Agenda Item

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Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Chief Social Work Officer Report
Reference Number:	CC-72-16 F
Author / Job Title:	Martha Nicolson, Chief Social Work Officer

Decisions / Action required:

The Integration Joint Board is asked to NOTE, DISCUSS and CONSIDER the Annual Report from the Chief Social Work Officer and highlight any issues/concerns to advise the Council of their views and/or 'direct' the Council on any matters where they want to see action taken.

High Level Summary:

The purpose of this report is to provide the IJB with the overview of social work and social care activity, performance and key achievements during the period 1 April 2015 to 31 March 2016. It provides information on the statutory responsibilities of the Chief Social Work Officer on behalf of Shetland Islands Council and highlights challenges for services in the forthcoming year.

Corporate Priorities and Joint Working:

The Chief Social Work Officer's report was prepared by engaging with service leads across social services to gather data and information on the way in which services are delivered and highlights good social work practice and improvement activity.

Social Care and Social Work services contribute the Corporate Priorities as detailed in the Children's Services and Community Health and Social Care Directorate plans and respective Service plans.

The Chief Social Work Officer report is presented to both the Integration Joint Board and Education and Families Committee.

Key Issues:

The key issues are:

We deliver good quality social work and social care services.

We have a skilled and committed workforce. We need to ensure that we are doing everything we can to improve our recruitment and retention of staff.

Strong leadership is needed in order to achieve:

- Acceleration of integration and collaborative working
- Delivery on prevention, early intervention and reablement
- The rebalance of provision in order to support individuals and families in their communities
- Clarity on professional governance and accountability.

We need to consider the impact of the developing health and social care integration agenda on Children's Services, particularly in relation to social work and social care.

Implications	
Service Users, Patients and Communities:	Social services are delivered, often in partnership with other services, and takes account of the views of carers and service users.
Human Resources and Organisational Development:	There are Human Resources implications in relation to the challenge of recruiting and retaining staff and the need to ensure that the training and development needs of our workforce are supported and prioritised appropriately. This report will also be presented to the Joint Staff Forum to ensure staff are consulted.
Equality, Diversity and Human Rights:	Ethical awareness, professional integrity, respect for human rights and a commitment to promoting social justice are at the core of social work practice.
Legal:	The legal framework in relation to the Chief Social Work Officer is provided by the Social Work (Scotland) Act 1968, which requires local authorities to appoint a single Chief Social Work Officer. The Public Bodies (Joint Working) (Scotland) Act 2014 is also relevant. Guidance on the Chief Social Work Officer role (Scottish Government, July 2016) summarises the scope of the role of the Chief Social Work Officer. Legal Services provide advice to the Chief Social Work Officer to support the role including support to ensure that the Council's Social Work Complaints handling is in accordance with the relevant legislation.
Finance:	This report is intended to provide Members with information to help when considering financial priorities.
Assets and Property:	No implications.
Environmental:	No implications.
Risk Management:	This report provides Members with information in relation to adult and child care and protection. Risk management of services is dealt with by the respective Directorates responsible for social services.

Policy and Delegated Authority:	Shetland's Integration Joint Board is responsible for the operational oversight of Integrated Services and through the Chief Officer is responsible for the operational management of Integrated Services, including Adult Social Work. The CSWO is required to ensure the provision of appropriate professional advice in the discharge of the Council's statutory social work duties. The CSWO is also required to assist local authorities and their partners in understanding the complexities and cross-cutting nature of social work service delivery – including in relation to particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders - and also the key role social work plays in contributing to the achievement of a wide range of national and local outcomes. The CSWO also has a contribution to make in supporting overall performance improvement and management of corporate risk.	
Considered by:	This report will be presented to: • Education and Families Committee • Joint Governance Group • Clinical Care and Professional Governance Committee • Chief Officers Group	 03 Oct 2016 18 Oct 2016 28 Nov 2016 02 Dec 2016

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Chief Social Work Officer Report
Reference Number:	CC-72-16 F
Author / Job Title:	Martha Nicolson, Chief Social Work Officer

1. Introduction

1.1 This report presents the annual Chief Social Work Officer Report 2015-2016.

2. Background

2.1 The purpose of this report is to provide the IJB with the overview of social work and social care activity, performance and key achievements during the period 1 April 2015 to 31 March 2016. It provides information on the statutory responsibilities of the Chief Social Work Officer on behalf of Shetland Islands Council and highlights challenges for services in the forthcoming year.

