of recovery goal practice and enablement outside of formal sessions with the Therapists.

Nursing input is essential to the current and proposed models, but it is clear that providing enhanced input during the daytime is where the specialist, multi-disciplinary intervention is needed. Overnight care can be met in a residential community setting and did not constitute complex, hospital based care as per the policy definitions.

The proposed model and pathways for: acute and non acute rehabilitation, reablement, early supported discharge, community based rapid response, assessment and management are shown in Appendix C.

Data for bed occupancy at Montfield Support Services from April 2016 to August 2016 shows that there is on average 2 beds available each day. The range of availability is 0-5 beds with a median bed availability of 2 beds. Therefore, with the predicted admission rate for non acute rehabilitation of less than one admission per week – there should be sufficient capacity for Montfield Support Services to receive admissions as part of the proposed pathway described, without impacting on other individuals who may also require access to Montfield Support Services for reablement or respite.

10. Staffing model and costs

Over the last six months, the multi-disciplinary team has been reviewing the caseload (current and predicted) to provide the staffing model for the extended ICT. The purpose of this work was to ensure that there is sufficient resource aligned to the team (and the correct skill mix) to deliver community rehabilitation and reablement, safely.

As shown in Appendix F, there is continued investment in the existing ICT service as well as transfer of some of the resources from the Rehabilitation Unit. Appendix F shows the resources aligned to the ICT and other initiatives supporting care closer to home, from the funding sources available. The cost of the ICT exceeds the available funding by £48,000, which will not be a cost pressure in 16/17 because of slippage in spend. For future years, the Strategic Planning process will need to consider how best to ~~deliver the~~deliver the ICT model and the investment required.

11. Efficiency, redesign and savings

The indicative savings associated with this change in the service model are aligned to the £3.725M 'set aside' budget that is part of the IJBs strategic commissioning arrangements.

The full year effect of the savings will be approximately £475,000 (recurrently) and the saving is attributed to the reduction in the running costs of the Rehabilitation Unit. The funding released from the closure of these beds has, effectively, already been re-invested in community health and care services locally.

The savings are not attributed to income from individuals who are eligible to pay for residential care once the period of community based rehabilitation or reablement has been completed. Any fees attributable to residential care are levied by the Local Authority, but it is not expected to increase the current income levels.

Staff who work on the Rehabilitation Unit will have the opportunity to work as part of the new ICT or take roles elsewhere in the hospital or community – we have a policy of no voluntary redundancy across the NHS. The service is funded across Health and Social Care Partnership and we have committed the Integration Fund to support it.

Having reviewed the length of stay of individuals receiving non-acute rehabilitation in hospital, the data shows that the average length of stay is 39 days. This means therefore that the majority of individuals will have reached a point in their recovery within the first six weeks to an extent that 24/7 care is no longer necessary and they are then ready for discharge into the care of community services. We expect this model will deliver the same approach and the majority of individuals who needed residential care will no longer need it after the first six weeks, especially in relation to meeting their non-acute rehabilitative potential. If after six weeks an individual has assessed need for ongoing residential care, they would have a financial assessment to determine what their contribution would be for remaining in residential care. This is because the charges for residential care are waived for the first six weeks where the placement is interim.

12. Proposed implementation plan

If the proposal is supported by the IJB in September 2016 and approved by NHS Shetland Health Board in October 2016; then the indicative plan is to implement the change in the model of care during quarter 3 of 2016-17.

DOCUMENT DEVELOPMENT COVERSHEET

Name of document	**A Proposal to develop an extended intermediate care and community rehabilitation team**
Author	Kathleen Carolan, Director of Nursing & Acute Services Simon Bokor Ingram, Director of Community Health & Social Care
Executive Lead	**As above**

DATE	VERSION	GROUP	REASON	OUTCOME
February 2016	In presentation slide format	Board	To gather views on redesign proposals for 2016-17	Supported the development of the proposals for consideration by the Integrated Joint Board (IJB) and NHS Shetland Board
February 2016	In presentation slide format	Senior staff who support inpatient and intermediate care services	To gather views on redesign proposals for 2016-17 - specifically where we deliver specialist vs community based services	Asked for clarity on potential impact of the proposals on patient flow and ensuring that new pathways are evidence based
February 2016	In presentation slide format	Staff who provide the current rehabilitation service	To gather views on redesign proposals for 2016-17 - specifically where we deliver specialist vs community based services	Asked for clarity on potential impact of the proposals on access to rehabilitation as well as the change management process for staff
February 2016	In presentation slide format	Area Partnership Forum	To gather views on the redesign proposal and options for specialist and community based services	Asked that we involve the multi-disciplinary teams explicitly in the model development
February 2016	In presentation slide format	Area Clinical Forum	To gather views on the redesign proposal and options for specialist and community based services	Asked that we ensure that there is a clear communication plan (for internal and external stakeholders) so that the 'right' advice can be identified to shape the proposal development
March 2016	In presentation slide format	Area Medical Committee	To gather views on the redesign proposal and options for specialist and community based services	Advice provided in respect of the proposed medical role aligned to the ICT. Supported the strategic option to focus on community based care delivery

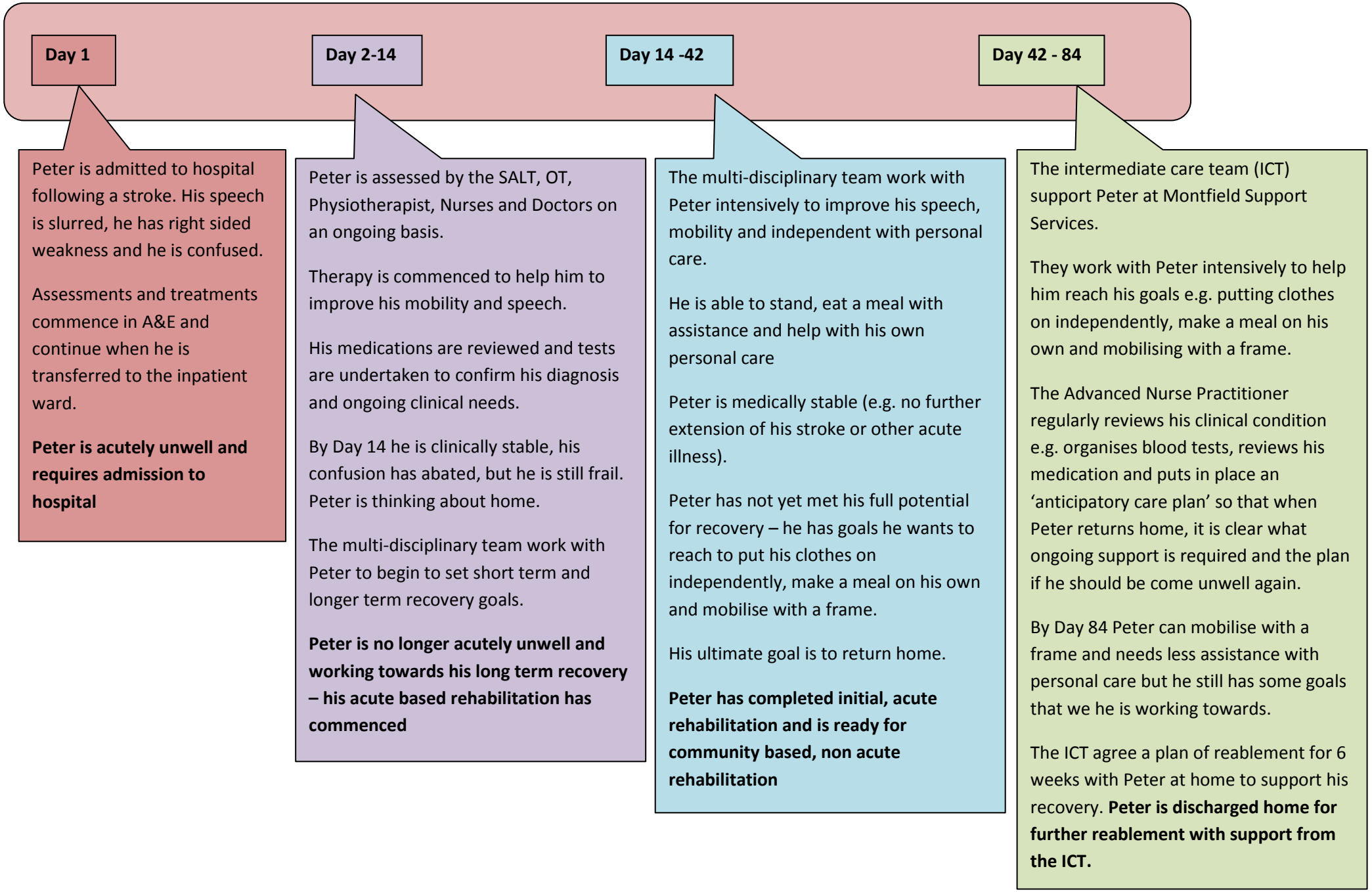
**To be attached to the document under development/review and presented to the relevant group*

DATE	VERSION	GROUP	REASON	OUTCOME
March 2016	In presentation slide format	Patient Focussed Public Involvement Group	To gather views on the redesign proposal and options for specialist and community based services – particularly in respect of gathering views from service users	Confirmed that the proposed communication plan was acceptable – in line with advice also received from the Scottish Health Council
March 2016	In presentation slide format	Strategy & Redesign Committee	To note the development of the redesign proposals for 2016-17 - specifically where we deliver specialist vs community based services (with comments gathered from the engagement exercise so far)	Supported the development of the proposals for consideration by the Integrated Joint Board (IJB) and NHS Shetland Board. Assisted in the development of the timeline and communication plan content.
March 2016	In presentation slide format	Area Partnership Forum	To note the development of the redesign proposals for 2016-17 - specifically where we deliver specialist vs community based services (with comments gathered from the engagement exercise so far)	Comments gathered from Staff Side and incorporated/addressed by the Project Team which was established in May 2016.
March 2016	In presentation slide format	Area Clinical Forum	To note the development of the redesign proposals for 2016-17 - specifically where we deliver specialist vs community based services (with comments gathered from the engagement exercise so far)	Nil
April 2016	General discussion	Staff who provide the current rehabilitation service	Update on progress to develop the options	Asked for clarity on potential impact of the proposals on access to rehabilitation as well as the change management process for staff
June 2016	Proposed pathways presented	Joint EMT & CMT	To note the pathway development, in light of early comments and the work undertaken by the Project Team	Proposal supported in principle. Assisted in the development of the timeline and communication plan content.

DATE	VERSION	GROUP	REASON	OUTCOME
June 2016	Proposed pathways presented	Area Clinical Forum	To note the pathway development, in light of early comments and the work undertaken by the Project Team	Proposal supported in principle.
June 2016	Proposed pathways presented	Area Medical Committee	To note the pathway development, in light of early comments and the work undertaken by the Project Team	Proposal supported in principle.
June 2016	Proposed pathways presented	Area Nursing & Midwifery Advisory Group	To note the pathway development, in light of early comments and the work undertaken by the Project Team	Proposal supported by ANMAC. Encouraged the utilisation of senior nurses in the model to support continuity of care
June to August 2016	Model development versions 1-6	Project Team	Multi-disciplinary team met regularly to shape the model development and the content of this paper	The draft proposal attached
July 2016	Proposed pathways presented	Staff who provide the current rehabilitation service	To note the pathway development and further iterations of the proposal – including plans to seek wider views from patients and the public	Asked for clarity on potential impact of the proposals on access to rehabilitation as well as the change management process for staff
August 2016	Proposed pathways presented	Area Medical Committee	To note the pathway development and further iterations of the proposal	Proposal supported by AMC
August 2016	Proposed pathways presented	Carers Group	To note the pathway development and comment on the proposals from a carers perspective	Proposal supported in principle (awaiting formal feedback)
August 2016	Proposed pathways presented	Patient Participation Forum (which is received by all members and Third Sector organisations in Shetland)	To note the pathway development and further iterations of the proposal	Proposal supported in principle (awaiting formal feedback)

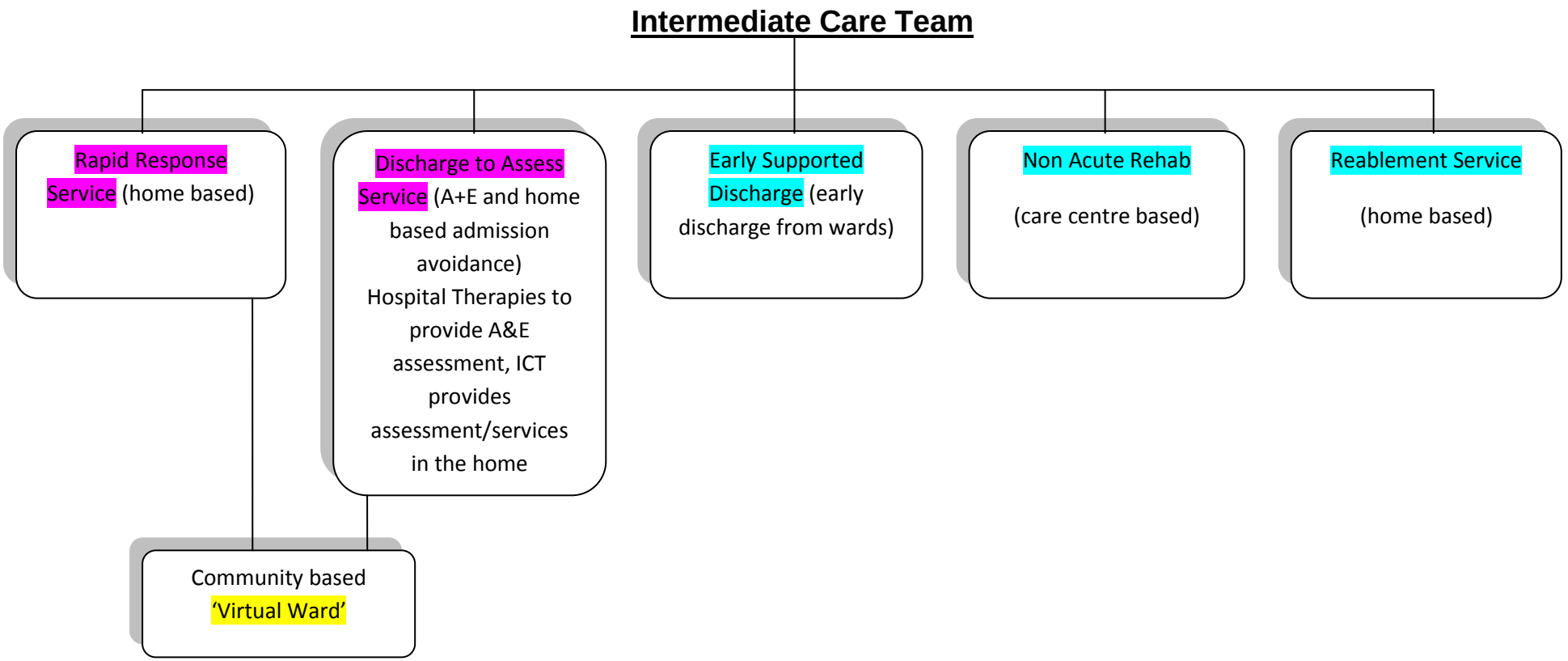
August 2016	Proposed pathways presented	IJB Seminar	To note the pathway development and further iterations of the proposal	Acknowledged that the full proposal would be received by the IJB in September 2016
September 2016	Proposed pathways presented	Lerwick Community Council	To note the pathway development and further iterations of the proposal	More information about the current activity and interface between hospital and community services requested. Acknowledged that the full proposal would be received by the IJB in September 2016.
September 2016	Proposed pathways will be presented	Stroke Support Group	To note the pathway development and further iterations of the proposal	More information about the current activity and interface between hospital and community services requested. Acknowledged that the full proposal would be received by the IJB in September 2016.
September 2016	Version 6 of the proposal	Area Medical Committee/Area Clinical Forum	To note the proposed model in final draft for submission to the IJB and Board	Awaiting comments through the clearing process
September 2016	Version 6 of the proposal	Project Team	To note the proposed model in final draft for submission to the IJB and Board	Awaiting comments through the clearing process

Appendix A An example of a patient pathway where there is access to 'non acute' rehabilitation in the community and through care from the ICT at home



Appendix B Proposed Enhanced Intermediate Care Structure and Extended Team

(Phase 1 Lerwick Central)



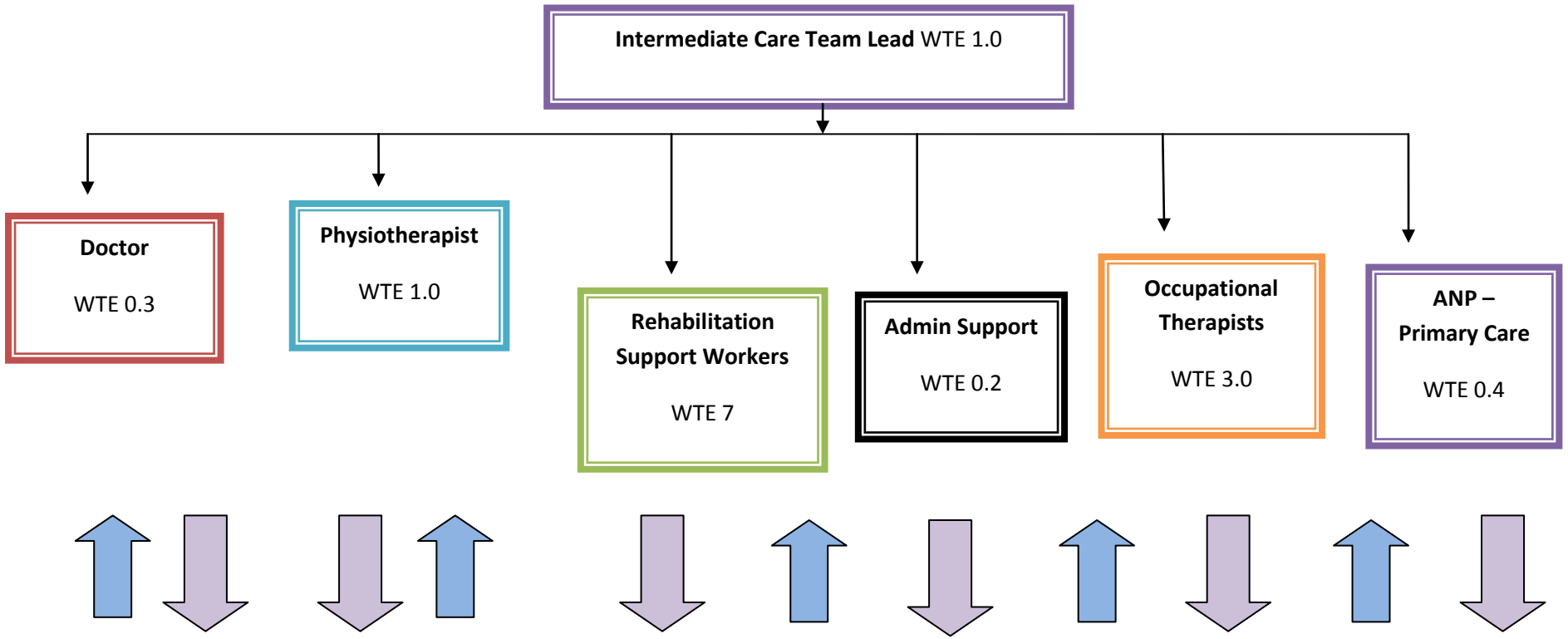
Existing services (Lerwick Central only will expand as the team grows)

Proposed additional services

Proposed structure for the intermediate care team to provide reablement and rehabilitation in the community setting

Phase 1: to provide an enhanced, consistent service in Lerwick/Central locality

Core ICT structure – staff dedicated to providing MDT input for transitional care into the community setting



Colleagues who are members of the 'virtual' ICT providing support as part of community services and input to Care Homes, including MSS

Advanced Practitioner – Oncology Specialist Nurse WTE 0.3

Locality Based Team – Social Worker, OT etc

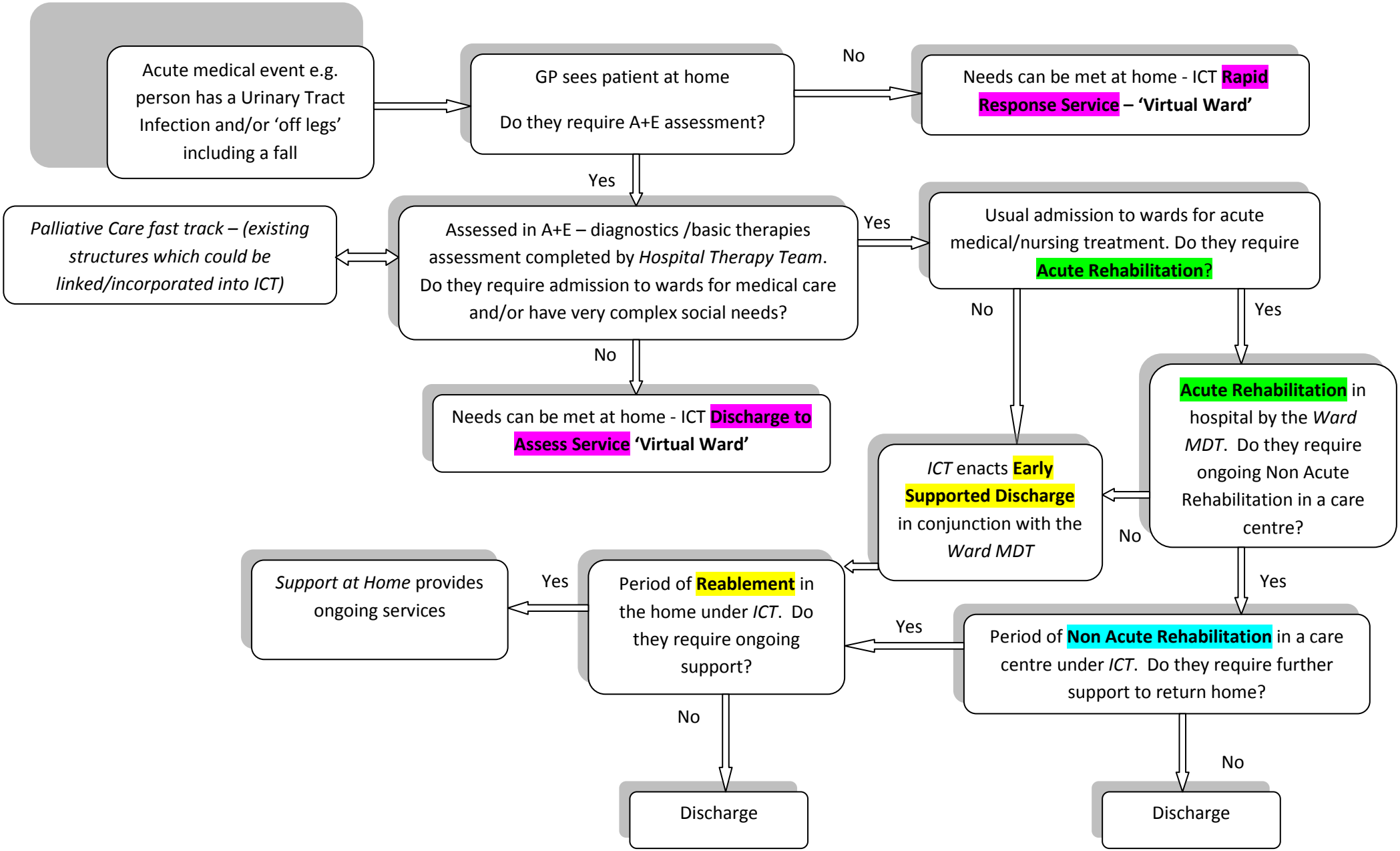
Community Nurses

GPs

Clinical Pharmacist

Appendix C Proposed Rehabilitation / Enhanced Intermediate Care Service Pathway

(Lerwick Central – phase 1)



Appendix D – Risk Register

Current Risk Rating:	**Risk ID:**	
Risk: Changes to the model of delivering non acute rehabilitation could lead to poorer health outcomes for people who have recovery and rehabilitation needs (due to factors such as lack of staff capacity to support rehabilitation in the community)	**Risk Owner (Director):**	Director of Community Health & Social Care Director of Nursing & Acute Services
	Lead Committee:	Integrated Joint Board
Objective(s): (See Appendix C for Board Corporate Objectives)	**Date added to RMG**	01/09/2016
	Last Revised Date:	
	Date review due:	**31/12/2016**

Risk Rating:
(Likelihood x consequence = rating)

Initial: Possible x Moderate = Medium

Current: Possible x Moderate = Medium

Target: Unlikely X Moderate = Medium

	Consequence				
Likelihood	Neg	Min	Mod	Maj	Ext
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Rationale for current score:

There are a number of factors which we cannot control entirely e.g. vacancies and sickness in the workforce, capacity and resilience of services during winter months – so whilst we have good controls and plans in place, it is still possible that these factors will impact on service delivery (whether we change the model of care or if it remains the same). There have been challenges around recruitment and retention particularly for social care workers, and the success of the Intermediate Care Team and the resilience of staffing in Care Centres and Care at Home, will rely upon our continued efforts to attract staff to these services.

On that basis, the case for change carries a 'possible' risk in respect of these factors described above (without any further mitigating controls).

Similarly, the consequences of making changes to the way we deliver community rehabilitation may impact on patient flow elsewhere in the health and social care system because of factors such as staffing, winter pressures and high levels of demand for services which against the impact assessment criteria would constitute a 'moderate' level of service disruption (without any further mitigating controls).

Risk context: (why the target score is set as it is, e.g. tension between additional controls/available resources)

We have undertaken detailed analysis of the current care requirements for people who receive non acute rehabilitation in the hospital setting to ensure that we understand the training, staffing and equipment requirements necessary to establish this service. It **is possible**, as there are challenges in recruitment across health and social care professions that we may need longer to recruit to vacant posts. Therefore the impact on the model would be **moderate** as a result of slower implementation, reducing the potential for

	savings during 2016-17 and continuing to run the risk of not being able to meet the needs of people with rehabilitation potential when the unit is full. It is also **possible**, following implementation that there will be times (as the ICT will continue to be a relatively small team) that people will need to wait for non acute rehabilitation and space on the caseload to become available from the ICT. This is the same situation we have with the delivery of the service from a hospital ward and we would continue to ensure that there was appropriate multi-disciplinary input whilst that individual was in hospital. Again, the impact of this would be **moderate** in terms of patient experience as we would ensure that the necessary support would be provided to meet agreed goals, but the lack of capacity in the ICT or beds at Montfield Support Services might impact on patient flow across the rest of the hospital (i.e. slowing down access for other patients) and create financial pressures as a result of flexing staffing levels to meet a higher level of patient care. Again, matching staffing levels to patient dependency and acuity is routine practice in the hospital setting.
Controls (what are we currently doing about mitigating the risk?) **We have a multi-agency, winter resilience plan in place for 2016-17 which sets out how we will manage high levels of service demand over the winter months.** **We review patient and service user flow across hospital and residential care facilities on a daily basis to ensure that we are able to identify and manage risks and impact on service delivery e.g. responding to higher service level demands, responding to recruitment/staffing/equipment issues etc. This demonstrates that we already have in place good, whole system planning arrangements across Health and Social Care services.** **We have reviewed the current service (and used that as a template) in order to ensure that the changes proposed are realistic and can be delivered in our community setting – plus we have looked to UK and international examples of similar services to ensure that the model is evidence based.** **We have agreed a pathway which has been developed by the practitioners who will directly deliver the service – demonstrating the pathway is evidence based, credible and realistic.** **We have reviewed the skill mix and staffing required to implement a community based model as an alternative to hospital based, non acute rehabilitation – demonstrating that the service can be delivered**	**Weaknesses or gaps in controls (where are we failing to put controls/systems in place or failing to make them effective?)** **Remote and rural services are provided by generic and often small teams of practitioners – despite the best of planning some services can become fragile and so there may be times when key staff are unavailable and we will have to adjust our pathways accordingly. This is an ongoing challenge in workforce planning across a wide range of services, some which are small occupational groups e.g. GPwSI in Older Peoples Medicine.**

in a safe and person centred/involved manner.	

Actions required to improve control (what more have we identified we should do?)	Timescale	Status (Red/Amber/Green)	Lead
Early recruitment of additional staff to the ICT where key practitioners are needed to extend the team e.g. Doctor, Physiotherapist and Occupational Therapists	**Aim to have additional practitioners in place during Q3 of 2016-17**	**GREEN**	**Individual Heads of Service**
Agree the final plans for the Joint Winter Plan 2016-17 by October 2016	**Winter Plan is being compiled and is on track**	**GREEN**	**Individual Heads of Service**
Finalise the details of the pathway e.g. individual roles and responsibilities to ensure that key decisions can be made quickly and effectively by staff who are skilled in rehabilitation medicine and care	**A project team will continue to meet through the planning phase and beyond to implementation is the proposal is supported**	**GREEN**	**Individual Heads of Service**

(Place cursor in last 'LEAD' cell and press <TAB> to get a new Action Line)

Internal Assurances (How do we know controls are in place and functioning as expected/are of sufficient quality?)	Timing	External Assurances (Are we receiving independent assurances?)
		External monitoring through published performance data on:
Daily (or more frequent depending on levels of service demand) hospital huddles are in place to ensure that we understand individual patient risks and delays in pathways	Already in place	**Stroke care outcomes (against national standards)** **Patient experience feedback**
Daily (and more frequent as necessary) sharing of information about use of resources in the hospital e.g. staffing levels and bed occupancy	Already in place	**HEAT and single outcome agreement targets including: number of people delayed in hospital for >14 days, emergency bed day rates for people admitted who are over 75, attendance rates at A&E and the proportion of older people receiving complex care at home in Shetland** **Joint Older Peoples Inspection of Health & Social Care Services**
Weekly reviews of patient pathways, to ensure that early action is taken to support people who may have a complex discharge plan – to reduce the likelihood that the individual will stay in hospital when care could be delivered in a community setting	Already in place	**Weaknesses or gaps in assurance (where are we failing to gain evidence that the controls we place reliance on are effective/where do we have gaps?)**
Current performance (with these actions taken, how serious is the problem?) We are the best improved Health & Social Care Partnership as measured against reducing the number of people who are delayed in hospital (improvement of 56% during 2015-16). We have maintained good performance against the 4 hour A&E access target and we have had minimal cancellations in planned hospital procedures – all of these measures are a marker for the performance of the whole system. Patient satisfaction as shown in locally produced and national surveys is high across our services.		**Next steps (e.g. communication - is there more we can do to focus efforts on this issue, e.g. Board paper, staff newsletter)** **Additional Comments** The IJB and the Board will receive a paper setting out the full proposal details in September and October 2016.

1. Rapid Impact Checklist

An Equality and Diversity Impact Assessment Tool:

Which groups of the population do you think will be affected by this proposal?
Other groups:

- Minority ethnic people (incl. Gypsy/travellers, refugees & asylum seekers)
- Women and men
- People with mental health problems
- People in religious/faith groups
- Older people, children and young people
- People of low income
- Homeless people
- Disabled people
- People involved in criminal justice system
- Staff
- Lesbian, gay, bisexual and transgender people

The main groups of the population affected by this proposal include: men and women, but particularly older people who may have a disability as a result of an acute illness or long term conditions. Staff are also affected by this proposal as the plan is to 'shift the balance of care' away from hospital based services and instead increase provision in the community.

N.B The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed	What positive and negative impacts do you think there may be? Following a review of the current arrangements to provide intensive, non acute rehabilitation in hospital the perceived benefits include: • Creating a team that can respond to the individual needs of a person in a way that is not so constrained by 'buildings and beds' – the ICT will be able to support people as appropriate in their own homes or in residential care whilst they participate in their programme of 'non acute rehabilitation'; • The ICT will be supported by overnight services– so there is greater scope to provide additional input to an individual overnight and avoid admission to hospital or residential care, when minimal assistance is needed. Providing care as needed overnight may also support Carers and avoid the need for a crisis response; • There is also scope for closer working with the Third Sector to provide home support services and linking the current arrangements with the proposal to extend the remit and resources available to the ICT; • The ICT will include a senior Doctor (either a GP with a Special Interest in Older Peoples Care or a Consultant Physician) who will help to co-ordinate the medical input required to support the ongoing clinical needs of individuals who are receiving support with 'non acute rehabilitation' in the community setting. This Doctor will work closely with medical staff in the community e.g. the GP and Health Centre team, other clinicians in Shetland and specialist services off island for example, the Old Age Psychiatrists.

	Which groups will be affected by these impacts? People who meet the criteria for 'non acute' rehabilitation Carers Staff who support hospital based rehabilitation (on Ronas Ward and the Acute Wards) Staff who support reablement at Montfield Support Services
What impact will the proposal have on lifestyles? For example, will the changes affect: • Diet and nutrition • Exercise and physical activity • Substance use: tobacco, alcohol and drugs? • Risk taking behaviour? • Education and learning or skills?	The model is aimed about supporting people to meet their recovery goals – this may include a level of personal risk taking in order to support an individual who has capacity to make their own decisions in a way that represents 'positive risk taking' and 'realistic medicine'. For example, an individual may have an overriding desire to stay at home, accepting that they have a high falls risk for instance but would rather deal with the balance of risk than spend additional time in hospital etc. In which case, we would support that plan with resources to the best of our ability e.g. using telecare, input from community care services, volunteers and family for as long as that plan was safe and sustainable.
Will the proposal have any impact on the social environment? Things that might be affected include: • Social status • Employment (paid or unpaid) • Social/Family support • Stress • Income	Perceived positive impacts on an individual's social circumstances/environment: Reduced length of stay in hospital – less exposure to harm e.g. infections Promotes early opportunity to return home to their family and social network - supporting positive relationships/quality of life and reducing likelihood of low mood/isolation Potential better support for carers – through input from the ICT at home Potential reduction in costs e.g. less reliance on care packages and respite services
Will the proposal have any impact on the following?	The proposal should have a positive impact on equality of access to services – currently 'non acute' rehabilitation is only available in the hospital setting. Developing a community based approach

• Discrimination? • Equality of opportunity? • Relations between groups?	means there is more scope for providing support to individuals in residential care and at home, not just in the hospital setting.
Will the proposal have an impact on the physical environment? For example, will there be impacts on: • Living conditions? • Working conditions? • Pollution or climate change? • Accidental injuries or public safety? • Transmission of infectious disease?	Yes, the proposal suggests that 'non acute' rehabilitation is provided in an individual's own home or a residential care setting. Therefore, staff who work in the ICT will need to take the physical environment into consideration – ensuring that lone working and moving and handling issues are risk assessed/addressed. The provision of community based rehabilitation promotes infection prevention measures as the individual is likely to be in an environment where they are less susceptible to infections. Undertaking assessments in a person's own home also provides a more realistic picture of how well they can cope at home (e.g. as opposed to assessments in a hospital setting).
Will the proposal affect access to and experience of services? For example, • Health care • Transport • Social services • Housing services • Education	The proposal should not negatively affect a person's experience of the service in that the package of support to aid their rehabilitation and recovery goals will be the same/comparable to the current model in hospital. Access to healthcare will be the same/comparable to the current model in hospital. Access to social care will be the same/comparable to the current model in hospital.

Rapid Impact Checklist: Summary Sheet	
Positive Impacts (Note the groups affected) See above	**Negative Impacts (Note the groups affected)** See above
Additional Information and Evidence Required	
Recommendations If the proposal is approved, then as part of the implementation we will evaluate the roll out of the model, but a full EQIA is not indicated at this stage.	
From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not? No specific risks/impacts identified for other equality groups not already noted. A full EQIA is not recommended at this stage – we already have a range of community based services which operate effectively, based on this model of care.	

Appendix F Setting out the current and proposed staffing models with costs

Current model

Table 3 Intermediate Care Team (Current establishment)

Role	WTE	Comments
Nurse (Team Lead)	1.0	Commitment to the ICT varies depending on community nursing caseload
OT	1.0	1.5 Funded
Physiotherapist	1.0	Input is currently provided flexibly around caseload of physiotherapy team
Rehabilitation Support Workers	7.0	4.8 WTEs in post.

Table 4 Intensive rehabilitation team aligned to Ronas Ward (current establishment)

Role	WTE	Comments
RGN	9.19	The ratio of nursing staff is to ensure that we meet RCN standards for older peoples care in a hospital setting and 2 staff are on duty where possible to ensure we are not at deminimus levels
HCSWs	3.72	
Physiotherapist	1.67	This post is currently covered by B5 WTE 1.0 Physiotherapist and B4 WTE 0.67 Physiotherapy Assistant
OT	0.6	The OT input requirements are variable but WTE 0.4 as a minimum has been needed over the last 3 months
Consultant	0.1	One session per week is aligned to case conferences

Table 5 Montfield Support Services (MSS)[1] (current establishment)

Role	WTE	Comments
Social Care Workers	17.04	
Senior Social Care Workers	2.8	

Table 5a Virtual team supporting MSS (current establishment)

[1] The staffing levels will remain the same at MSS in the new model.

Role	WTE	Comments
GP		An approximate calculation of GP is being identified.
Community Nurse	0.6	Community Nurses support between 100-150 visits per month which equates to approximate WTE shown.
Advanced Practitioner – Oncology Specialist Nurse	0.3	Three visits per week from an advanced nurse practitioner.

Table 6 Proposed staffing model to provide community based rehabilitation and reablement (Phase 1 – enhanced, consistent service in Lerwick/Central locality)

Role	WTE	Funding[2]	Comments
Nursing Lead (Team Leader)	1	NHS	This could be an ANP with elderly care or community care background.
Doctor	0.3	ICF	
Rehabilitation Support Workers	7	ICF	
Physiotherapist	1	ICF	
OT	3	ICF	
Advanced Nurse Practitioner	0.4	ICF	
Admin Support	0.2	NHS	

Table 7 Clinicians who are part of the 'virtual' intermediate care team[3]

Role	WTE	Funding	Comments
Community Nurses	0.6	NHS	
Clinical Pharmacist	0.1	NHS	
Advanced Practitioner – Oncology Specialist Nurse	0.3	NHS	
Community OT/Social Worker (based in localities)	TBC	SIC	Within existing resources

[2] All of the funding sits within the strategic commissioning arrangements for the IJB, but the funding streams e.g. core Council, core NHS and pump priming funding from the Integrated Care Fund (ICF) are shown

[3] Providing sessional support rather than dedicated role within the ICT

Integrated Care Fund (ICF) ***[£410,000 available]***	**WTE**	**Indicative Cost**	**Funding Source**	**Service/Project Status**
Proposed Intermediate Care Model				
Team Leader	1	£54,780	£49302 from Ronas Staffing Budget the remainder from the ICF	Recurrent
Physiotherapist	1	£46,708	ICF	Recurrent
OT	3	£140,124	ICF	Recurrent
Rehabilitation Support Worker	7	£209,279	ICF	Recurrent
Administrator	0.2	£5,388	ICF	Recurrent
Advanced Nurse Practitioner	0.4	£21,912	ICF	Recurrent
GP	0.3	£30,000	ICF	Recurrent
Grand Total		**£508,191**		
Total of which is aligned to the ICF		**£458,889**		

Other Projects Aligned to the ICF in 2016-17	**WTE**	**Indicative Cost**	**Service/Project Status**
Neuro-physiotherapist	NA	£16,906	Non Recurrent
Anticipatory Care	NA	£15,627	Non Recurrent
Hearing Impairment Training	NA	£16,000	Non Recurrent
Third Sector - Support at Home	NA	£30,000	Non Recurrent
Contingency Fund	NA	£30,000	Non Recurrent
Total aligned to the ICF in 2016-17 only		**£108,533**	

Social Care Fund (Additionality for Social Care Services) ***[£512,000 available]***	**WTE**	**Indicative Cost**	**Service/Project Status**
Social Worker - Hospital Liasion	NA	£78,330	Review Relative Priority Annually
Reablement Programme Support to Care Centres	NA	£86,100	Review Relative Priority Annually
Self Directed Support Packages	NA	£347,570	Review Relative Priority Annually
Total		**£512,000**	

Appendix G Glossary of Terms

Term	Definitions
Intermediate care	A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. Intermediate care services are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less. Intermediate care should be available to adults age 18 or over.
Crisis response	Community based services provided to service users in their own home/care home, with an expected standard response time of less than 4 hours. Crisis response services will typically provide an assessment and some may provide short-term interventions (usually up to 48 hours) with the aim of avoiding hospital admission. Services are usually delivered by the multi-disciplinary team, but predominantly by health professionals.
Non acute rehabilitation	Non acute rehabilitation is the point in an individual's recovery when they are clinically stable and acute care/treatment is no longer required (e.g. the individual has ongoing care needs but does not meet the criteria for hospital based complex care). Non acute rehabilitation can be delivered in a range of settings included bed based intermediate care services or home based services.
Bed based rehabilitation	Bed based intermediate care services are provided within a community hospital, residential care home, nursing home, or other bed based setting with the aim of preventing unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital. Services are usually delivered by the multi-disciplinary team, but predominantly by health professionals and carers (in care homes).
Home based rehabilitation and recovery	Community based services provided to service users in their own home/care home. These services will usually offer assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living. Services are usually delivered by the multi-disciplinary team, but predominantly by health professionals and carers (in care homes).
Re-ablement	Community based services provided to service users in their own home/care home. These services help people recover skills and confidence to live at home and maximise their independence. Services are usually delivered by the multi-disciplinary team, but predominantly by social care professionals.
Step up	Intermediate care function to receive patients from home/community settings to prevent unnecessary acute hospital admissions or premature admissions to long term care.
Step down	Intermediate care function to receive patients from acute care for rehabilitation and to support timely discharge from hospital.

Agenda Item

5

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Risk Registers – IJB -*Cover*
Reference Number:	CC-62-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

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

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

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

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

Agenda Item

5

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Risk Register – IJB
Reference Number:	CC-62-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

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

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

2. Background

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

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

2.3 Risk IJB023 relates to the Mental Health Service. The residual risk rating remains high whilst interim capacity is being put in place and pending reviews of particular functions within the service.

3. Conclusions

3.1 Embedding a structured and consistent approach to managing risk ensures that the IJB is best placed to direct the mitigation of risk.

3.2 The role of the IJB is to review and direct on any issues which they see as significant to sustaining and progressing service delivery in order that the IJB continues to meet its strategic aims set out in the 2016/17-19 Strategic Plan.