2.2 This report is for information only and reflects the requirements set out in Guidance published by the Scottish Government in February 2009, which requires Shetland Islands Council to consider a report from the Chief Social Work Officer on an annual basis.

2.3 This report is shared with the Chief Social Work Advisor for the Scottish Government. The structure of the report follows the template produced by the Office of the Chief Social Work Advisor to the Scottish Government. Use of the template by Chief Social Work Officers across Scotland is intended to help information sharing and benchmarking across services regarding good social work practice and improvement activity.

3. Detail

3.1 The report begins with a reflection on challenges and achievements over the past year. It gives an overview of how social services are delivered in Shetland then provides detail on service quality and performance. There is a section on partnership structures and governance arrangements and the statutory responsibilities of the Chief Social Work Officer are highlighted. The remainder of the report covers finance, workforce, examples of user and care empowerment and improvement approaches.

3.2 By way of introducing this report, I would highlight the following:

a) I want to commend social work and social care staff for their continued commitment and dedication to delivering very good services to the people of Shetland. We have a skilled workforce that works with others to make a positive difference to our children, young people, families and communities.

b) It is important that we continue to support the workforce as there are challenges in achieving and maintaining the quality of services that we currently have. These include: capacity challenges, particularly amongst our managers; recruitment challenges, especially for foster carers, social care staff and experienced social workers; increasing complexity of need; and, a changing service delivery context. A valued and motivated workforce will deliver improvement through innovation.

c) There is a need to identify ways in which we can improve our recruitment and retention of staff. Pressures on workload impact on morale, recruitment and ultimately on the quality of care and support provided. Over the next year the Chief Social Work Officer will work with the Executive Manager in Human Resources to better understand our pay, terms and conditions challenges in relation to social services staff with a view to identifying and resolving difficulties.

d) Alongside this, there is a focus on strengthening and protecting the professionalism of social work and social care, especially as we progress towards greater integration of health and social care. Implementing clear governance frameworks and providing clarity around professional and operational supervision and accountability will support new integrated service delivery models.

e) Over the reporting year, progress has been made to ensure that formal structures are in place to support the functioning of the Integration Joint Board. Social services are delivered across two Directorates with Children's Services reporting to Education and Families Committee and Community Health and Social Care reporting to the Integration

Joint Board. The Clinical, Care and Professional Governance Committee remit was revised to include all social work and social care matters across both children and adult services. Going forward, the impact of the developing health and social care agenda on children's services will need consideration and in particular, to ensure that the two separate governance structures for social services does not result in a widening gap.

f) There is also a need to ensure the Joint Staff Forum is used to best effect to ensure consultation takes place on the impact of change on the workforce

g) It is recognised that some services are experiencing growth, for example, children's residential and foster care. Adult social work and Criminal Justice services report increased activity but in other areas demand can fluctuate, for example, off island placements and direct payments, for which any unexpected demand may be costly.

h) In order to meet the demands of increasing complexity of need, changing demographics and shrinking resources, services must change and adapt and explore different models of service delivery that can deliver positive outcomes to individuals.

i) We have statutory obligations to fulfil, corporate priorities to meet and a vision for excellence and sustainability to realise. There are inevitably tensions within these as we balance risk, rights and needs of individuals and communities. Developing strong leadership across our social services will help us take bold steps to deliver prevention, early intervention and enablement whilst continuing to respond to immediate need.