Contact Details:

For further information please contact:
Simon Bokor-Ingram
Director of Community Health and Social Care
E-mail: *simon.bokor-ingram@nhs.net* or *simon.bokor-ingram@shetland.gov.uk*
Telephone: 01595 743087
9 September 2016

Appendices
Appendix 1 – IJB Risk Register

Background documents
Community Health & Social Care Directorate Plan

Risk Assessment - Integration Joint Board

Responsible Officer: Simon Bokor-Ingram, Director Community Health & Social Care

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Controlled Probability	Controlled Impact	Controlled Risk Profile
Category	**Corporate**						
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*						
IJB0003 - Policies - effect of - Health & Social Care Integration governance arrangements through the Integration Joint Board are not fully implemented. Risk that when in place they will not be effective.	Unlikely	Major	Medium	Governance arrangements in place. Internal and external audit to scrutinise effectiveness of governance arrangements with reports and actions presented to IJB Audit Committee.	Unlikely	Significant	Medium
IJB0017 - Policies - effect of - Strategic Planning for Health & Social Care is ineffective. The Strategic Plan does not reflect the needs of communities and identify appropriate communication strategies.	Unlikely	Major	Medium	Participation and Engagement Strategy in place. Action plans developed for the preparation of the strategic plan. Strategic planning group in place. Work in localities is being developed engaging with a wide range of stakeholders including staff, service users, other service providers, community representatives.	Unlikely	Significant	Medium
IJB0018 - Policies - effect of - The IJB fails to direct service delivery to meet the outcomes required, these include local and national outcomes, service standards and quality measures and targets.	Unlikely	Major	Medium	Direction will be through the detail of the strategic plan. The strategic plan for 2016/17-19 has been approved by the IJB. Quarterly performance monitoring is well established.	Unlikely	Significant	Medium
IJB0019 - Partnership working failure - Failure of the IJB to agree a Strategic Plan or Budget proposals. Failure to agree the budget or a budget recovery plan for any identified shortfalls in budget allocations to the IJB could lead to overspend or a lack of direction to the Council and the Health Board through the commissioning process.	Likely	Major	High	Where failure of the IJB to agree means there is a dispute between the Council and the Health Board then a dispute resolution mechanism in the integration scheme can be used. IJB standing orders also cover any failure to agree. IJB has agreed proposals for a 2016/17-19 Strategic Plan and for 2016/17 budgets. A recovery plan has been presented to the IJB because of pressures in the health budgets.	Possible	Major	High
IJB0020 - Partnership working failure - Poor attendance or lack of commitment to the IJB from among its members.	Likely	Major	High	Need to look at ways of taking into account the diverse commitments of members. In particular clinical commitments of clinicians on the IJB. Commitment has been given to find backfill and look at individual work plans.	Possible	Significant	Medium
IJB0021 - Technological - Other - Failure to provide adequate corporate services support to the IJB eg. finance, legal, committee services, ICT & HR	Possible	Major	High	During the implementation phase (2014 and 2015) the transition programme board brought together representatives of corporate support services from the council and the Health Board. A link group will continue to meet under the direction of the Director of Corporate Services in order to ensure a co-ordinated approach to Corporate support services. Key joint groups will continue to work on key technical areas. These include the Local Partnership Finance Team, Joint Staff Forum and Data Sharing Partnership	Unlikely	Significant	Medium

Risk Assessment - Integration Joint Board

Responsible Officer: Simon Bokor-Ingram, Director Community Health & Social Care

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Controlled Probability	Controlled Impact	Controlled Risk Profile
Category	**Corporate**						
IJB0022 - Policies - effect of - The IJB fails to adequately identify community needs through the planning processes and is unable to differentiate the particular differences between localities and so cannot begin to address issues arising within a defined community.	Possible	Major	High	Locality planning in the development of the Strategic Plan. The planning process for the Strategic Plan 2016-19 included conversations at a locality level. Locality leads need to be identified.	Unlikely	Significant	Medium
IJB023 - Modernisation - too slow - Inability to deliver safe and effective Mental Health services. Unable to deliver the strategic aims and objectives for mental health as set out in the 2016/2017-19 Strategic Commissioning Plan.	Almost Certain	Major	High	NHS Shetland recognise the risk of not being able to deliver the mental health service and are updating their Corporate Risk Register. A range of measures are in place to support the existing team so that they can deliver the clinical service. Additional capacity is being procured as an interim measure.	Possible	Major	High

Agenda Item

6

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Risk Register – Community Health & Social Care Directorate
Reference Number:	CC-63-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

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

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

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

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

Agenda Item

6

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	Risk Register – Community Health & Social Care Directorate
Reference Number:	CC-63-16
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The purpose of this report is to present to the IJB the Risk Register that includes risks that affect all areas of business in the Community Health and Social Care directorate and the measures being taken to address those risks.

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

2. Background

2.1 All Directorate risks have been reviewed by the Operational Management Group which provides a high level overview of service areas risks (Appendix 1).

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

2.3 Directorate risk EM0046 has increased to a high rating as the eradication of duplication is not happening fast enough and capacity continues to be consumed running more than one system for a number of functions.

2.4 Directorate risk EM0031 has been updated and the residual risk rating increased to reflect the current challenges that exist in the Mental Health service. Mitigating actions are in place and being closely monitored.

3. Conclusions

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

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

Contact Details:

For further information please contact:
Simon Bokor-Ingram
Director of Community Health and Social Care
E-mail: simon.bokor-ingram@nhs.net or *simon.bokor-ingram@shetland.gov.uk*
Telephone: 01595 743087
9 September 2016

Appendices
Appendix 1 – Community Health & Social Care Directorate Risk Register

Background documents
Community Health & Social Care Directorate Plan

Risk Assessment - Community Health & Social Care

Responsible Officer: Simon Bokor-Ingram

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Controlled Probability	Controlled Impact	Controlled Risk Profile
Category	**Directorate**						
Corporate Plan	*F1. Our "20 by '20" - Leadership & Management*						
EM0039 - Strategic priorities wrong - Management capacity issues	Possible	Significant	Medium	The structure will ensure that there is adequate management capacity including professional leadership for adult social work. The structure for CH&SC will ensure that there is adequate management capacity including professional leadership for adult social work within the directorate.	Unlikely	Minor	Low
EM0048 - Physical - People / Property - Other - CH&SC has a high number of staff performing relatively physical tasks. If staff are injured through manual handling, they may be off work, they may allege negligence by the organisation and make a civil claim, and it may lead to a shortage of staff.	Possible	Significant	Medium	Moving and handling training part of yearly plan for staff development. Risk assessment processes in place for clients/patients	Unlikely	Significant	Medium
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*						
EM0034 - Professional Errors and Omissions - Services operate within a complex legislative, contractual and compliance environment. Clients/ patients are many and varied in age, vulnerabilities and needs	Unlikely	Significant	Medium	Monitoring by professional leads re skills and capacity. Staff training plan developed each year. Incidents fully investigated. Clinical, Care & Professional Governance Committee structure in place.	Rare	Significant	Low
Corporate Plan	*F6. Our "20 By '20" - Financial Management*						
EM0035 - Demographic change - Maintaining and improving the oral health of the local population	Likely	Major	High	Review taking place of current Dental Service staffing levels and skill mix to ensure the model in place is working effectively with flexibility for the future. Encourage local development of independent NHS dental practices to help mitigate this risk	Possible	Minor	Medium
Corporate Plan	*F8. Our "20 by '20" - Efficient*						
EM0031 - Modernisation - too slow - Inability to deliver safe and effective Mental Health services. Absence through sickness of key staff in service.	Almost Certain	Major	High	Refresh of mental health action plan which is being closely monitored. Additional personnel being procured to ensure adequate capacity. Consultant Clinical Psychologist recruited to start November 2016.	Possible	Major	High
Category	**Operational**						
Corporate Plan	*F2. Our "20 By '20" - Staff Value & Motivation*						
EM0044 - Key staff - loss of - Difficulty in ensuring sustainable provision of services and retention of skills in small and remote communities.	Likely	Significant	High	Cover provided using permanent or temporary staff. Temporary cover provided by community and hospital staff banks. Use of agency locum staff as a last resort. More focussed approach to supervision and performance management to aid staff retention. Good workforce development plan - long term monitoring of key posts and review of recruitment processes.	Possible	Significant	Medium

Risk Assessment - Community Health & Social Care

Responsible Officer: Simon Bokor-Ingram

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Controlled Probability	Controlled Impact	Controlled Risk Profile
Category	**Directorate**						
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*						
EM0007 - Partnership working failure - Conflict of interest between roles of NHS and Council.	Possible	Significant	Medium	There is a mechanism for calling an informal Liaison Group at a senior level for members of the Council, Health Board and IJB to discuss issues which cannot be resolved through other channels and where the Group can then inform any remedial action required.	Unlikely	Minor	Low
EM0018 - Legal / Compliance - Other - NHS and SIC are required to comply with Scottish Social Services Council and National Care Standards	Possible	Significant	Medium	Regular inspections; Staff aware of the standards required. Recent joint inspection of older people's services will give overview of quality	Rare	Significant	Low
EM0023 - Business continuity plan inadequate - Response to an emergency situation	Possible	Significant	Medium	Business continuity plans in place for community health and social care services. Involvement in planning and exercises.	Possible	Minor	Medium
Category	**Strategic**						
Corporate Plan	*B2. Older People - Independent Living*						
EM0021 - Legal - Other - Inability to provide consistent, high quality, sustainable Out of Hours Care	Likely	Major	High	Opportunities to extend ANP model. National review of out of hours primary care delivery with local project in place. Community Nursing review will consider level of out of hours provision.	Unlikely	Minor	Low
Corporate Plan	*B5. Older People - Integrated Health And Social Care Services*						
EM0002 - Deadlines - failure to meet - Delayed Discharges	Possible	Significant	Medium	Create capacity through use of Integrated Care Fund with rapid access to resources which avoid unnecessary hospital admission and expedite timely discharge. Whole system approach to reducing bottlenecks in the pathway.	Possible	Minor	Medium
Corporate Plan	*D1. Community Strength - Community Support*						
EM0004 - Staff number/skills shortage - Reduced response to an emergency situation on Remote areas of Shetland and the outer islands	Unlikely	Major	Medium	Emergency response arrangements in place. Coastguard Search and Rescue Helicopter will respond to life and limb threatening injuries/illness Memorandum of Understanding in place with Direct Flight for transfer of "walking wounded" NHS Shetland continuing discussions with SAS and GAMA regarding additional helicopter coverage, especially for urgent (rather than emergency) transfer Temporary control measure (for managing situation short term) to ensure staff on NDI have increased stock of Oxygen and consumables Longer term need to conduct training needs analysis and increase staff skill set to support ill patients for longer period of time (if timeliness of air evacuation options not enhanced) Continue to develop First Responder schemes on NDIs to support the nurse in caring for critically ill patient	Unlikely	Major	Medium

Risk Assessment - Community Health & Social Care
Responsible Officer: Simon Bokor-Ingram

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Controlled Probability	Controlled Impact	Controlled Risk Profile
Category	**Directorate**						
Corporate Plan	*F13. Our "20 By '20" - Workforce Planning*						
EM0014 - Key staff - loss of - Inability to recruit to key posts	Likely	Significant	High	Work closely with both HR departments on recruitment and retention. Develop schemes to attract people to health and care work. Develop dynamic joint health and care roles.	Possible	Minor	Medium
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*						
EM0013 - Economic - Other - Adult Protection Issues	Possible	Minor	Medium	The professional leads are tasked with ensuring that there are adequate levels of skill and capacity to manage protection issues. Training is a key requirement for staff working in services so they have the knowledge to raise issues. Training on Adult Protection being prioritised. Adult Protection included in the clinical and care governance framework.	Unlikely	Minor	Low
Corporate Plan	*F6. Our "20 By '20" - Financial Management*						
	Possible	Significant	Medium	SLAs in place. Joint Commissioning & Procurement Strategy being developed.	Unlikely	Minor	Low
EM0016 - Economic - Other - Not achieving full use of the Integrated Care Fund	Likely	Significant	High	Plans are reflected in the Strategic Plan. Early development of plans.	Possible	Minor	Medium
EM0045 - Failure of Key supplier - Budgets / Service planning	Likely	Significant	High	The Strategic Plan sets out direction and more detailed plans on how to spend specific funds. Need to better co-ordinate service planning and budget setting through the IJB to ensure budget is aligned to agreed service priorities.	Possible	Minor	Medium
Corporate Plan	*F8. Our "20 by '20" - Efficient*						
EM0046 - Customer / Citizen - Other - Task Duplication	Almost Certain	Significant	High	Agreement for lead organisation for functions or on use of one template and/or system. Clinical and care governance framework in place. Duplication still exists for some key functions	Almost Certain	Significant	High

Agenda Item

7

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board Audit Committee Integration Joint Board
Date:	26 September 2016
Report Title:	Annual Audit Report on the 2015/16 Audit - *Cover*
Reference Number:	CC-69-16 F
Author / Job Title:	Karl Williamson / IJB Chief Financial Officer

Decisions / Action required:

The IJB Audit Committee is asked to RESOLVE to:

a) Note Audit Scotland's Annual Audit Report on the 2015/16 Audit.

The IJB is asked to RESOLVE to:

a) Note Audit Scotland's Annual Audit Report on the 2015/16 Audit.
b) Approve the Action Plan.

High Level Summary:

IJBs are specified in legislation as 'Section 106' bodies under the terms of the Local Government (Scotland) Act 1973, so are expected to prepare their financial statements in compliance with the Code of Practice on Local Government Accounting in the United Kingdom. These Annual Accounts are then subject to external audit. Audit Scotland is currently the IJB's nominated auditors.

The purpose of this report is to receive Audit Scotland's Annual Audit Report on the 2015/16 Audit.

Corporate Priorities and Strategic Aims:

The IJB is a separate legal entity, accountable for the stewardship of public funds and expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities.

Section 95 of the Local Government (Scotland) Act 1973 requires that every local authority shall make arrangements for the proper administration of their financial affairs. One of the key controls for financial management is the preparation of annual accounts which will be submitted for external audit.

Key Issues:

Audit Scotland has issued an unqualified independent auditor's report on the 2015/16 financial statements. They have been prepared in accordance with accounting

regulations and guidance.

Implications :	
Service Users, Patients and Communities:	None
Human Resources and Organisational Development:	None
Equality, Diversity and Human Rights:	None
Partnership Working	The core nature of the IJB represents joint working between Shetland Islands Council and NHS Shetland.
Legal:	None
Finance:	There a no financial implications arising from this report.
Assets and Property:	None
Environmental:	None
Risk Management:	The Annual Audit Report includes the identification of key risks and internal control arrangements in place to manage those risks, together with any improvement actions required.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB Audit Committee remit includes consideration of all reports from the external auditors, including the External Auditor's Annual Report and to review the IJB's financial performance as contained in the Annual Report. Receiving the audited accounts of the IJB and related certificates and reports is a matter reserved by the IJB.
Previously considered by:	This report has not been presented at any formal meeting.

Agenda Item

7

Shetland Islands Council

Meeting:	Integration Joint Board Audit Committee Integration Joint Board
Date:	26 September 2016
Report Title:	Annual Audit Report on the 2015/16 Audit
Reference Number:	CC-69-16 F
Author / Job Title:	Karl Williamson/IJB Chief Financial Officer

1. Summary

1.1 The purpose of this report is to receive Audit Scotland's Annual Audit Report on the 2015/16 Audit.

2. Detail

2.1 The IJB is required to prepare and publish a set of Annual Accounts within a set timetable, which are then subject to external audit. Audit Scotland is currently the IJB's nominated auditors.

2.2 The Local Authority Accounts (Scotland) Regulations 2014 require elected Members to consider the report issued by the appointed auditor as a communication to those charged with governance on the audit of the Annual Accounts.

2.3 International Standard on Auditing 260 (ISA 260) requires that external auditors to communicate significant findings from the audit, including:

- the auditor's views about significant qualitative aspects of the entity's accounting practices, including accounting policies, accounting estimates and financial statement disclosures
- significant difficulties encountered during the audit
- significant matters arising from the audit that were discussed, or

subject to correspondence with management

- written representations requested by the auditor
- other matters which in the auditor's professional judgement, are significant to the oversight of the financial reporting process

2.4 Audit Scotland's ISA 260 report is included at Appendix 1 to this Report. This confirms that Audit Scotland will be certifying the accounts as being a true and fair statement of the IJB's financial position at 31 March 2016.

2.6 The Annual Audit Report is included at Appendix 2 and this contains one risk that requires to be addressed by the IJB. An Action Plan to address this issue has been drawn up and is included as Appendix IV: Action Plan (part of Appendix 2). The Action Plan is realistic and achieveable within the timescales identified.

3. Conclusions

3.1 Audit Scotland has provided an Annual Audit Report on the 2015/16 audit.

3.2 Audit Scotland will be certifying the accounts as being a true and fair statement of the IJB's financial position at 31 March 2016 and an unqualified independent auditors report has been issued.

3.3 Areas of risk have been identified in the Annual Audit Report which officers are required to address. An Action Plan has been agreed to ensure that those risks are well managed and resolved, within a reasonable time frame.

For further information please contact:
Karl Williamson
IJB Chief Financial Officer
E-mail: karlwilliamson@nhs.net
Telephone: 01595 743301
16 September 2016

Appendices:
Appendix 1 – Audit Scotland ISA 260 Report 2015/16
Appendix 2 – Audit Scotland Annual Audit Report 2015/16

Background documents:

The Local Authority Accounts (Scotland) Regulations 2014

END

4th Floor, South Suite
8 Nelson Mandela Place
Glasgow
G2 1BT

T: 0131 625 1500
E: info@audit-scotland.gov.uk
www.audit-scotland.gov.uk

AUDIT SCOTLAND

September 2016

Shetland Islands Health & Social Care Partnership
2015/16 Annual Audit Report

1. International Standard on Auditing (UK and Ireland) 260 (ISA 260) requires auditors to report specific matters arising from the audit of the financial statements to those charged with governance of a body in sufficient time to enable appropriate action. We are drawing to your attention matters for your consideration before the financial statements are approved and certified. We also present for your consideration our draft annual report on the 2015/16 audit which identifies significant findings from the financial statements audit. The section headed "Significant findings from the audit in accordance with ISA260" in the attached annual audit report sets out the issues identified. This report will be issued in final form after the financial statements have been certified.

2. Our work on the financial statements is now substantially complete. Subject to the satisfactory conclusion of any outstanding matters, we anticipate being able to issue an unqualified auditor's report (the proposed report is attached at Appendix A). There are no anticipated modifications to the audit report.

3. In presenting this report to the Audit Committee we seek confirmation from those charged with governance of any instances of any actual, suspected or alleged fraud; any subsequent events that have occurred since the date of the financial statements; or material non-compliance with laws and regulations affecting the entity that should be brought to our attention.

4. We are required to report to those charged with governance all unadjusted misstatements which we have identified during the course of our audit, other than those of a trivial nature and request that these misstatements be corrected. We have no unadjusted misstatements to bring to your attention.

5. As part of the completion of our audit we seek written assurances from the Proper Officer on aspects of the financial statements and judgements and estimates made. A draft letter of representation under ISA580 is attached at Appendix B. This should be signed and returned by the Proper Officer with the signed financial statements prior to the independent auditor's opinion being certified.

APPENDIX A: Proposed Independent Auditor's Report

Independent auditor's report to the members of the Shetland Islands Health and Social Care Partnership and the Accounts Commission for Scotland

I certify that I have audited the financial statements of Shetland Islands Health and Social Care Partnership for the period ended 31 March 2016 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Statement of Income and Expenditure, Balance Sheet and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the 2015/16 Code).

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 125 of the Code of Audit Practice approved by the Accounts Commission for Scotland, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Respective responsibilities of the Chief Financial Officer and auditor

As explained more fully in the Statement of Responsibilities, the Chief Financial Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland) as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. Those standards require me to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances of the Shetland Islands Health and Social Care Partnership and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Financial Officer; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the Annual Accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view in accordance with applicable law and the 2015/16 Code of the state of the affairs of the Shetland Islands Health and Social Care Partnership as at 31 March 2016 and of the income and expenditure for the period then ended; and
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Opinion on other prescribed matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014; and
- the information given in the Management Commentary for the period for which the financial statements are prepared is consistent with the financial statements.

Matters on which I am required to report by exception

I am required to report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or
- I have not received all the information and explanations I require for my audit; or
- the Annual Governance Statement has not been prepared in accordance with Delivering Good Governance in Local Government; or

I have nothing to report in respect of these matters.

David McConnell, MA, CPFA

Audit Scotland
4th Floor, South Suite
8 Nelson Mandela Place
Glasgow
G2 1BT

September 2016

APPENDIX B: Letter of Representation (ISA 580)

To be reproduced on letterhead and returned with the signed accounts

David McConnell, Assistant Director
Audit Scotland
4th Floor, South Suite
8 Nelson Mandela Place
Glasgow
G2 1BT

September 2016

Dear David

Shetland Islands Health and Social Care Partnership
Annual Accounts 2015/16

1. This representation letter is provided in connection with your audit of the financial statements of Shetland Islands Health and Social Care Partnership for the year ended 31 March 2016 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the financial position of Shetland Islands Health and Social Care Partnership, as at 31 March 2016 and its income and expenditure for the year then ended.

2. I confirm to the best of my knowledge and belief, and having made appropriate enquiries of the Audit Committee, the following representations given to you in connection with your audit of Shetland Islands Health and Social Care Partnership Integration Joint Board for the period from 27 June 2015 to 31 March 2016.

General

3. I acknowledge my responsibility and that of Shetland Islands Health and Social Care Partnership for the financial statements. All the accounting records requested have been made available to you for the purposes of your audit. All material agreements and transactions undertaken by Shetland Islands Health and Social Care Partnership have been properly reflected in the financial statements. All other records and information have been made available to you, including minutes of all management and other meetings.

4. The information given in the Management Commentary and Remuneration Report to the financial statements, presents a balanced picture of Shetland Islands Health and Social Care Partnership and is consistent with the financial statements.

5. I confirm that the effects of uncorrected misstatements are immaterial, individually and in aggregate, to the financial statements as a whole. I am not aware of any uncorrected misstatements other than those identified in the auditor's report to those charged with governance (ISA 260).

Financial Reporting Framework

6. The financial statements have been prepared in accordance with 2015/16 Code of Practice on Local Authority Accounting in the United Kingdom 2015/16, and in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003 and directions

made thereunder by the Scottish Ministers including all relevant presentation and disclosure requirements.

7. Disclosure has been made in the financial statements of all matters necessary for them to show a true and fair view of the transactions and state of affairs of Shetland Islands Health and Social Care Partnership for the period from 27 June 2015 to 31 March 2016.

Accounting Policies & Estimates

8. All material accounting policies adopted are as shown in the Accounting Policies included in the financial statements. The continuing appropriateness of these policies has been reviewed since the introduction of IAS 8 and on a regular basis thereafter, and takes account of the requirements set out in the 2015/16 Code of Practice on Local Authority Accounting.

9. The significant assumptions used in making accounting estimates are reasonable and properly reflected in the financial statements. There are no changes in estimation techniques which should be disclosed due to their having a material impact on the accounting disclosures.

Going Concern

10. The Board has assessed Shetland Islands Health and Social Care Partnership's ability to carry on as a going concern, as identified in the Accounting Policies, and have disclosed, in the financial statements, any material uncertainties that have arisen as a result.

Related Party Transactions

11. All transactions with related parties have been disclosed in the financial statements. I have made available to you all the relevant information concerning such transactions, and I am not aware of any other matters that require disclosure in order to comply with the requirements of IAS24, as interpreted by the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16.

Events Subsequent to the Date of the Balance Sheet

12. There have been no material events since the date of the Balance Sheet which necessitate revision of the figures in the financial statements or notes thereto including contingent assets and liabilities.

13. Since the date of the Balance Sheet no events or transactions have occurred which, though properly excluded from the financial statements, are of such importance that they should be brought to your notice.

Corporate Governance

14. I acknowledge as Chief Financial Officer my responsibility for the corporate governance arrangements. I confirm that I have disclosed to the auditor all deficiencies in internal control of which I am aware.

15. The corporate governance arrangements have been reviewed and the disclosures I have made are in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16. There have been no changes in the corporate governance arrangements or issues identified, since the 31 March 2016, which require disclosure.

Fraud

16. I have considered the risk that the financial statements may be materially misstated as a result of fraud. I have disclosed to the auditor any allegations of fraud or suspected fraud affecting the financial statements. There have been no irregularities involving management or employees who have a significant role in internal control or that could have a material effect on the financial statements.

Assets

17. The assets shown in the Balance Sheet on at 31 March 2016 were owned by Shetland Islands Health and Social Care Partnership, other than assets which have been purchased under operating leases. Assets are free from any lien, encumbrance or charge except as disclosed in the financial statements.

Liabilities

18. All liabilities have been provided for in the books of account, including the liabilities for all purchases to which title has passed prior to 31 March 2016.

Carrying Value of Assets and Liabilities

19. The assets and liabilities have been recognised, measured, presented and disclosed in accordance with Code of Practice on Local Authority Accounting in the United Kingdom 2015/16. There are no plans or intentions that are likely to affect the carrying value of classification of the assets and liabilities within the financial statements.

Provisions

20. Provisions have been made in the financial statements for all material liabilities which have resulted or may be expected to result, by legal action or otherwise, from events which had occurred by 31 March 2016 and of which Shetland Islands Health and Social Care Partnership could reasonably be expected to be aware. The amount recognised as a provision is the best estimate of the expenditure likely to be required to settle the present obligation at 31 March 2016.

Yours sincerely

Chief Financial Officer (Proper Officer)

AUDIT SCOTLAND

Shetland Islands Integration Joint Board

2015/16 Annual Audit Report for members of Shetland Islands Integration Joint Board and the Controller of Audit

September 2016

Key contacts

David McConnell, Assistant Director
dmcconnell@audit-scotland.gov.uk

Patricia Fraser, Audit Manager
pfraser@audit-scotland.gov.uk

Graeme Samson, Senior Auditor
gsamson@audit-scotland.gov.uk

Audit Scotland
4th floor, South Suite
8 Nelson Mandela Place
Glasgow
G2 1BT
Telephone: 0131 625 1500
Website: www.audit-scotland.gov.uk

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively (www.audit-scotland.gov.uk/about/).

David McConnell, Assistant Director, Audit Scotland is the engagement lead of Shetland Islands Integration Board 2015/16 year.

This report has been prepared for the use of Shetland Islands Integration Joint Board and no responsibility to any member or officer in their individual capacity or any third party is accepted.

Contents

Key messages

Audit of financial statements	• This is the first year that Shetland Islands Integration Joint Board (IJB) has operated, and published its accounts. • We have issued an unqualified independent auditor's report on the 2015/16 financial statements. They have been prepared in accordance with accounting regulations and guidance.
Financial management & sustainability	• Shetland Islands IJB spent over £16 million on delivering health and social care services for the residents of the Shetland Islands during the period 27 June 2015 to 31 March 2016. • Shetland Islands IJB has introduced effective financial management arrangements and the financial position is sustainable but challenging. • Regular budgetary control reports are provided to Shetland Islands IJB and to the partner bodies. • There was an underspend of £0.688 million in 2015/16 against the Shetland Islands Council (SIC) arm of the budget which was returned to the SIC as per the Integration scheme. Likewise there was an overspend of £0.367 million in the Shetland Health Board (NHS Shetland) arm of the budget which had to be funded by additional contributions from the NHS Shetland.
Governance & transparency	• Appropriate governance arrangements are in place. • We obtained audit assurance over the accuracy and completeness of financial transactions processed by the partner bodies. • Internal audit services provided to Shetland Islands IJB comply with Public Sector Internal Audit Standards. A protocol is in place which ensures all internal audit work and subsequent reports are considered by and approved by the IJB.
Best Value	• Shetland Islands IJB was one of the first established in Scotland. • An annual performance report has been published which provides details of progress against performance targets set out in the Strategic Plan.
Outlook	• Shetland Islands IJB will continue to operate in a period of austerity with reduced funding in real terms, increasing cost pressures and a growing demand for services. Shetland Islands IJB will need to demonstrate its evolving approach is making a positive impact on users and outcome measures. • It will be challenging for the IJB to develop and implement workforce strategies which enable the redesign of health and care services to meet future needs will be challenging. Current difficulties in recruiting and retaining staff may heighten this challenge.

Introduction

1. In October 2015 the Accounts Commission approved the appointment of Audit Scotland's Audit Services Group as external auditors of Shetland Islands IJB. Our audit appointment is for one year, covering the 2015/16 financial year, the first accounting period for which Shetland Islands IJB is required to prepare financial statements.

2. This report is a summary of our findings arising from the 2015/16 audit of Shetland Islands IJB. The report is divided into sections which reflect our public sector audit model.

3. The management of the IJB is responsible for:
   - preparing financial statements which give a true and fair view
   - implementing appropriate internal control systems
   - putting in place proper arrangements for the conduct of its affairs
   - ensuring that the financial position is soundly based.

4. Our responsibility, as the external auditor of Shetland Islands IJB, is to undertake our audit in accordance with International Standards on Auditing, the principles contained in the Code of Audit Practice issued by Audit Scotland in May 2011 and the ethical standards issued by the Auditing Practices Board.

5. An audit of financial statements is not designed to identify all matters that may be relevant to those charged with governance. It is the auditor's responsibility to form and express an opinion on the financial statements; this does not relieve management of their responsibility to prepare financial statements which give a true and fair view.

6. Appendix I lists the audit risks that we identified in the annual audit plan we issued in March 2016. It also summarises the assurances provided by management to demonstrate that risks are being addressed and the conclusions of our audit work Appendix II lists the reports we issued to the IJB during the year. A number of national reports have been issued by Audit Scotland during the course of the year. These reports, summarised at Appendix III, include recommendations for improvements.

7. Appendix IV is an action plan setting out our recommendations to address the high level risks we have identified during the course of the audit. Officers considered the issues and agreed to take steps to address them. The IJB should ensure it has a mechanism in place to assess progress and monitor outcomes.

8. We have included in this report only those matters that have come to our attention as a result of our normal audit procedures; consequently, our comments should not be regarded as a comprehensive record of all deficiencies that may exist or improvements that could be made.

9. The cooperation and assistance afforded to the audit team during the course of the audit is gratefully acknowledged.

Audit of the 2015/16 financial statements

Audit opinion	• We have completed our audit and issued an unqualified independent auditor's report.
Going concern	• The financial statements were prepared on the going concern basis.
Other information	• We review and report on other information published with the financial statements, including the management commentary, annual governance statement and the remuneration report. We consider whether these reports have been properly prepared, comply with extant guidance and are consistent with the financial statements. • We report any material errors or omissions, any material inconsistencies with the financial statements or any otherwise misleading content. We have nothing to report in respect of the other information published as part of the annual report and accounts.

Submission of financial statements for audit

10. The Public Bodies (Joint Working) (Scotland) Act 2014 specifies that IJBs should be treated as if they were bodies falling within section 106 of the Local Government (Scotland) Act 1973. The financial statements of the IJB are prepared in accordance with the 1973 Act and the 2015/16 Code of Practice on Local Authority Accounting in the United Kingdom (the Code).

11. NHS Shetland is required to submit audited accounts by 30 June each year. The IJB had satisfactory arrangements in place to ensure that information required by its stakeholder bodies was received by specified dates to enable incorporation into the group accounts of the stakeholder bodies. This included details of balances held at the year-end, the transactions in the year and other information including assurances needed for the governance statement.

12. We received the unaudited financial statements of Shetland Islands IJB on 27 June 2016, in accordance with the agreed timetable. The working papers were of a good standard and finance staff provided good support to the audit team which assisted the delivery of the audit by the deadline.

Overview of the scope of the audit of the financial statements

13. Information on the integrity and objectivity of the appointed auditor and audit staff, and the nature and scope of the audit, were outlined in our Annual Audit Plan presented to the Audit Committee on 27 May 2016.

14. As part of the requirement to provide full and fair disclosure of matters relating to our independence, we can confirm that we have not undertaken non-audit related services. The 2015/16 agreed fee for the audit was set out in the Annual Audit Plan and as we did not carry out any work additional to our planned audit activity, the fee remains unchanged.

15. The concept of audit risk is central to our audit approach. We focus on those areas that are most at risk of causing material misstatement in the financial statements. In addition, we consider what risks are present in respect of our wider responsibility, as public sector auditors, under Audit Scotland's Code of Audit Practice.

16. During the planning phase of our audit we identified a number of risks and reported these to you in our Annual Audit Plan along with the work we proposed doing in order to obtain appropriate levels of assurance. Appendix I sets out the significant audit risks identified and how we addressed each risk.

17. Our audit involved obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error.

Materiality

18. Materiality can be defined as the maximum amount by which auditors believe the financial statements could be misstated and still not be expected to affect the decisions of users of financial statements. A misstatement or omission, which would not normally be regarded as material by amount, may be important for other reasons (for example, an item contrary to law).

19. We consider materiality and its relationship with audit risk when planning the nature, timing and extent of our audit and conducting our audit programme. Specifically with regard to the financial statements, we assess the materiality of uncorrected misstatements, both individually and collectively.

20. We summarised our approach to materiality in our Annual Audit Plan. Based on our knowledge and understanding of Shetland Islands IJB we set our planning materiality for 2015/16 at £0.190m million (or 1% of gross expenditure). Performance materiality was calculated at £0.095 million, to reduce to an acceptable level the probability of uncorrected and undetected audit differences exceeding our planning materiality level. Additionally, we set a misstatement threshold of £0.020 million (approximately 1% of planning materiality) for reporting errors. Our annual audit plan highlighted that we would report all misstatements greater than £0.020 million.

21. On receipt of the financial statements and following completion of audit testing we reviewed our materiality levels and concluded that our original calculations remained appropriate.

Evaluation of misstatements

22. All misstatements identified during the audit which exceeded our misstatement threshold have been amended in the financial statements.

23. The audit identified some presentational adjustments which were discussed and agreed with management.

Significant findings from the audit

24. International Standard on Auditing 260 requires us to communicate to you significant findings from the audit, including:

- The auditor's views about significant qualitative aspects of the entity's accounting practices, including accounting policies, accounting estimates and financial statement disclosures.
- Significant difficulties encountered during the audit.
- Significant matters arising from the audit that were discussed, or subject to correspondence with management.
- Written representations requested by the auditor.
- Other matters which in the auditor's professional judgment are significant to the oversight of the financial reporting process.

There are no matters other than those set out elsewhere in this report that we want to bring to your attention.

Future accounting and auditing developments

Audit appointment from 2016/17

25. The Accounts Commission is responsible for the appointment of external auditors to IJB's. Paragraph 1 referred to Audit Scotland's one year appointment as the auditor of Shetland IJB in 2015/16. This was restricted to one year to reflect the final year of our five year appointment as auditors of NHS Shetland and Shetland Islands Council. External auditors are appointed for a five year term either from Audit Scotland's Audit Services Group or private firms of accountants.

26. The procurement process for the new round of audit appointments was completed in March 2016**.** From next year (2016/17) Deloitte LLP will be the appointed auditor for Shetland Islands IJB.

Code of Audit Practice

27. A new Code of Audit Practice applies to public sector audits for financial years starting on or after 1 April 2016. It replaces the Code issued in May 2011. It outlines the objectives and principles to be followed by auditors.

28. The new Code increases the transparency of our work by making more audit outputs available on Audit Scotland's website. In addition to publishing all Annual Audit Reports, Annual Audit Plans and other significant audit outputs will be put on the website for all audited bodies. This is irrespective of whether the body meets in public or makes documents.

Financial management and sustainability

Budget

NHS Shetland £8.554m

Shetland Islands Council £7.747m

Total £16.301m

Outturn

NHS Shetland £8.921m

Shetland Islands Council £7.059m

Total £15.980m

Usable Reserves

There were no reserves at the end of the financial year.

Financial management

29. In this section we comment on Shetland Islands IJB's financial performance and assess Shetland Islands IJB's financial management arrangements.

30. Shetland Islands IJB does not have any assets, nor does it directly incur expenditure or employ staff, other than the Chief Officer. All funding and expenditure for Shetland Islands IJB is processed in the stakeholders' accounting records. Satisfactory arrangements are in place to identify this income and expenditure and report this financial information to Shetland Islands IJB.

31. The integration scheme between NHS Shetland and Shetland Islands Council sets out the amount to be paid by the parties to Shetland Islands IJB. Delegated baseline budgets for 2015/16 were subject to due diligence and comparison to actual expenditure in previous years.

32. Legislation empowers Shetland Islands IJB to hold reserves. The integration scheme set out the arrangements between the partners for addressing and financing any overspends or underspends. It highlights that underspends in an element of the operational budget arising from specific management action may be retained by the IJB to either fund additional in year capacity, or be carried forward to fund capacity in future years of the Strategic Plan. Alternatively, these can be returned to the partner bodies in the event of a windfall saving.

33. Where there is a forecast overspend the partner bodies must agree a recovery plan to balance the budget.

Financial performance 2015/16

34. Shetland Islands IJB set a breakeven budget for 2015/16. This was based on expenditure of £16.301 million to deliver partnership services: with £8.554 million contributed from NHS Shetland; and £7.747 million contributed by Shetland Islands Council. During the year additional contributions of £0.019 million were made from Parties to meet Integration Joint Board direct costs.

35. The actual outturn for the year was an underspend of £0.321 million for the year as illustrated in Table 1:

Table 1: Summary of financial performance

	SIC (£m)	NHSS (£m)	Total (£m)
Budgets delegated to the parties from Shetland IJB	(7,747)	(8,554)	(16,301)
Contribution from the parties to the IJB (against delegated budgets)	7,059	8,921	15,980
Variance	(688)	367	(321)

	SIC (£m)	NHSS (£m)	Total (£m)
Additional contributions from Parties to meet IJB direct costs	9	10	19
IJB Direct costs	(9)	(10)	19
Fortuitous underspend repaid to SIC	688	-	688
Additional contribution from NHS Shetland to the IJB to meet overspend	-	(367)	(367)
Final balanced position of the IJB	-	-	-

Source: Shetland Islands IJB Annual report and accounts 2015/16

36. The potential for a year end overspend in the Community Health & Social Care directorate and the whole of Acute & Specialist Services was recognised by NHS Shetland at the end of September 2015.

37. A budget deficit recovery plan was approved by NHS Shetland in November 2015 to try to ensure a break even position at the year end.

38. The recovery plan was unsuccessful and at 31 March 2016 NHS Shetland had to contribute additional funds of £0.367 million to the IJB to meet the overspend on health services.

39. The outturn position for SIC at 31 March 2016 was a favourable variance of £0.688 million and as this underspend was fortuitous it was returned to SIC. The IJB therefore finished the year with no reserves.

40. To try to create sustainability for 2016/17 and beyond the Integration Joint Board approved a programme of work between November and the end of March 2016 to develop detailed efficiency schemes, with clear timeframes. This work was done in conjunction with the work being undertaken by NHS Shetland to meet the same objectives.

Financial management arrangements

41. As auditors, we need to consider whether audited bodies have established adequate financial management arrangements. We do this by considering a number of factors, including whether:

- the Chief Financial Officer has sufficient status to be able to deliver good financial management
- standing financial instructions and standing orders are comprehensive, current and promoted within the Board
- reports monitoring performance against budgets are accurate and provided regularly to budget holders
- monitoring reports do not just contain financial data but are linked to information about performance

- IJB members provide a good level of challenge and question budget holders on significant variances.

42. The Chief Finance Officer was in post throughout the accounting year, and is responsible for ensuring that appropriate financial services are available to the IJB and the Chief Officer.

43. We reviewed the standing financial instructions and standing orders, which were created on the formation of Shetland Islands IJB. These were approved by the IJB and we consider these to be comprehensive.

44. Financial monitoring of Shetland Islands IJB budget is reported in an agreed format to the IJB, the Audit Committee, and externally to NHS Shetland and Shetland Islands Council. This is reported every quarter and ann annual review for the year to March is provided with the annual accounts.

45. Projections of the year end position are included in the budget monitoring reports. These provide information on any adjustments to the baseline budgets, together with forecast outturn for the year and reasons for variances. Income and expenditure is analysed in accordance with the joint services provided by Shetland Islands IJB. Underspends and overspends are also attributed to the relevant partner body. The IJB has responsibility for carrying out detailed scrutiny of the financial and operational performance and ensuring that prompt corrective actions are taken where appropriate.

Conclusion on financial management

46. Overall we have concluded that Shetland Islands IJB has satisfactory financial management arrangements. These support the review and scrutiny of financial performance, the achievement of financial targets, and awareness of any potential overspends.

Financial sustainability

47. Financial sustainability means that the IJB has the capacity to meet its current and future plans. In assessing financial sustainability we are concerned with whether:

- spending is being balanced with income in the short term
- long-term financial pressures are understood and planned for.

Financial planning

48. Shetland Islands IJB allocates the resources it receives from NHS Shetland and Shetland Islands Council in line with the Strategic Plan. Due diligence was undertaken to consider the sufficiency of the 2015/16 budget provided for Shetland Islands IJB. The 2015/16 budget for the IJB was set and approved prior to the IJB going live in November 2015.

49. This has not been the case for 2016/17. The IJB was unable to carry out planned due diligence on its 2016/17 budget as a result of delays to the agreement of the Scottish Government's financial plans which meant that the Shetland Islands IJB budget for 2016/17 was not formally set at the beginning of the financial year. The

Shetland Islands Council budget was set on 10 February 2016. This provided confirmation around the council element of Shetland Islands IJB funding for 2016/17. The health board budget was formally set on 28 June 2016. During the intervening period the IJB set an interim working budget at the end of February 2016, based on assumed funding from the Health Board.

50. This meant that for the first few months of 2016/17 the IJB was pursuing its strategic plan activities but there was uncertainty during this period regarding the extent to which the IJB could develop and implement its strategic plan objectives.

51. The final agreed 2016/17 budget for the services the IJB has responsibility for is £42.820m. The funding that is anticipated from each organisation has been advised as follows:

	SIC	NHS Shetland	NHS Shetland set-aside	Total
	£'000	£'000	£'000	£'000
Total	19,920	19,175	3,725	42,820

52. The report from the Chief Financial Officer in September 2016 presented to Shetland Islands IJB is reporting a projected outturn to the end of March 2017 for the IJB as an overall adverse variance of £1.255 million which represents an under spend in the Shetland Islands Council arm of the budget of £0.376 million and an over spend in NHS Shetland arm of £1.631million.

53. In the Chief Financial Officer's report is an Appendix with a detailed recovery plan designed to restore financial balance to the health care budget in 2016/17.

54. If savings plans are insufficient to deliver a break even position in 2016/17 then Shetland Islands IJB will need to consider how to address this taking account of the options set out in the Integration Scheme. It is essential that the IJB continues to monitor its financial position closely throughout the year and engages with its funding partners on a regular basis to review the financial position. With significant pressures on Shetland Islands IJB's budget, it is important that budget monitoring continues to be undertaken on a timely basis so that a financial recovery plan can be developed and agreed in time for actions to be effective.

Action Plan No. 1

Conclusion on financial sustainability

55. Overall we conclude that adequate financial planning arrangements are in place. Shetland Islands IJB's financial position is sustainable but it is challenging currently and in the foreseeable future.

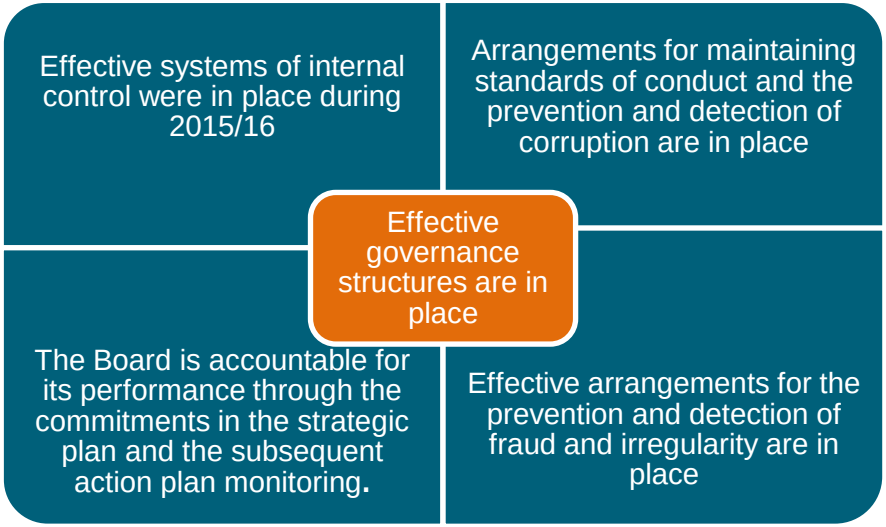
56. While there were well documented reasons why the IJB required to set an interim working budget for 2016/17, there are risks to service delivery when operating without an agreed budget.

Outlook

57. NHS boards and councils have faced several years of financial constraints and this is expected to continue in the coming years. The ageing population and increasing numbers of people with long term conditions and complex needs have already placed significant pressure on health and social care budgets. This puts further pressure on finances.

58. Strategic plans, while setting out the broad direction, will need to be clear regarding the IJB's priorities and the financing and staff that will be available over the longer term to match these priorities. It is important that they provide detail on the level of resources required in each key area and how they will shift resources towards preventative and community based care.

Governance and transparency



59. Good governance is vital to ensure that public bodies perform effectively. This can be a particular challenge in partnerships, with IJB members drawn from a wide range of backgrounds.

60. The integration scheme between Shetland Islands Council and NHS Shetland sets out the key governance arrangements. It also sets out the requirement to identify and collate a core set of indicators and measures which relate to integrated functions to enable the reporting of performance targets and improvement measures.

61. The IJB is responsible for establishing arrangements for ensuring the proper conduct of the affairs of Shetland Islands IJB and for monitoring the adequacy of these arrangements.

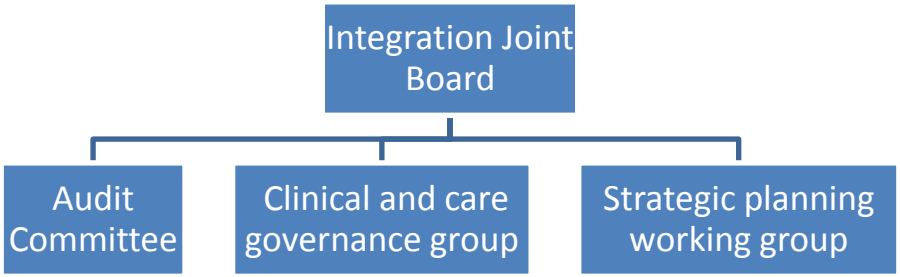
62. Shetland Islands IJB comprises a wide range of service users and partners including three elected councillors nominated by Shetland Islands Council and three Directors nominated by NHS Shetland.

63. Shetland Islands IJB is supported by a Chief Officer who provides overall strategic and operational advice to the IJB, and is directly accountable to the IJB for all of its responsibilities. The Chief Officer is also accountable to both the Chief Executive of Shetland Islands Council and the Chief Executive of NHS Shetland. The Chief Officer provides regular reports to both the Council and the NHS Board.

64. The IJB is responsible for the management and delivery of health and social care services in Shetland, and is supported by a number of groups as illustrated at Exhibit 1.

65. Shetland Islands IJB and each of the groups met on a regular basis throughout the year. We review Partnership Board minutes and Audit Committee minutes to ensure they are fulfilling their responsibilities.

Exhibit 1: Committees and Groups at Shetland Integration Joint Board



66. Standing Orders for Shetland Islands IJB were approved when it was established in June 2015. Schemes of Delegation are in place which clarify the functions delegated by Shetland Islands Council and NHS Shetland. These delegate operational management of services to the Chief Officer. We concluded that Shetland Islands IJB has appropriate governance arrangements in place and they provide a framework for effective organisational decision making.

67. A Clinical and Care Governance Group has been established which will report to the Chief Officer and through him to the IJB. The membership reflects the professional groups within Shetland Islands

IJB including nursing, medical, social work and primary care colleagues.

68. The role of the Clinical and Care Governance Group is to consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, learning, continuous improvement and inspection activity.

69. Overall we concluded that Shetland Islands IJB has appropriate governance arrangements in place and they provide a framework for effective organisational decision making.

70. Notwithstanding our overall conclusion we experienced some degree of confusion between the IJB and SIC during 2015/16 around the date the IJB officially went live. In February 2016 we were advised by the IJB that it was confirmed as live from November 2015 but the council advised us at that time that the IJB was not live. Obtaining adequate assurance of the go live date proved to be problematic and it was not until April 2016 that SIC and Audit Scotland received adequate assurance to confirm the go live date as 20 November 2015 for the IJB. No other governance matters were highlighted during 2015/16.

Internal control

71. While auditors concentrate on significant systems and key controls in support of the opinion on the financial statements, their wider responsibilities require them to consider the financial systems and controls of audited bodies as a whole. However, the extent of this work should also be informed by their assessment of risk and the activities of internal audit.

72. Shetland Islands Council and NHS Shetland are the partner bodies. All financial transactions of the Partnership are processed through the financial systems of the partner bodies and are subject to the same controls and scrutiny of the council and health board, including the work performed by internal audit.

73. Shetland Islands IJB is keen to ensure only relevant information is shared and accessed by relevant people, and therefore keeping information secure. Until the structure of service provision has been developed further each party will remain responsible for its element of data security, protection, maintenance, training and technical support.

74. We sought and obtained assurances from the external auditor of the council and health board regarding the systems of internal control used to produce the transactions and balances recorded in Shetland Islands IJB's annual accounts.

75. We also reviewed Shetland Islands IJB's budget setting and financial monitoring arrangements. We consider the systems of internal control to be effective.

Internal audit

76. Internal audit provides the IJB and Chief Officer with independent assurance on the IJB's overall risk management, internal control and corporate governance processes. Internal audit services are provided to Shetland Island's IJB by the internal auditors of Shetland Islands Council who provide a review of all internal audit reports issued in the financial year that relate to the IJB. We carried out a review of the adequacy of the internal audit functions at each of the partner bodies. We concluded that internal audit at each partner body operates in accordance with the Public Sector Internal Audit Standards (PSIAS) and has sound documentation standards and reporting procedures in place.

77. To avoid duplication of effort we place reliance on the work of internal audit wherever possible. In 2015/16 we placed reliance on internal audit's work on:

- Integration assurance
- Due diligence and governance arrangements.

78. The Chief Internal Auditor concluded that reasonable assurance can be placed on the adequacy and effectiveness of the IJB's systems of governance, risk and internal control. This assertion was based on the Chief Internal Auditor's audit work carried out at Shetland Islands Council that related to the Board and a review of internal audit reports prepared for Shetland NHS that related to the IJB.

79. As services become more integrated, transactions relating to the IJB will be more fluid between the parties. This provides a challenge to auditors since the annual audit plans of each partner are based on carrying out audit work which may be based on the accounting systems and governance arrangements that relate only to the partner that the auditor is appointed to.

Arrangements for the prevention and detection of fraud and other irregularities

80. Arrangements are in place to ensure that suspected or alleged frauds or irregularities are investigated by one of the partner bodies internal audit sections. Since Shetland Islands IJB does not directly employ staff, it has been agreed that investigations will be carried out by the internal audit service of the partner body where any fraud or irregularity originates.

81. We concluded that Shetland Islands IJB had appropriate arrangements in place for fraud detection and prevention during 2015/16.

Arrangements for maintaining standards of conduct and the prevention and detection of corruption

82. The IJB requires that all members must comply with the Standards in Public Life - Code of Conduct for Members of Devolved Public Bodies. A register of members' interests is in place for Board Members and senior officers.

83. Based on our review of the evidence we concluded that the IJB has effective arrangements in place for the prevention and detection of corruption and we are not aware of any specific issues that we need to record in this report.

Transparency

84. Shetland Islands IJB is committed to ensuring that a wide range of partners including Community Planning Partners, third sector, independent sector and communities have an opportunity to become engaged, involved and are able to contribute to the success of the IJB. The Strategic Plan and locality planning arrangements enable wider partners to engage in, and support the delivery of the Strategic Plan. The Integration Scheme sets out the requirement for the consultation and engagement of key groups.

85. In addition to Shetland Islands Council and NHS Shetland representation, Shetland Islands IJB Board includes a number of representatives from health and social care professionals, including GPs, employees, unpaid carers, service users, and the third sector.

86. Shetland Islands IJB receives regular financial monitoring reports, which are clear and concise.

87. Local residents should be able to hold Shetland Islands IJB to account for the services it provides. Transparency means that residents have access to understandable, relevant and timely information about how Shetland Islands IJB Board is taking decisions and how it is using its resources.

88. Shetland Islands IJB has its own website which contains information about services provided by the IJB and details of the meetings held by the IJB, including access to committee papers and minutes of meetings.

89. Members of the public can attend meetings of Shetland Islands IJB. A significant amount of Shetland Islands IJB's business is transacted through the Audit Committee, or through the groups listed at Exhibit 1. Minutes and related papers for Shetland Islands IJB Board and Audit Committee are available on Shetland Islands IJB's websites which highlights that Shetland Islands IJB demonstrates transparency.

90. Overall we concluded that the IJB is sufficiently open and transparent.

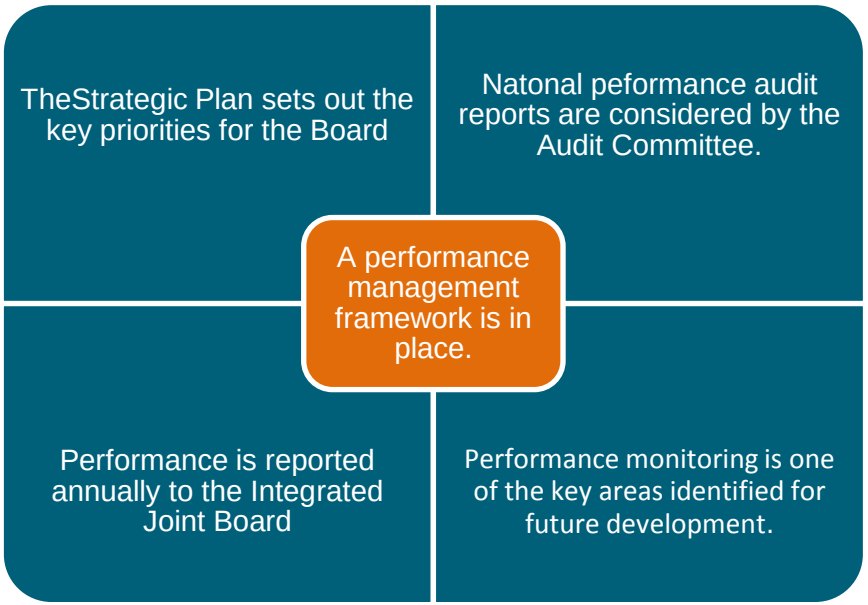
Outlook

91. Shetland Islands IJB faces continuing challenges on a number of fronts including mounting financial challenges, meeting exacting performance targets, and delivering the Scottish Government's aim of having people living longer and healthier lives at home or a homely setting (i.e. the 2020 Vision).

92. The design of IJBs brings the potential for real or perceived conflicts of interest for board members and senior managers. Partners need to be clear regarding how governance arrangements will work in practice, particularly when disagreements arise. This is because there are potentially confusing lines of accountability, which could hamper the IJB's ability to make decisions about the changes involved in redesigning services. People may also be unclear who is ultimately responsible for the quality of care.

93. Embedding robust governance arrangements will be an essential element in meeting these challenges and maintaining accountability. All stakeholders including patients, clinicians, carers, the public, staff, partner bodies and the Scottish Government, benefit from the assurance and confidence a good governance regime brings.

Best Value



94. The Public Bodies (Joint Working) (Scotland) Act 2014 set out a broad framework for creating integration authorities and gave councils and NHS boards a great deal of flexibility to enable them to develop integrated services that are best suited to local circumstances.

95. Integration authorities are required to contribute towards nine national health and wellbeing outcomes. These high level outcomes seek to measure the quality of health and social care services and their impact on, for example, allowing people to live independently

and in good health, and reducing health inequalities. This signals an important shift from measuring internal processes to assessing the impact on people using health and social care services.

96. Shetland Islands IJB Board approved the 2015/16 Strategic Plan on 20 November 2015 which is predominantly based on the previously approved targets and actions set out in strategic plans already produced during the previous Community Healthcare Partnership (CHCP). This is a logical process to adopt as it reflects the fact that Shetland Islands Council has had in place integrated working via the CHCP and collaboration within the Community Planning Partnership for a number of years.

97. In June 2016 The IJB approved a revised strategic plan for the period 2016/19. During 2016/17 the IJB intends to produce locality plans for Shetland to inform the first year update of the 2016/19 strategic plan. Financial analysis of service delivery and change will also be developed over the coming year to support analytical processes such as programme budgeting / marginal analysis, and budgeting for locality plans to show how the Integration Authority's resources are currently used by the locality population.

98. Shetland Integration Joint Board was one of the first to be established in Scotland. The integration scheme specifies the very wide range of functions delegated by the council and the health board to the Board. These include all services previously carried out by the council's social services department plus a wide range of service previously carried out by the health board including accident and emergency, all community hospitals, all mental health inpatients services, and primary care. Good progress is being made.

99. Accountable officers have a specific responsibility to ensure that arrangements have been made to secure Best Value. IJBs need to establish effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives, and holding partners to account. There is also a need for regular reporting to partner organisations. This is particularly important as most members of Shetland Islands Council and NHS Shetland are not directly involved in the Board's work.

Arrangements for securing Best Value

100. The integration scheme committed the Board to delivering the national outcomes for Health & Wellbeing. The Parties (NHS Shetland (NHSS) and Shetland Islands Council (SIC)) have identified a core set of indicators linked to national outcomes that relate to health and social care services for delegated integration functions.

101. The Board is also committed to a number of high profile deliverables, including national HEAT targets relating to delayed discharge from hospital, psychological therapy, and smoking cessation.

102. Overall, we concluded that the Board has arrangements for securing BV and continuous improvement.

Performance management

103. Performance is reported annually to the IJB and in June 2016 the annual performance report included:

- the Projects and Actions for the Community
- sickness absence levels
- the suite of national core indicators generated by NHSS that are relevant to the IJB
- indicators which are grouped under the headings of the 9 National Health & Wellbeing outcomes
- complaints recorded to date.

104. The strategic commissioning plan for 2016/17 highlights performance monitoring as one of the key areas for future development. In particular the focus during 2016/17 will be on developing the key performance indicators already in place to show progress towards meeting the national health and wellbeing outcome indicators.

105. We concluded that the IJB has established a satisfactory performance management framework which should evolve over the next three years.

National performance audit reports

106. Audit Scotland carries out a national performance audit programme on behalf of the Accounts Commission and the Auditor General for Scotland. During 2015/16, a number of reports were issued which are of direct interest to the IJB. These are outlined in Appendix III accompanying this report.

107. Shetland Islands IJB has processes in place to ensure that all national performance reports and their impact on the IJB are considered by the IJB and the Audit committee. The Chief Officer prepares a covering report highlighting the key issues in national performance reports relevant to Shetland Islands IJB.

Outlook

108. Pressures on health and social care services are likely to continue to increase for the foreseeable future. These increasing pressures have significant implications on the cost of providing health and social care services and challenges in ensuring that people receive the right care, at the right time, and in the right setting.

109. The IJB is responsible for co-ordinating health and social care services and commissioning NHS Shetland and Shetland Islands Council to deliver services in line with the strategic plan. Over time, the intention is that this will lead to a change in how services are provided, with a greater emphasis on preventative services and allowing people to receive care and support in their home or local community.

110. The IJB will need to continue to demonstrate and report whether this is making a positive impact on service users and improving outcomes. To help achieve this it is important that the IJB has

strategies covering the workforce, risk management, engagement with service users, and data sharing arrangements which help to enable delivery of the IJB's strategic priorities.

Appendix I: Significant audit risks

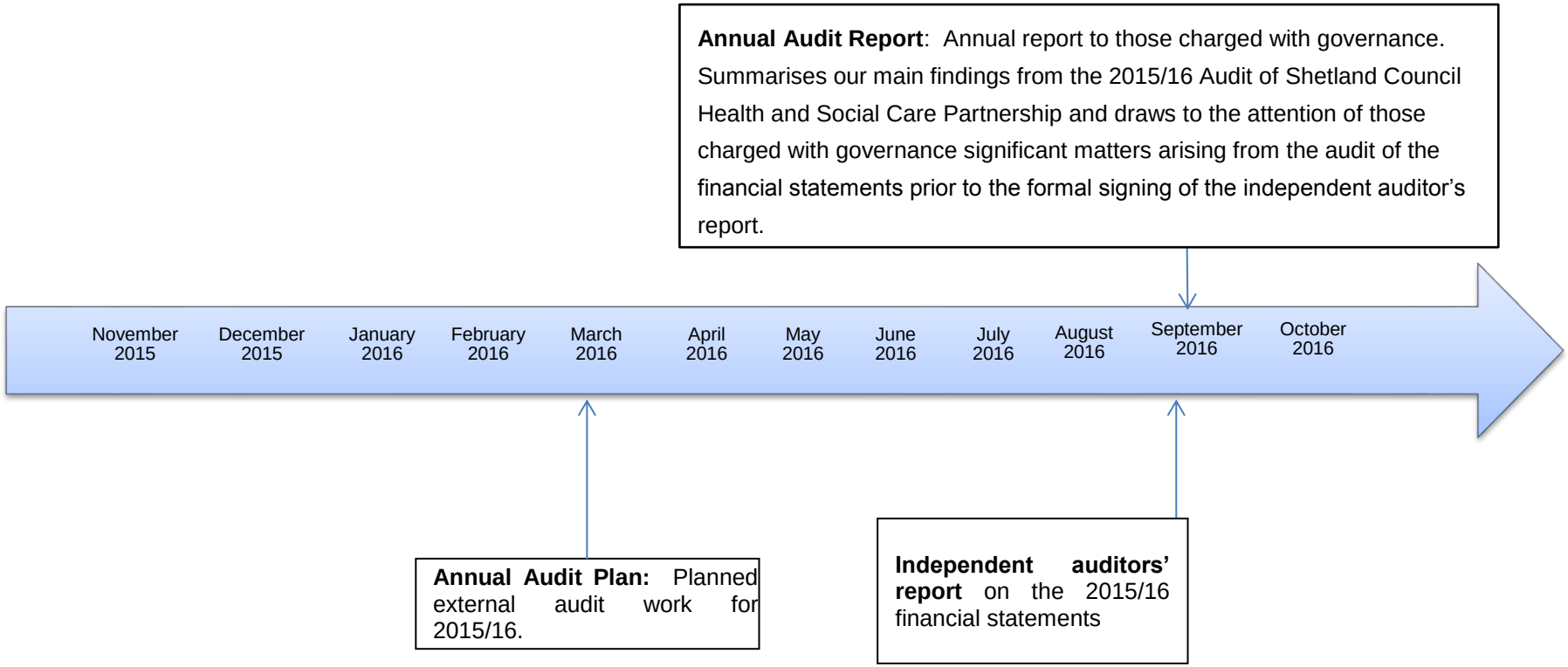
The table below sets out the audit risks we identified during the course of the audit and how we addressed each risk in arriving at our opinion on the financial statements.

Audit Risk	Assurance procedure	Results and conclusions
Risk of material misstatement in the financial statements		
Financial statements As Shetland Islands IJB is a new body, there is a risk that adequate systems and procedures are not in place to allow the body to submit its financial statements on time, and in line with statutory guidance.	• We engaged with officers prior to the accounts being prepared to help ensure the relevant information would be disclosed and timetable met. • We ensured the governance statement complies with the Code requirements. • Reviewed technical guidance from IRAG and LASAAC • Ensured accounting policies are appropriate and complete. • Obtained assurances from the auditors of Shetland Islands Council and NHS Shetland over the accuracy, completeness and appropriate allocation of the IJB ledger entries.	Financial statements were prepared in accordance with the Code and in accordance with timescales to meet NHS reporting requirements

Audit Risk	Assurance procedure	Results and conclusions
Preparation of the IJB financial statements relies on the provision of financial and non-financial information from the systems of the two partner bodies. The Chief Finance Officer of the IJB must obtain assurance; that the costs transferred to the accounts of the IJB are complete and accurate and were incurred on behalf of the IJB for services prescribed in the integration scheme. There is a risk that the Chief Finance officer does not have adequate assurance that information received from each party is accurate and complete.	We ensured the governance statement adequately reflects the position of IJB. We ensured financial reporting throughout the year was accurately reflected in the year end position. We considered whether appropriate action was taken on issues raised in any Internal Audit reports.	The governance statement adequately reflects the position of IJB. Financial reporting throughout the year was accurately reflected in the year end position. Appropriate action was taken on issues raised in any Internal Audit reports.
The IJB was established in June 2015 and assumed responsibility for its delegated functions in November 2015. There is a risk that costs relating to services prior to the board assuming responsibility are not correctly identified and excluded from the accounts.	We obtained audit assurances from the auditor of the council and health board regarding the accuracy and allocation of IJB transactions and to ensure they are recorded in the correct financial year.	Costs are all accurately identified.

Audit Risk	Assurance procedure	Results and conclusions
Risks identified from the auditor's wider responsibility under the Code of Audit Practice		
The board will need strong financial management and budgetary control to address the challenges and risks to future finance.	We reviewed ongoing budget monitoring reports to ensure they accurately reflect the position of the board. We obtained evidence of remedial action being taken against areas of overspend.	Budget monitoring arrangements audited as satisfactory but risks identified for future spending.
The board may not be able to comply with the requirement and deadline for an annual performance report, given that this is the first year of operation and external guidance regarding how this should be presented is not yet available.	We reviewed the annual performance report to ensure it accurately reflects the work of the board during the year and covers the information required by the Act.	Annual performance report was published within three months of the year end.

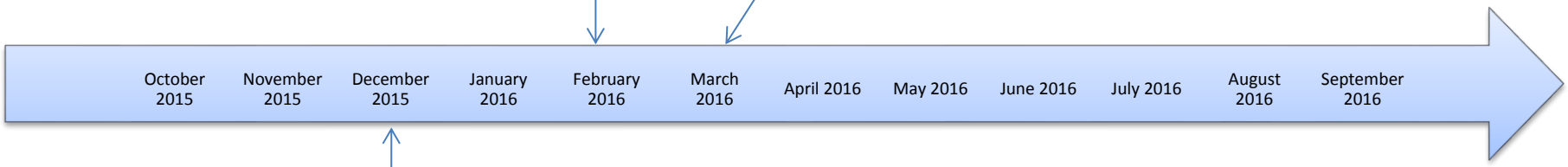
Appendix II: Summary of Shetland Islands HSCP local audit reports 2015/16



Appendix III: Summary of Audit Scotland national reports 2015/16

Reshaping care for older people – impact report (February 2016). This report looked at the extent to which care for older people has shifted towards communities and away from hospitals and care homes. The report considered whether the Change Fund was helping to improve care for older people in ways that can be sustained. It also examined the challenges facing organisations that deliver services for older people and how well they are meeting them.

Changing models of health and social care report (March 2016): This report says that transformational change is required to meet the Scottish Government's vision to shift the balance of care to more homely and community-based settings. NHS boards and councils need to significantly change the way they provide services and how they work with the voluntary and private sectors.



Health and Social Care Integration (December 2015): This report reviewed the progress made to establish new integration authorities, which will be responsible for planning joint health and social care services and managing budget totalling over £8 billion by 1 April 2016. The report highlights that significant risks must be addressed if a major reform of health and social care is to fundamentally change how services are delivered and improve outcomes for the people who use them.

Appendix IV: Action plan

No. AS ref.	Paragraph ref.	Issue/risk/Recommendation	Management action/response	Responsible officer / Target date
1.	51-54	**2016/17 Projected Revenue Budget Overspend** The 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. If savings plans are insufficient to deliver a break even position in 2016/17 then Shetland Islands IJB will need to consider how to address this taking account of the options set out in the Integration Scheme. **Recommendation** Shetland Islands IJB should monitor its financial position closely throughout the year and engage with its funding partners on a regular basis to review the financial position, including the achievement of savings and take appropriate action to address existing and emerging budget pressures.	Management Accounts will be presented to the IJB quarterly during 2016/17. Progress reports on the Recovery Plan will also be presented regularly during 2016/17. The first of these progress reports is being presented to the IJB on 19/10/16	Chief Financial Officer March 2017

Agenda Item

8

Shetland Islands Council

Meeting:	Integration Joint Board Audit Committee Integration Joint Board
Date:	26 September 2016
Report Title:	Final Audited Accounts 2015/16
Reference Number:	CC-70-16
Author / Job Title:	Karl Williamson/IJB Chief Financial Officer

1. Summary

1.1 The purpose of this report is to present the 2015/16 final audited annual accounts for the Integration Joint Board (IJB) for approval.

2. Background

2.1 IJBs are specified in legislation as 'Section 106' bodies under the terms of the Local Government (Scotland) Act 1973. Consequently, IJBs are expected to prepare their financial statements in compliance with the Code of Practice on Local Government Accounting in the United Kingdom.

2.2 The Local Authority Accounts (Scotland) Regulations 2014 require elected Members to consider the audited annual accounts and approve them for signature by 30 September 2016, and publish them no later than 31 October 2016.

2.3 The 2014 Regulations require IJB Members to consider the unaudited accounts at a meeting to be held no later than 31 August. The unaudited accounts were discussed and considered at an IJB meeting on 28 June 2016. There are no material changes between the unaudited accounts and the audited accounts.

2.4 The regulations also require IJB members to consider the report issued by the appointed auditor as a communication to those charged with

governance on the audit of the financial statements. This was presented as a separate item on the agenda.

2.5 Audit Scotland's report 'Financial Reporting and Scrutiny: Why the Accounts Matter' recommends that Members consider the following information when scrutinising and approving the annual accounts:

- The Management Commentary on page 3 of the accounts. This statement informs users of the most significant aspects of the IJB's performance during 2015/16.

- The Annual Governance statement on page 13 of the accounts. This provides information on the Governance framework and the effectiveness of the organisation, including any concerns raised during the year. The overall conclusion from Internal Audit is that the IJB's system of internal control environment operation during the reporting period provides reasonable and objective assurance that any significant risk impacting upon the achievement of its principal objectives will be identified and actions taken to avoid or mitigate their impact. They also concluded that systems are in place to continually review and improve the internal control environment to identify areas of improvement.

- The Statement of Income and Expenditure on page 27 of the accounts. This statement shows the accounting costs of providing the services commissioned by the IJB. Budgets are delegated from to the IJB from the Parties (Shetland Islands Council and NHS Shetland) for the delivery of these services. As the IJB only became live on 20 November 2015, a 19 week apportionment has been made of the overall Parties budgets in respect of the accounts.

- The Balance Sheet on page 28, which shows the value of the assets and liabilities of the IJB, and is a snapshot of the position as at 31 March 2016. In this first period of operation, the total budget delegated to the IJB has been repaid in full to the Parties, which means the net worth of the IJB as at 31 March 2016 was nil.

2.6 Audit Scotland has confirmed it will be issuing an unqualified audit opinion of the 2015/16 accounts. The overall conclusion being that 2015/16 Annual Accounts:

- Give a true and fair view in accordance with applicable law and the 2015/16 Code of the state of the affairs of the Shetland Health and Social Care Partnership as at 31 March 2016 and of the income and expenditure of the body for the period from 27 June 2015 to 31 March 2016.

- Have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16

Code; and

- Have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973 and the Local Government in Scotland Act 2003.

3. Conclusions

3.1 The IJB is required to prepare and publish a set of Accounts, within a set timescale, and elected members are required to approve the accounts for signature by 30 September 2016.

3.2 Audit Scotland has confirmed that it anticipates certifying the accounts are being a true and fair statement of the IJB's financial position at 31 March 2016.

For further information please contact:
Karl Williamson
IJB Chief Financial Officer
E-mail: karlwilliamson@nhs.net
Telephone: 01595 743301
14 September 2016

Appendices:
Appendix 1 – Shetland Health and Social Care Partnership Audited Annual Accounts 2015/16

Background documents:

The Local Authority Accounts (Scotland) Regulations 2014

END

Agenda Item

8

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board Audit Committee Integration Joint Board
Date:	26 September 2016
Report Title:	Final Audited Accounts 2015/16 - *Cover*
Reference Number:	CC-70-16
Author / Job Title:	Karl Williamson / IJB Chief Financial Officer

Decisions / Action required:

The IJB Audit Committee is asked to RESOLVE to:

a) Consider the audited Annual Accounts for 2015/16 (Appendix 1); and

The IJB is asked to RESOLVE to:

a) Approve the audited Annual Accounts for 2015/16 for signature (Appendix 1).

High Level Summary:

IJBs are specified in legislation as 'Section 106' bodies under the terms of the Local Government (Scotland) Act 1973, so are expected to prepare their financial statements in compliance with the Code of Practice on Local Government Accounting in the United Kingdom.

Regulations require that IJB Members consider the audited annual accounts and approve them for signature by 30 September 2016 and publish them no later than 31 October 2016.

Corporate Priorities and Strategic Aims:

The IJB is a separate legal entity, accountable for the stewardship of public funds and expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. The preparation and presentation of the accounts is a key element of the IJB's overall governance and reporting arrangements.

Key Issues:

These are the first set of IJB accounts, as the IJB was established on 27 June 2015 and became live on 20 November 2015 after the approval of the Strategic Commissioning Plan 2015-16.

The accounts cover the period from 27 June 2015 to 31 March 2016. Accounting guidance stipulates that the budgets delegated to and from the IJB in this first period must be apportioned from the date the IJB became live, so only 19 weeks of both Parties

agreed annual budgets for 2015/16 has been included in the Accounts.

The IJB is presenting a breakeven position in 2015/16, although there were significant variances in both arms of the operational budget. It was agreed that the underspend in the Shetland Islands Council (SIC) arm of the budget was fortuitous. The Integration Scheme stipulates that only planned, forecast, underspend on an element of the operational budget may be retained by the IJB, so this budget was returned to the SIC. There was an overspend in the NHS Shetland (NHSS) arm of the budget, which NHSS provided additional contribution to cover.

Implications :	
Service Users, Patients and Communities:	None
Human Resources and Organisational Development:	None
Equality, Diversity and Human Rights:	None
Partnership Working	The core nature of the IJB represents joint working between SIC and NHSS.
Legal:	None
Finance:	There a no financial implications arising from this report.
Assets and Property:	None
Environmental:	None
Risk Management:	There are no significant issues in relation to the audited Annual Accounts. Audit Scotland's Annual Report on the 2015/16 audit was presented as a separate item on the agenda. This contains a number of matters arising. For each matter, a resolution accompanies it to set out how this will or has been addressed.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 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 20 November 2015.
Previously considered by:	This report has not been presented at any formal meeting.

Shetland Health and Social Care Partnership

Annual Accounts 2015/16 Audited

Contents

Introduction

The Shetland Health and Social Care Partnership (Integration Joint Board) is a body corporate, established by Parliamentary Order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014, on 27 June 2015.

The Parties:

Shetland Islands Council ("the Council" or "SIC"), established under the Local Government etc (Scotland) Act 1994

Shetland Health Board ("the Health Board" or "NHS Shetland"), established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as Shetland NHS Board)

The Parties agreed the Integration Scheme of Shetland Island Health and Social Care Partnership, which sets out the delegation of function by the Parties to the Integration Joint Board.

The Shetland Health and Social Care Partnership Members for 2015/16 were as follows:

Voting Members:

Mr C Smith (Chairperson)
Ms C Waddington (Vice Chairperson)
Mr G Cleaver (SIC Member)
Mr B Fox (SIC Member)
Mr K Massey (NHS Shetland)
Mrs M Williamson (NHS Shetland)

Non-Voting Members:

Mr S Bokor-Ingram (Chief Officer)
Mr K Williamson (Chief Financial Officer)
Ms S Beer (Carers' Representative)
Mrs K Hughson (Third Sector Representative)
Mr H Massie (Patient/Service User Representative)
Mrs M Nicolson (Chief Social Work Officer)
Dr S Bowie (GP Representative)
Ms E Watson (Lead Nurse for the Community)
Mr I Sandilands (Staff Representative)
Ms S Gens (Staff Representative)
Mr J Unsworth (Senior Consultant: Local Acute Sector)

Management Commentary

The purpose of the Management Commentary is to inform all users of these Accounts and help them to understand the most significant aspects of Shetland Health and Community Care Partnership's financial performance from its establishment on 27 June 2015 to 31 March 2016, and its financial position as at 31 March 2016.

Background

Integration of health and social care is the Scottish Government's ambitious programme of reform to improve services for people who use health and social care service. Integration will ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.

The new Public Bodies (Joint Working) (Scotland) Act was granted royal assent on 1 April 2014. Shetland Islands Council and the Board of NHS Shetland took the decision that the Model of integration of health and social care services in Shetland would be the Body Corporate, known as an Integrated Joint Board.

Under the Body Corporate model, the Health Board and the Council delegate the responsibility, for planning and resourcing service provision of adult health and social care services to an Integration Joint Board.

The Integration Joint Board (IJB) was established as a Body Corporate by order of Scottish Ministers on 27 June 2015 and the inaugural meeting, which confirmed the full membership of the IJB, was held on 20 July 2015. The IJB approved their Standing Orders, Scheme of Administration and Financial Regulation at their second meeting on 29 July 2015.

As a separate legal entity the IJB has full autonomy and capacity to act on its own behalf and can, accordingly, make decision about the exercise of its functions and responsibilities as it sees fit.

The IJB is responsible for the strategic planning of the functions delegated to it by SIC and NHS Shetland. The Strategic Plan specifies the service to be delivered by the Parties. The IJB is responsible for ensuring the delivery of its functions through the locally agreed operational arrangements set out within its Integration Scheme.

The practical application of the Integration Scheme will be managed and administered in accordance with the Financial Regulations, Standing Orders and Scheme of Administration of the Parties as amended to meet the requirements of the Act.

The IJB approved its Joint Strategic Commissioning Plan 2015-16 on 20 November 2015.

Purpose and Objectives

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act:

National Health and Wellbeing Outcomes

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

The following objectives were set out in the Shetland Joint Strategic Commissioning Plan 2015-16;

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

Operational Review

During 2015/16 there was a continued focus on reducing delayed discharges from hospital. Performance was much improved from the previous winter in 2014/15, with an overall reduction in the number of delays at any one time, and reducing lengths of delay for individuals. This work has extended through the entire patient/client pathway journey, along with initiatives funded through the Integrated Care Fund including intermediate care and third sector provision.

The balance of care in Shetland remains very good, with less care centre bed usage than the national average, and more people with high needs being cared for in their own homes. The implementation of the With You For You Review of our joint assessment process has continued at pace, and staff training as part of the implementation has seen better goal

orientated outcomes for individual clients. This will underpin our continuing journey to maintain an ageing population in community based settings, and tailoring support for fulfilling lives in older age.

Staff is our greatest asset, and it is pleasing to see sickness rates reducing over the course of the year. Whilst the rate remains high compared to other SIC Directorates, nonetheless this is the second year that rates have improved. We held open staff meetings in each of the 7 planning localities, and heard how teams are working together, and what more we need to do to remove barriers to joint working. This will start to be addressed in 2016/17.

The operational management team had a continued challenge to find further efficiencies, and whilst the Council part of the budget has under spent, considerable pressures remain in the Health Board budget which will require continued attention in 2016/17 in order to achieve a balanced position.

Primary Financial Statements

The Annual Accounts detail Shetland Health and Social Care Partnership's transactions for the period from 27 June 2015 to 31 March 2016. The Annual Accounts are prepared in accordance with the International Accounting Standards Board (IASB) Framework for the Preparation and Presentation of Financial Statements (IASB Framework) as interpreted by the Code of Practice on Local Authority Accounting in the United Kingdom.

A description of the purpose of the primary statements has been included immediately prior to each of the financial statements: the Statement of Income and Expenditure for the period from 27 June 2015 to 31 March 2016 and the Balance Sheet. These Statements are accompanied by Notes to the Accounts which set out the Accounting Policies adopted by the Partnership and provide more detailed analysis of the figures disclosed on the face of the primary financial statements.

The primary financial statements and notes to the accounts, including the accounting policies, form the relevant Annual Accounts for the purpose of the auditor's certificate and opinion.

Remuneration of the Chief Officer of the Partnership is disclosed in the Remuneration Report.

Financial Review

The Strategic Commissioning Plan 2015/16 sets out the functions which have been delegated by the Parties and the associated agreed budgets. The Plan was agreed by IJB Members on 20 November 2015. As defined in the Public Bodies (Joint Working) (Scotland) Act 2014, Section 29 (6), this is considered the "integration start day".

The Accounts include the part year contributions from the Parties, representing 19 weeks of the annual agreed budgets. Similarly, part year payments to the Parties from the IJB for carrying out its directions have been made based on the 19 week period from the integration start date to 31 March 2016.

Running costs for the IJB have been included from the establishment date.

The purpose of the Annual Accounts is to present a public statement on the stewardship of funds for the benefit of both Members of the IJB and the public. The IJB is funded by Shetland Islands Council (SIC) and Shetland Health Board (NHSS).

The Statement of Income and Expenditure presents the full economic cost of providing the Board's services in 2015/16 from the date of establishment to 31 March 2016.

The IJB is presenting a breakeven position in 2015/16 even though there were significant variances in both arms of the operational budget. This is due to the fact that the under spend in the SIC arm of the budget was fortuitous and was therefore returned to the SIC as per the Integration Scheme. Likewise the over spend in the NHSS arm of the budget had to be funded by additional contributions from the NHSS.

The Integration Scheme states that where there is a planned, forecast, under spend on an element of the operational budget due to agreed changes in line with the Strategic Plan, this will be retained by the IJB to either fund other service areas in-year in line with the Strategic Plan or be carried forward to fund services in subsequent years of the Strategic Plan. However, any windfall under spend will be returned to the Council and/or the Health Board in line with the original budget allocation for 2015/16.

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

The table below details the variances and additional transactions required:

	SIC £'000	NHSS £'000	Total £'000
1 Budgets delegated to the Parties from the IJB	(7,747)	(8,554)	(16,301)
2 Contribution from the Parties to the IJB (against delegated budgets)	7,059	8,921	15,980
3 Variance	(688)	367	(321)
4 Additional contributions from Parties to meet IJB Direct Costs	9	10	19
5 IJB Direct Costs (Audit fee, Insurance & Members Expenses)	(9)	(10)	(19)
6 Fortuitous underspend repaid to SIC	688	-	688
6 Additional contribution from NHS to IJB to meet overspend	-	(367)	(367)
7 Final balanced position of IJB	-	-	-

The table below details the full year financial position for the IJB and is broken down by service area. Although the accounts are apportioned to represent the period from 20 November 2015 (the date the functions were delegated) to 31 March 2016, the full year analysis provides a more meaningful summary.

Service Heading	ANNUAL BUDGET				OUTTURN				OUTTURN VARIANCE			
	JOINT BUDGETS		SET ASIDE		JOINT BUDGETS		SET ASIDE		JOINT BUDGETS		SET ASIDE	
	NHS	SIC	BUDGET	TOTAL	NHS	SIC	BUDGET	TOTAL	NHS	SIC	BUDGET	TOTAL
	£	£	£	£	£	£	£	£	£	£	£	£
Mental Health	1,318,107	1,347,701	0	2,665,808	1,298,925	1,091,149	0	2,390,074	19,182	256,553	0	275,735
Substance Misuse	570,117	254,519	0	824,636	562,731	209,310	0	772,041	7,386	45,209	0	52,595
Oral Health	3,253,206	0	0	3,253,206	3,281,661	0	0	3,281,661	-28,455	0	0	-28,455
Pharmacy & Prescribing	4,916,057	0	1,121,864	6,037,921	5,173,668	0	1,062,790	6,236,458	-257,611	0	59,074	-198,537
Primary Care	4,563,657	0	0	4,563,657	4,904,407	0	0	4,904,407	-340,750	0	0	-340,750
Community Nursing	2,387,175	0	0	2,387,175	2,355,228	0	0	2,355,228	31,947	0	0	31,947
Directorate	-238,276	561,381	0	323,105	169,786	349,975	0	519,761	-408,062	211,406	0	-196,656
Pensioners	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Health	0	0	39,876	39,876	0	0	44,189	44,189	0	0	-4,313	-4,313
Adult Services	66,574	5,342,082	0	5,408,656	63,077	4,603,161	0	4,666,238	3,497	738,921	0	742,417
Adult Social Work	0	2,099,480	0	2,099,480	0	2,126,910	0	2,126,910	0	-27,429	0	-27,429
Community Care Resources	0	10,305,222	0	10,305,222	0	9,511,227	0	9,511,227	0	793,995	0	793,995
Criminal Justice	0	15,539	0	15,539	0	4,929	0	4,929	0	10,610	0	10,610
Speech & Language Therapy	81,180	0	0	81,180	76,991	0	0	76,991	4,189	0	0	4,189
Dietetics	103,764	0	0	103,764	89,809	0	0	89,809	13,955	0	0	13,955
Podiatry	222,588	0	0	222,588	213,581	0	0	213,581	9,007	0	0	9,007
Orthotics	137,409	0	0	137,409	138,258	0	0	138,258	-849	0	0	-849
Physiotherapy	585,232	0	0	585,232	560,667	0	0	560,667	24,565	0	0	24,565
Occupational Therapy	184,383	1,382,767	0	1,567,150	168,047	1,367,915	0	1,535,962	16,336	14,852	0	31,188
Health Improvement	0	0	337,348	337,348	0	0	324,233	324,233	0	0	13,116	13,116
Unscheduled Care	0	0	3,289,230	3,289,230	0	0	3,720,671	3,720,671	0	0	-431,441	-431,441
Renal	0	0	138,967	138,967	0	0	157,210	157,210	0	0	-18,243	-18,243
	18,151,173	21,308,691	4,927,285	44,387,150	19,056,838	19,264,575	5,309,094	43,630,507	-905,665	2,044,116	-381,808	756,643

The outturn position to the end of March 2016 is an overall favorable variance of £757k which represents an under spend in SIC of £2.044m and an over spend in NHSS of £1.287m.

The main reasons for the variances from budget are explained below;

Mental Health

The anticipated closure of Viewforth Care Home took place sooner than expected, leading to a £292k underspend within Mental Health.

Pharmacy & Prescribing

The cost of drugs dispensed in the community, hospital and on-island high cost drugs has increased by £235k from the previous year, equivalent to 4.3%. This includes £45.8k in respect of the new medicines fund and Hepatitis C new drug cost of £163.9k, an increase of 9.9% on last year. Excluding these two issues year on year costs growth was only 3.2%.

Primary Care

Locum GP usage in the Lerwick Health Centre during 2015/16 was £249k. In Yell there were no issues until November when the substantive GP moved to another practice. Since then locums have been used to supplement the associate GP at a cost of £152k. Whalsay Health Centre also required locum cover during the year at a cost of £191k.

Directorate

There is an NHSS unachieved efficiency target of £407k included in the Directorate line above which will be carried forward into 2016/17.

The SIC Directorate budgets included 2014/15 carry-forward funding of £278k, of which £162k was underspent due to delays in getting modern apprenticeship underway, inability to utilise budget provided to back-fill training of staff due to level of vacancies and non-recruitment to a planned joint temporary ICT post within the Directorate.

Adult Services

Due to difficulty in recruiting and retaining staff, there was an underspend in employee costs of £286k. Budgets had been set aside to cover borrowing costs (£188k) and also allow revenue to be transferred to cover initial capital costs (£177k) of the replacement Eric Gray Centre, but due to delay in the start of this project were not required.

Community Care Resources

Due to difficulty in recruiting and retaining staff, there was an underspend in employee costs of £674k. This also meant that car allowance and mileage payment were £99k less than anticipated. Income charges for Board and Accommodation were £168k more than expected, but this can vary from year to year as it is dependent on the financial circumstances of those people receiving care. This has been off-set by expenditure on Reshaping Care and Integrated Care Fund for which contingency was available if required, but has been met from the overall underspend.

The Balance Sheet as at 31 March 2016

The IJB does not own any fixed assets or inventories and has no bank account or cash of its own. Due to the contributions to/from the SIC and NHSS being equal in 2015/16 the Balance Sheet has a zero value.

2016/17 Budget and Medium Term Financial Outlook

The 2016/17 budget has been approved on 28th June 2016 as part of the 2016/17 Strategic Commissioning Plan. The plan also contains an indicative budget allocation for 2017/18 and 2018/19.

The Shetland IJB, like all others, faces significant financial challenges and is required to operate within tight fiscal constraints for the foreseeable future due to the continuing difficult national economic outlook and increasing demand for services. Additional funding of £250m was announced for Health and Social Care Partnerships for 2016/17 to address social care pressures, as well as providing funding to offset the costs of the national Living Wage and reduced income through increased charging thresholds. Despite this additional funding, pressures continues on public sector expenditure at a UK and Scottish level with further reductions in government funding predicted in 2018/19.

The anticipated reduction in funding coupled with the demographic challenges which Shetland is facing, results in key risks which can be summarised as follows:

- Increased demand for services alongside reducing resources;
- The wider financial environment which continues to be challenging; and
- Political uncertainty including Scottish Parliament and local elections in the next two years, as well as the financial powers arising from the Scotland Act 2012 and recommendations arising from the Smith Commission.

There is currently a shortfall in the NHS funding to the IJB in 2016/17 of £1.777m. A recovery plan has been agreed but it will be very challenging to deliver in year. Progress on the recovery plan will be closely monitored throughout the year to identify any slippage for the plan early to allow remedial action.

Acknowledgement

We would like to acknowledge the significant effort of all the staff across the IJB who contributed to the preparation of the Annual Accounts and to the budget managers and support staff whose financial stewardship contributed to the favourable financial position at 31 March 2016.

……..... 26 September 2016
Simon Bokor-Ingram
Chief Officer

……... 26 September 2016
Catriona Waddington
Vice-Chair

..... 26 September 2016
Karl Williamson
Chief Financial Officer

Annual Governance Statement

Scope of Responsibility

The Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The IJB also aims to foster a culture of continuous improvement in the performance of the IJB's functions and to make arrangements to secure Best Value.

In discharging these responsibilities, the Chief Officer has a reliance on the systems of internal control of both Shetland NHS Board (the Health Board) and Shetland Islands Council (the Council) that support compliance with both organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the IJB.

The IJB has adopted a Local Code of Corporate Governance ("the Local Code") consistent where appropriate with the six principles of CIPFA and the Society of Local Authority Chief Executives (SOLACE) framework "*Delivering Good Governance in Local Government*". This statement explains how the IJB has complied with the Local Code and also meets the Code of Practice on Local Authority Accounting in the UK, which details the requirement for an Annual Governance Statement.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the risks facing the organisation. The system aims to evaluate the nature and extent of failure to achieve the organisation's policies, aims and objectives and to manage risks efficiently, effectively and economically. As such it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control has been in place at the IJB for the financial year ended 31 March 2016 and up to the date of the approval of the Statement of Accounts.

The Governance Framework

The Board of the IJB comprises the Chair and 5 Members with voting rights; 3 are Council Members appointed by the Council and 3 are Health Board Members appointed by the Health Board from among those

Members of the local NHS system appointed by Scottish Ministers. The IJB via a process of delegation from the Health Board and the Council has responsibility for the planning, resourcing and operational delivery of all integrated health and social care within its geographical area through its Chief Officer. The IJB also has strategic planning responsibilities for a range of acute health services for which the budget is "set aside".

The main features of the IJB's system of internal control are summarised below.

- The overarching strategic vision and objectives of the IJB are detailed in the IJB's Integration Scheme which sets out the key outcomes the IJB is committed to delivering through the Council and the Health Board as set out in the IJB's Strategic Plan and Annual Financial Statement.
- Services are able to demonstrate how their own activities link to the IJB's vision and priorities through their Corporate Improvement Plans and Service Plans.
- Performance management, monitoring of service delivery and financial governance is provided through quarterly reports to the IJB as part of the Planning and Performance Management Framework. Quarterly reports include financial monitoring of the integrated budget and the "set aside" budget, the IJB Risk Registers, performance against national outcome measures, local outcome measures and service development projects. The IJB also receives regular reports from the joint Council, Health Board and IJB Clinical, Care and Professional Governance Committee and the IJB Audit Committee.
- The Participation and Engagement Strategy sets out the IJB's approach to engaging with stakeholders. Consultation on the future vision and activities of the IJB is undertaken collaboratively with the Council and the Health Board and through existing community planning networks. The IJB publishes information about its performance regularly as part of its public performance reporting.
- The IJB operates within an established procedural framework. The roles and responsibilities of Board Members and officers are defined within Standing Orders, Scheme of Administration and Financial Regulations; these are subject to regular review.
- Effective scrutiny and service improvement activities are supported by the formal submission of reports, findings and recommendations by Audit Scotland, the external auditors, national inspection agencies and the appointed Internal Audit service to the IJB's

Senior Management Team, to the IJB and the main Board and Audit Committee.

- The IJB follows the principles set out in CoSLA's *Code of Guidance on Funding External Bodies and Following the Public Pound* for both resources delegated to the Partnership by the Health Board and the Council and resources paid to its Council and Health Board Partners.
- Responsibility for maintaining and operating an effective system of internal financial control rests with the Chief Financial Officer. The system of internal financial control is based on a framework of regular management information, Financial Regulations and Standing Financial Instructions, administrative procedures (including segregation of duties), management and supervision, and a system of delegation and accountability. Development and maintenance of the system is undertaken by managers within the IJB.
- The IJB's approach to risk management is set out in the Integration Scheme and IJB Risk Management Strategy. Reports on risk management are considered regularly by the H&SC Management Team with quarterly reporting on the IJB Risk Registers to the IJB Board and an annual report to the IJB Audit Committee.
- The IJB has adopted a code of conduct for its employees. IJB Board Members observe and comply with the Nolan Seven Principles of Public Life. Comprehensive arrangements are in place to ensure IJB Board Members and officers are supported by appropriate training and development.
- Staff are made aware of their obligations to protect client, patient and staff data. The NHS Scotland *Code of Practice on Protecting Patient Confidentiality* has been issued to all NHS Shetland staff working in IJB directed services and all staff employed by the Council working in IJB directed services have been issued with the SSSC Codes of Practice.
- Employee Codes of Conduct within the partner organisations set out the requirement for employee confidentiality. The Joint Staff Forum provides a mechanism for discussing concerns and issues affecting staff governance and the workforce within integrated services that enable the early identification of potential workforce risks.

Review of Adequacy and Effectiveness

The IJB has responsibility for conducting at least annually, a review of effectiveness of the system of internal control and the quality of data used throughout the organisation. The review is informed by the work of the Service Managers within the Council and the Health Board (who have responsibility for the development and maintenance of the internal control framework environment), the work of the internal auditors, the Chief Internal Auditor's annual report, and reports from external auditors and other review agencies and inspectorates.

The review of the IJB's governance framework is supported by a process of self-assessment and assurance certification by Directors within the Council and the Health Board. The IJB directs the Council and the Health Board to provide services on its behalf and does not provide services directly. Therefore, the review of the effectiveness of the governance arrangements and systems of internal control within the IJB places reliance upon the individual bodies' management assurances in relation to the soundness of their systems of internal control.

There was one significant internal control issue identified by the review regarding the 2016/17 savings target and another 4 issues worthy of noting – see the table below. A recovery plan has been developed to address the 2016/17 savings target but this will need developed and refined during the year. We propose over the coming year to take steps to address all these matters to further enhance our internal control arrangements. We are satisfied that these steps will address the need for improvements which were identified in our review of effectiveness and will monitor their implementation and operation as part of our next annual review.

Roles and Responsibilities of the Audit Committee and Chief Internal Auditor

IJB Members and officers of the IJB are committed to the concept of sound internal control and the effective delivery of IJB services. The IJB's Audit Committee operates in accordance with CIPFA's Audit Committee Principles in Local Authorities in Scotland and Audit Committees: Practical Guidance for Local Authorities.

The Audit Committee performs a scrutiny role in relation to the application of CIPFA's Public Sector Internal Audit Standards 2013 (PSIAS) and reviews the performance of the IJB's Internal Audit Service.

The appointed Chief Internal Auditor has responsibility to review independently and report to the Audit Committee annually, to provide assurance on the adequacy and effectiveness of the IJB's system of internal control.

The internal audit service undertakes an annual programme of work, approved by the Audit Committee, based on a strategic risk assessment. The appointed Chief Internal Auditor provides an independent opinion on the adequacy and effectiveness of internal control.

The Chief Internal Auditor has conducted a review of all Internal Audit reports issued in the financial year that relate to the IJB (2 Scott Moncrieff internal audit reports): 1) Integration Assurance, due diligence and governance arrangements 2) Review of governance, risk management and project management of the Integration Board. In conclusion, although no system of internal control can provide absolute assurance nor can Internal Audit give that assurance, on the basis of audit work undertaken during the reporting period, there have been no significant issues reported by Internal Audit.

Furthermore, on the basis of the audit work undertaken during the reporting period, the Chief Internal Auditor is able to conclude that a reasonable level of assurance can be given that the system of internal control is operating effectively within the organisation.

Compliance with Best Practice

The IJB complies with the CIPFA Statement on "*The Role of the Chief Financial Officer in Local Government 2010*". The IJB's Chief Finance Officer has overall responsibility for the IJB's financial arrangements and is professionally qualified and suitable experienced to lead the IJB's finance function and to direct finance staff in both partner organisations to ensure the effective financial management of the IJB. The Chief Financial Officer has direct access to the Director of Finance in Shetland NHS Board and the Executive Manager – Finance in Shetland Islands Council to address financial issues and is a member of the Local Partnership Finance Team.

The Partnership complies with the requirements of the CIPFA Statement on "*The Role of the Head of Internal Audit in Public Organisations 2010*". The IJB's appointed Chief Internal Auditor has responsibility for the IJB's internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit

service generally operates in accordance with the CIPFA "*Public Sector Internal Audit Standards 2013*".

Internal Control Issues and Planned Actions

The IJB continues to recognise the need to exercise strong management arrangements to manage the pressures common to all public bodies. Regular reviews of the IJB's arrangements are undertaken by the appointed internal auditors and overall the IJB's arrangements are sound. The table below sets out improvement actions to the system of internal control identified from the IJB's ongoing review and monitoring of its governance arrangements. These represent corporate initiatives that will be undertaken or further progressed during the next financial period.

	Where are we now?	*Where do we want to be?*	*How will we know we are getting there?*	*Who is responsible?*
	1 Financial Assurance: The Integration Scheme outlines various protocols to be followed in particular situations. It is less clear how these will work in practice. The shortfall in funding from the Health Board reflected in the IJB budget for 2016/17 has to some extent been addressed; however, it is not yet clear how the required savings will be made.	*a) Detailed Annual Accounts financial transactions to be developed and understood. b) An achievable detailed recovery plan for the shortfall in funding from the Health Board agreed and approved by the IJB.*	*a) Detailed processes and transactions have been developed and will be reviewed by external audit during the annual accounts process. b) Recovery Plan approved by IJB and Financial Monitoring Reports evidencing adherence to*	*a) Chief Financial Officer b) Chief Officer*

			plan.	
	2 IJB Governance: An up to date version of the Joint Strategic Commissioning Plan must be maintained in order to reflect the evolving financial position and to comply with the Public Bodies (Joint Working) (Scotland) Act 2014.	*A fully agreed and approved Strategic (Commissioning) Plan with detailed budgets for 2016/17 and outline budgets for 2017/18 and 2018/19.*	*When plan has been approved by the IJB.*	*Chief Officer*
	3 IJB Governance: Consideration should be given to developing formal training needs assessments for members of the IJB.	*A formal training needs assessment should be carried out and subsequent action plans developed.*	*Action plans in place.*	*Chief Officer*
	4 IJB Governance: Register of Interest forms should be completed and maintained for all members of the IJB in line with IJB Standing Orders Para 5.7.1.	*Completed Register of Interests forms for all members*	*Completed Register of Interests forms for all members*	*Chief Officer*
	5 Risk Management: Consideration should be given to risk management reports having a dedicated item on the agenda in	*Risk management reports being on the agenda in relation to risk management*	*When risk manageme nt reports are on the agenda in*	*Chief Officer*

	relation to risk management issues each quarter. Within this report, IJB strategic risks and services' risks should be reported separately.	*issues each quarter. Within this report, IJB strategic risks and services' risks are reported separately.*	*relation to risk manageme nt issues each quarter. Within this report, IJB strategic risks and services' risks are reported separately.*	

Assurance

Subject to the above, and on the basis of assurances provided, we consider that the internal control environment operating during the reporting period provides reasonable and objective assurance that any significant risks impacting upon the achievement of our principal objectives will be identified and actions taken to avoid or mitigate their impact. Systems are in place to continually review and improve the internal control environment and action plans are in place to identify identified areas for improvement.

Certification

It is our opinion that reasonable assurance, subject to the matters noted above, can be placed upon the adequacy and effectiveness of the Integration Joint Board's systems of governance.

……...	…….....
Simon Bokor-Ingram	Catriona Waddington
Chief Officer	Vice-Chair
26 September 2016	26 September 2016

Remuneration Report

Introduction

The Local Authority Accounts (Scotland) Regulations 2014 (SSI 2014/200) require local authorities and IJBs in Scotland to prepare a Remuneration Report as part of their annual statutory accounts.

All information disclosed in the tables on page 23 and 24 in this Remuneration Report was audited by Audit Scotland. The other sections of the Remuneration Report were reviewed by Audit Scotland to ensure that they are consistent with the financial statements.

Integration Joint Board

The voting members of the Integration Joint Board shall comprise three persons appointed by NHS Shetland (NHSS), and three persons appointed by the Shetland Islands Council (SIC), as follows:

Member	Nominating Organisation(s)	Appointing Organisation
3 NHS Non-Executive Board Members Ms C Waddington (Vice Chairperson) Mr K Massey Mrs M Williamson	N/A	NHSS
3 Councillors Mr C Smith (Chairperson) Mrs G Cleaver Mr B Fox	N/A	SIC

The professional advisors to the IJB are non-voting members. These are identified as follows:

Member	Nominating Organisation(s)	Appointing Organisation
Chief Officer	SIC/NHSS	IJB
Chief Financial Officer (Section 95 Officer)	SIC/NHSS	IJB
Chief Social Worker Officer	N/A	SIC
General Practitioner Representative	NHSS	IJB

Senior Consultant: Local Acute Sector	NHSS	IJB
Lead Nurse for the Community	NHSS	IJB
Staff Representative	NHSS	IJB
Staff Representative	SIC	IJB
Third Sector Representative	Voluntary Action Shetland	IJB
Patient/Service User Representative	Public Partnership Forum	IJB
Carers' Representative	Carers' Link Group	IJB

Senior officers

The IJB does not directly employ any staff. All Partnership officers are employed by either NHS Shetland or Shetland Islands Council, and remuneration to senior staff is reported through the employing organisation.

The Chief Officer, Simon Bokor Ingram, was appointed as Director of Community Health and Social Care on 1 February 2014, and formally appointed as Chief Officer of the Integration Joint Board on 20 July 2015 in consultation with Shetland Islands Council and NHS Shetland.

The Chief Officer is employed by NHS Shetland but this is a joint post with Shetland Islands Council, with 50% of his cost being recharged to the Council. Performance appraisal and terms and conditions of service are in line with NHS Scotland circulars and continuity of service applies. Formal line management is provided through the Chief Executive, NHS Shetland, but Director of Community Health and Social Care is accountable to both the Chief Executive of NHS Shetland and the Chief Executive of Shetland Islands Council.

The IJB approved the appointment of the Chief Financial Officer at its meeting on 20 July 2015. The role of Chief Financial Officer for the IJB is carried out by the NHS Shetland Head of Finance, Karl Williamson, with NHS Shetland meeting his full cost.

Remuneration policy

The IJB does not pay allowances or remuneration to the voting board members. Voting board members are remunerated by their parent organisation and receive expenses from their parent organisation. The

cost of any Member expenses which were wholly, exclusively and necessarily incurrered on IJB business during the period have been charged to the IJB, with NHS Shetland and Shetland Islands Council providing equal additional contributions to meet the cost. The level of expenses is not material.

Remuneration

The Chief Officer received the following remuneration in the period from his appointment on 20 July 2015 to 31 March 2016:

	2015/16 Salary, fees and allowances £	2015/16 Taxable expenses £	2015/16 Total Remuneration £
Simon Bokor-Ingram	63,460	0	63,460
Total	**63,460**	**0**	**63,460**

Pension benefits

The Chief Officer participates in the National Health Service Superannuation Scheme (Scotland). The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and from those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations.

For more information on the National Health Service Superannuation Scheme (Scotland) please see the link below.

http://www.sppa.gov.uk/index.php?option=com_content&view=article&id=43&Itemid=4

Pension entitlement for the Chief Officer for the year to 31 March 2016 is shown in the table below, together with the contribution made by the employing body to this pension during the period from 20 July 2015 to 31 March 2016.

	In-year Employer Pension Contributions 31 March 2016 £	Accrued Annual Pension Benefits 31 March 2016 £	Lump sum Entitlement 31 March 2016 £
Simon Bokor-Ingram	13,383	25,918	72,645
Total	**13,383**	**25,918**	**72,645**

…….. ……..

Simon Bokor-Ingram
Chief Officer

26 September 2016

Catriona Waddington
Vice-Chair

26 September 2016

Statement of Responsibilities for the Annual Accounts

The Integration Joint Board's Responsibility

The Integration Joint Board is required to:

- make arrangements for the proper administration of its financial affairs and to secure that the proper officer has the responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this Integration Joint Board the proper officer is the Chief Financial Officer;
- manage its affairs to secure economic, efficient and effective use of resources and to safeguard its assets;
- ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014) and, so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003); and
- approve the Annual Accounts for signature.

I can confirm that these Annual Accounts were approved for signature by the Integration Joint Board on 28 June 2016.

Signed on behalf of Shetland Islands Integration Joint Board

…… 26 September 2016
Catriona Waddington
Vice-Chair

The Chief Financial Officer's Responsibilities

The Chief Financial Officer is responsible for the preparation of the Board's Annual Accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

It is the responsibility of the Chief Financial Officer to sign, date and submit the un-audited Annual Accounts to the appointed auditor by 30 June 2016.

In preparing this Annual Accounts, the Chief Financial Officer has:

- selected suitable accounting policies and then applied them consistently;
- made judgements and estimates that were reasonable and prudent;
- complied with legislation; and
- complied with the local authority Accounting Code (in so far as it is compatible with legislation).

The Chief Financial Officer has also:

- kept adequate accounting records which were up to date;
- taken reasonable steps for the prevention and detection of fraud and other irregularities.

I certify that the Annual Accounts give a true and fair view of the financial position of the Integration Joint Board at the reporting date and the transactions of the Integration Joint Board for the year ended 31 March 2016.

…….. 26 September 2016
Karl Williamson
Chief Financial Officer

Statement of Income and Expenditure for period from 27 June 2015 to 31 March 2016

The **Statement of Income and Expenditure** shows the accounting costs of providing the service in accordance with generally accepted accounting practices (GAAP).

	2015/16 Gross Expenditure £000	2015/16 Gross Income £000	2015/16 Net Expenditure £000
Health Services	8,554	(8,554)	0
Social Care Services	7,747	(7,747)	0
Corporate Services	19	(19)	0
Services commissioned by IJB	**16,320**	**(16,320)**	**0**
(Surplus)/Deficit on provision of services	**16,320**	**(16,320)**	**0**

Balance Sheet as at 31 March 2016

The **Balance Sheet** shows the value of the assets and liabilities recognised by the Board (ie the net worth of the entity).

	Notes	31 March 2016 £000
Short Term Debtors	2	16,320
Current Assets		**16,320**
Short Term Creditors	3	(16,320)
Current Liabilities		**(16,320)**
Net Assets		**0**
Usable Reserves		0
Unusable Reserves		0
Total Reserves		**0**

The Statement of Accounts presents a true and fair view of the financial position of the Integration Joint Board as at 31 March 2016 and its income and expenditure for the year then ended.

The unaudited Annual Accounts were authorised for issue on 28 June 2016.

…… 26 September 2016
Karl Williamson
Chief Financial Officer

Notes To The Primary Financial Statements

Note 1 - Summary Of Significant Accounting Policies

General Principles

The Shetland Health and Social Care Partnership is formed under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a Joint Venture between NHS Shetland and Shetland Islands Council.

Integration Joint Boards (IJBs) are specified as section 106 bodies under the Local Government (Scotland) Act 1973 and as such are required to prepare their Annual Accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

The Annual Accounts summarise the IJB's transactions for period from 27 June 2015 to 31 March 2016 and its position as at 31 March 2016.

The Code specifies the applicable accounting policies for:

- selecting measurement bases for recognising assets, liabilities, gains and losses in the Annual Accounts;
- making changes to reserves;
- the minimum disclosure requirements.

A valid estimation technique can be used to derive the monetary amount (i.e. the one that best reflects the economic reality of a transaction or event) to be recognised in the financial statements in such circumstances when the basis of measurement for the monetary amount cannot be applied with certainty (and the range of options is considered to be material).

Accounting Conventions and Concepts

The accounting convention adopted in the Annual Accounts is historical cost.

The concept of the IJB as a going concern is based on the premise that its functions and services will continue in existence for the foreseeable future.

The concept of materiality derives from the premise that financial statements need not be precisely accurate to represent a true and fair view. It is a matter of professional judgement as to whether users of the accounts could come to different conclusions about the IJB's standards of stewardship or make different economic decisions as a result of deviations from the provisions set out in the Code.

The accounting policies which have a significant effect on the amounts recognised in the financial statements of the IJB are summarised below.

(a) Accruals of income and expenditure

Activity is accounted for in the year that it takes place, not simply when the payments are made or received.

- revenue from the sale of goods is recognised when the Board transfers the significant risks and rewards of ownership to the purchaser and it is probable that economic benefits or service potential associated with the transaction will flow to the Board; and
- revenue from the provision of services is recognised when the Board can measure reliably the percentage of completion of the transaction and it is probable that economic benefits or service potential associated with the transaction will flow to the Board.

(b) Funding

The Integrated Joint Board receives contributions from its funding partners, namely Shetland Islands Council and NHS Shetland to fund its services. Expenditure is incurred in the form of charges for services provided to the IJB by these partners.

(c) Value Added Tax

The Integration Joint Board is a non-taxable person and does not charge or recover VAT on its functions.

(d) Provisions, contingent liabilities and assets

Provisions

Provisions are made where an event has taken place that gives the IJB a legal or constructive obligation that probably requires settlement by a transfer of economic benefits or service potential, and a reliable estimate can be made of the amount of the obligation.

Provisions are charged as an expense to the appropriate service lines in the Income and Expenditure Statement in the year that the IJB becomes aware of the obligation, and are measured at the best estimate at the Balance Sheet date of the expenditure required to settle the obligation, taking into account relevant risks and uncertainties.

When payments are eventually made, they are charged to the provision carried in the Balance Sheet. Estimated settlements are reviewed at the end of each financial year. Where it becomes less than probable that a transfer of economic benefits will now be required (or a lower settlement than anticipated is made), the provision is reversed and credited back to the relevant service.

Contingent asset and liabilities

A contingent asset or liability arises where an event has taken place that gives the IJB a possible obligation or benefit whose existence will only be confirmed by the occurrence or otherwise of uncertain future events not wholly within the control of the IJB. Contingent liabilities or assets also arise in circumstances where a provision would otherwise be made but, either it is not probable that an outflow or resources will be required or the amount of the obligation cannot be measured reliably.

Contingent assets and liabilities are not recognised in the Balance Sheet but disclosed in a note to the Accounts where they are deemed material.

(e) Events after the reporting period

Events after the Balance Sheet date are those events, both favourable and unfavourable, that occur between the end of the

reporting period and the date when the Annual Accounts is authorised for issue.

Two types of events can be identified:

- those that provide evidence of conditions that existed at the end of the reporting period whereby the Annual Accounts is adjusted to reflect such events; and
- those that are indicative of conditions that arose after the reporting period whereby the Annual Accounts is not adjusted to reflect such events, but where a category of events would have a material effect and disclosure is made in the notes of the nature of the events and their estimated financial effect.

Events taking place after the date of authorisation for issue are not reflected in the Annual Accounts.

(f) Reserves

Reserves are created by appropriating amounts out of revenue balance in the Movement in Reserves Statement. When expenditure to be financed from a reserve is incurred, it is charged to the appropriate service in that year so as to be included within the Income and Expenditure Statement. There are no reserves as at 31 March 2016, so a Movement of Reserves Statement has not been included in these Accounts.

(g) Corresponding Amounts

The Integration Joint Board was formally established on 27 June 2015 and hence the period to 31 March 2016 is its first period of operation. Consequently there are no corresponding amounts for previous years to be shown.

(h) Related Party Transactions

Related parties are organisations that the IJB can control or influence or who can control or influence the IJB. As partners in the Joint Venture of Shetland Integration Joint Board, both Shetland Islands Council and NHS Shetland are related parties and material transactions with those bodies are disclosed in note 5 in line with the requirements of IAS 24 Related Party Disclosures.

(i) Support Services

Support services were not delegated to the IJB and are provided by the Council and the Health Board free of charge as a "service in kind".

Note 2 – Short Term Debtors

	31 March 2016 £000
Shetland Islands Council	7,757
NHS Shetland	8,563
Total	**16,320**

Note 3 – Short Term Creditors

	31 March 2016 £000
Shetland Islands Council	(7,757)
NHS Shetland	(8,563)
Total	**(16,320)**

Note 4 - Corporate expenditure

	2015/16 £000
Travel & Subsistence	2
Audit Fees	17
Total	**19**

Note 5 - Related party transactions

The Integration Joint Board (IJB) was formally constituted on 27 June 2015 and became live on 20 November 2015 when its Strategic Plan was adopted by Members. In the period from 27 June 2015 to 31 March 2016 the following transactions were made with NHS Shetland and Shetland Islands Council relating to integrated health and social care functions:

Income – payments for integrated functions:

	£000
Shetland Islands Council	(7,756)
NHS Shetland	(8,564)
Total	**(16,320)**

Expenditure – payments for integrated functions:

	£000
Shetland Islands Council	7,756
NH Shetland	8,564
Total	**16,320**

Note 6 - Post Balance Sheet Events

The unaudited Annual Accounts were authorised for issue on 28 June 2016 at the meeting of the IJB. Where events which took place before this date provided information about conditions which existed at 31 March 2016, the Annual Accounts and notes have been adjusted in all material respects to reflect the impact of this information. Events taking place after this date have not been reflected in the Annual Accounts and notes.

Note 7 – Contingent assets and liabilities

A review of potential contingent assets and liabilities has been undertaken for the IJB and none have been identified at 31 March 2016.

Independent Auditor's Report

Independent auditor's report to the members of the Shetland Islands Health and Social Care Partnership and the Accounts Commission for Scotland

I certify that I have audited the financial statements of **Shetland Islands Health and Social Care Partnership** for the period ended 31 March 2016 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Statement of Income and Expenditure, Balance Sheet and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the 2015/16 Code).

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 125 of the Code of Audit Practice approved by the Accounts Commission for Scotland, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Respective responsibilities of the Chief Financial Officer and auditor

As explained more fully in the Statement of Responsibilities, the Chief Financial Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland) as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. Those standards require me to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether

caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances of the **Shetland Islands Health and Social Care Partnership** and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Financial Officer; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the Annual Accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view in accordance with applicable law and the 2015/16 Code of the state of the affairs of the **Shetland Islands Health and Social Care Partnership** as at 31 March 2016 and of the income and expenditure for the period then ended; and
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Opinion on other prescribed matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014; and
- the information given in the Management Commentary for the period for which the financial statements are prepared is consistent with the financial statements.

Matters on which I am required to report by exception

I am required to report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or
- I have not received all the information and explanations I require for my audit; or
- the Annual Governance Statement has not been prepared in accordance with Delivering Good Governance in Local Government; or

I have nothing to report in respect of these matters.

.....
David McConnell, MA, CPFA

Audit Scotland
4th Floor, South Suite
8 Nelson Mandela Place
Glasgow
G2 1BT

26 September 2016

Agenda Item

9

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	2017/18 Budget Setting Process
Reference Number:	CC-71-16 F
Author / Job Title:	Karl Williamson / Chief Financial Officer

Decisions / Action required:

That the Integration Joint Board RESOLVES to approve that the Strategic Commissioning Plan is updated within the budgetary constraints of the indicative 3 year financial plan.

High Level Summary:

The purpose of this report is to present the Integration Joint Board (IJB) with the indicative 3-Year Financial Plan which is the constraint within which the Strategic Commissioning Plan must be updated.

The budget setting process for 2017/18 will be aligned to the Strategic Commissioning Plan Annual Update which is the subject of another paper on today's agenda.

Corporate Priorities and Strategic Aims:

The Strategic Commissioning Plan and associated budgets describes how health and care services can be delivered, jointly, across the services described in the Board's Integration Scheme. This describes how key priorities, as well as day to day operational, services, will be delivered.

The Plan is a significant part of public sector delivery in Shetland and supports the Shetland Community Partnership's Local Outcome Improvement Plan, Shetland Islands Council's Corporate Plan, NHS Shetland's 2020 Vision and Local Delivery Plan.

Delivery of the Strategic Commissioning Plan relies on partnership working between Shetland Islands Council, NHS Shetland, other regional and national organisations (such as the Scottish Ambulance Service and NHS Grampian and other specialist Health Boards) and voluntary sector providers.

Key Issues:

It is evident from this decrease in funding that services cannot continue to be planned and delivered in the same way. With the full involvement of all stakeholders and the creation of a single system for strategic commissioning of services, Integration Authorities must now think innovatively about how services might be provided in the future.

The aim of the Strategic Commissioning Plan update, aligned to the budget setting process, is to minimise or ideally eliminate the need for a Recovery Plan in 2017/18 and beyond. Service plans will have to be developed in a manner which will reduce their cost by approx £3.8m in 2017/18.

Implications :	
Service Users, Patients and Communities:	The Strategic Commissioning Plan sets out the services to be delivered over the next 3 years. Any significant changes to that plan will be of interest to services users, patients and communities, particularly in respect of accessibility and availability.
Human Resources and Organisational Development:	Any service development proposals or changes affecting staff will be subject to full staff engagement and consultation using the relevant agencies policies and procedures and reported via the Joint Staff Forum.
Equality, Diversity and Human Rights:	Any equalities impacts will be assessed and considered as part of any proposals for change and schemes for efficiency savings.
Partnership Working	The Budget in this report will support partnership working across the Health and Social Care Partnership and include budget proposals for integrated services.
Legal:	The proposals in this report are consistent with the Public Bodies Act and the Integration Scheme for Shetland's IJB.
Finance:	There are potentially significant financial implications associated with the update of the Strategic Commissioning Plan. The Joint Strategic (Commissioning) Plan 2016-19 required to be supported by a Recovery Plan for NHS Shetland. The aim of the update is to ensure that the Joint Strategic (Commissioning) Plan 2017-20 minimises, or ideally eliminates, the need for a Recovery Plan in 2017-18. This may mean that the updated Plan needs to include details of significant change projects required to operate within the financial limits set. However, having the planning and budgeting process aligned will give confidence to the IJB that the services described within the Plan can be delivered for the available funding.
Assets and Property:	At this stage, there are no implications for Assets and Property. However, any significant changes to existing service models and methods of delivery may, in time, affect the overall estate in order that service costs can be accommodated within the total budget allocation.
Environmental:	None arising directly from this report.
Risk Management:	There are significant risks associated with the failure to deliver the Strategic Commissioning Plan, which are recorded and reported separately on the Risk Register.

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. Establishing the process of updating the Strategic Commissioning Plan and associated budgets provides clarity and decision points for officers to work within and the IJB has the authority to do so.
Previously considered by:	The proposals in this report have not been presented to any other committee or organisation.

Agenda Item

9

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	26 September 2016
Report Title:	2017/18 Budget Setting Process
Reference Number:	CC-71-16 F
Author / Job Title:	Karl Williamson / Chief Financial Officer

1. Introduction

1.1 The purpose of this report is to present the Integration Joint Board (IJB) with the indicative 3-Year Financial Plan which is the constraint within which the Strategic Commissioning Plan must be updated.

1.2 The budget setting process for 2017/18 will be aligned to the Strategic Commissioning Plan Annual Update which is the subject of another paper on today's agenda.

2. Background

2.1 The IJB is responsible for the preparation of the Strategic Commissioning Plan. The Plan is prepared on a 3-year basis but is required to be updated annually.

2.1 The Strategic Commissioning Plan 2016-19 was approved by the IJB on 28th June 2016 and within that plan was a 3-year indicative Financial Plan from 2016/17 to 2018/19.

2.2 This report updates the 3-Year Financial Plan for the period 2017/18 to 2019/20 and is based on the best information available at this time.

2.3 Shetland Islands Council (SIC) and NHS Shetland (NHSS) both have their own internal processes of consultation and development of their annual budgets. These processes combined with IJB participation will result in modification of these figures as we move through the cycle.

3. 2017/18 Budget Setting Process

3.1 The IJB should, at the start of the process, set the direction and constraints within which it wishes the Strategic Commissioning Plan to be updated. This will include the instruction to both organisations to refresh the Plan within the financial resources available.

3.2 SIC and NHSS have begun their 2017/18 budget setting process in July and plan to have finalised budgets by December 2016.

3.3 The IJB and its Committees will be key to generating ideas and critically appraising the process. The timetable for IJB participation in the budget setting process is shown below.

Date	IJB Participation
26/09/16	IJB set the scene and resolve to approve that the Strategic Commissioning Plan is updated within the financial constraints of the 3-Year Financial Plan.
06/10/16	IJB Seminar to inform the budget setting process by providing feedback to SIC and NHSS.
27/10/16	IJB Seminar to inform the budget setting process by providing further feedback to SIC and NHSS.
23/11/16	IJB will be presented with progress report on budget setting and will be asked to provide further feedback to inform the budget setting process.
09/12/16	IJB will be presented with draft budget for comment prior to both organisations finalising their 17/18 budgets.
NN/02/16	IJB will approve 17/18 budget as part of the updated Strategic Commissioning Plan and issue formal Directions to both organisations.

4. 3-Year Financial Plan

4.1 The indicative 3-Year Financial Plan is shown in Appendix 1 and shows a total delegated budget of £120.514m for the three year period.

4.2 In line with SIC Medium Term Financial Plan and NHSS Local Delivery Plan the resources delegated to the IJB will decrease over the period of the plan. The indicative available budget in 2019/20 will be £3.228m (7.5%) less than the 2016/17 budget of £42.820m.

4.3 Currently there is an efficiency gap of £3.796m in the 2017/18 budget which is made up as follows.

	NHSS		SIC
	Managed Services	Set Aside	
2016/17 unachieved carried forward	1.458m	0.420m	-
2017/18 new target	0.562m	0.106m	-
Medium Term Financial Plan Assumptions	-	-	1.250m
Total	**2.020m**	**0.526m**	**1.250m**
Grand Total	**3.796m**		

4.4 Please note that SIC has considered a budget strategy for 2017/18 that includes a potential reduction in funding for Social Care of £1.250m that balances current spend levels and current demand. At the same time there are a number of scenarios being considered and from a worst case position SIC would also have to find 4.2% of savings across all services, on top of the £1.250m referred to above.

4.5 To highlight the extent of the financial challenge over the next few years the SIC indicative budget reduction of £1.250m has been included in 2017/18 and remains constant for the remaining two years of the financial plan. However, this reduction is likely to increase in 2018/19 and again in 2019/20 as the budget setting process progresses and more information becomes available.

4.6 It is evident from this decrease in funding that services cannot continue to be planned and delivered in the same way. With the full involvement of all stakeholders and the creation of a single system for strategic commissioning of services, Integration Authorities must now think innovatively about how services might be provided in the future.

4.7 The aim of the Strategic Commissioning Plan update, aligned to the budget setting process, is to minimise or ideally eliminate the need for a Recovery Plan in 2017/18 and beyond. Service plans will have to be developed in a manner which will close the £3.796m efficiency target shown in paragraph 4.3 above.

4.8 The £250m additional government funding for adult social care will continue on a recurrent basis for the duration of the current Parliament. Shetland's allocation of £1.024m is assumed to continue for the duration of this 3 year financial plan and the IJB will be asked to approve its application on an annual basis.

4.9 The Integrated Care Fund of £0.410m has now been moved to NHSS baseline allocation but will continue to be made available to the IJB for the duration of this financial plan. The IJB will again be asked to approve its application on an annual basis.

5. Recommendations

5.1 That the Integration Joint Board RESOLVES to approve that the Strategic Commissioning Plan is updated within the budgetary constraints of the indicative 3-Year Financial Plan.

Contact Details:
For further information please contact:
Karl Williamson, NHS Head of Finance & Procurement / IJB Chief Financial Officer
karlwilliamson@nhs.net Tel 01595 743301
09th September 2016

Appendices
Appendix 1 - IJB 3-Year Indicative Financial Plan

Appendix 1

	2017/2018			2018/2019			2019/2020		
Service	**SIC**	**NHSS**	**NHSS Set Aside**	**SIC**	**NHSS**	**NHSS Set Aside**	**SIC**	**NHSS**	**NHSS Set Aside**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mental Health	1,060	1,353	-	1,060	1,353	-	1,060	1,353	-
Substance Misuse	257	496	-	257	496	-	257	496	-
Oral Health	-	3,123	-	-	3,123	-	-	3,123	-
Pharmacy & Prescribing	-	5,714	462	-	5,714	462	-	5,714	462
Primary Care	-	4,571	-	-	4,571	-	-	4,571	-
Community Nursing	-	2,330	-	-	2,330	-	-	2,330	-
Directorate	259	94	-	259	94	-	259	94	-
Pensioners	78	-	-	78	-	-	78	-	-
Sexual Health	-	-	38	-	-	38	-	-	38
Adult Services	5,201	66	-	5,201	66	-	5,201	66	-
Adult Social Work	1,665	-	-	1,665	-	-	1,665	-	-
Community Care Resources	10,512	-	-	10,512	-	-	10,512	-	-
Criminal Justice	29	-	-	29	-	-	29	-	-
Speech & Language Therapy	-	83	-	-	83	-	-	83	-
Dietetics	-	112	-	-	112	-	-	112	-
Podiatry	-	225	-	-	225	-	-	225	-
Orthotics	-	143	-	-	143	-	-	143	-
Physiotherapy	-	603	-	-	603	-	-	603	-
Occupational Therapy	1,371	185	-	1,371	185	-	1,371	185	-
Health Improvement	-	-	310	-	-	310	-	-	310
Unscheduled Care	-	-	3,190	-	-	3,190	-	-	3,190
Renal	-	-	145	-	-	145	-	-	145
Total	**20,432**	**19,098**	**4,145**	**20,432**	**19,098**	**4,145**	**20,432**	**19,098**	**4,145**
Scottish Government Additionality Funding for Adult Social Care	512	-	-	512	-	-	512	-	-
Integrated Care Funding	-	410	-	-	410	-	-	410	-
SIC Medium Term Financial Planning Assumptions	-1,250			-1,250			-1,250		
NHSS Efficiency Target	-	-2,020	-526	-	-2,594	-632	-	-3,017	-738
Total	**19,694**	**17,488**	**3,619**	**19,694**	**16,914**	**3,513**	**19,694**	**16,491**	**3,407**
Grand Total		**40,801**			**40,121**			**39,592**	
Total 3 Year Indicative budget allocation					**120,514**				