4 Decision

4.1 The Integration Joint Board is asked to discuss and consider the main issues as highlighted in this report and direct the Council on any matters where they want to see action taken.

5 Conclusion

5.1 The Chief Social Work Officer has statutory responsibilities that are specific to the role (see Appendix 2). These are embedded in legislation and statutory guidance, and relate primarily to the issues of public protection and the promotion of professional standards. This annual report summarises activity related to professional social work and social care functioning.

5.2 It is evident that high quality and effective social services are delivered in Shetland by staff committed to making a difference to some of our most vulnerable people in our communities. They make a vital contribution to the sustainability of our services.

5.3 The demands on the workforce will undoubtedly increase as the needs of the people in Shetland continue to change. Investing in this service area is likely to improve Shetland –wide outcomes and we can do that by developing leadership, strengthening and supporting the professionalism of social work and social care and ensuring clear governance arrangements are in place to support greater integration and collaboration.

Contact Details:
For further information please contact:
Martha Nicolson, Chief Social Work Officer
martha.nicolson@shetland.gov.uk
2 September 2016

Appendices:
Appendix 1 Chief Social Work Officer Annual Report 2015-16
Appendix 2 The Role of Chief Social Work Officer

Shetland Islands Council

CHIEF SOCIAL WORK OFFICER

ANNUAL REPORT

2015-2016

Contents

1 Introduction

This Annual Report from the Council's Chief Social Work Officer is intended to provide an overview of social work activity, performance and key achievements during the period 1 April 2015 - 31 March 2016. It will provide information on the statutory responsibilities of the Chief Social Work Officer on behalf of Shetland Islands Council and highlight key challenges for services in the forthcoming year.

This report is not intended to be exhaustive and generally summarises activity relating to professional social work functioning. The structure of the report follows the template produced by Scottish Government and Social Work Scotland to aid consistency across Chief Social Work Officer annual reports.

2 Summary Reflections

The joint inspection of Children's Services recognised some of the very good work taking place. Shetland is recognised as a good place for children growing up: children are generally in good health, they perform well at school and benefit from accessible sport and leisure facilities. Inspectors considered that planning for individual children and young people is also good and many families receive flexible support, which is making a real difference to them and their children. However, there were areas that needed prioritisation, one of which was for Shetland to develop its supply of both residential and fostering placements. In response to this, two new sets of carers were approved and a further residential service in Lerwick opened for one young person. As a result, all children requiring a placement on care grounds have been provided with this within the Shetland community. Within a more strategic context, the social work service has been developing a business case for the longer term provisioning of residential care and will launch a Carer Recruitment Strategy for the period 2016 - 2019 later in the year.

Self directed support works well for a handful of Shetland families but there are ambitions to make this support available to all who are eligible. Working with colleagues in adult services and learning from their experiences will help to promote care that is flexible to meet the needs of young people and their families.

Key management posts across Children's Social Work services have been successfully recruited to this year. A new Executive Manager was appointed in November 2016 and key middle management posts were successfully recruited to for Family Support, Family Placement and Children and Families services. The next step in 2016 for children's residential services will be to implement the findings of the CELCIS Residential Review and appoint Registered Managers. One important post remains unfilled, the Independent Reviewing Officer, responsible for chairing child protection case conferences and looked after children reviews. This has put additional strain on services and the benefit of arms length scrutiny of these key processes is missing. Interim temporary arrangements are now in place with the appointment of an agency worker.

Achieving permanence for children who are unable to remain with their birth family in a more timely way is a strategic objective. Towards the end of the reporting year, Shetland agreed to work in partnership with the Centre for Excellence for Looked After Children and the Scottish Government in a programme aimed at improving practice in permanency. Working collaboratively with partners, a series of workshops were set up to first understand what some of the challenges are in delivering the best outcomes for children and then to develop work steams to address some of these. This will continue to be a priority through 2016/17.

One of the highlights in 2015/16 must be the recognition given to staff and carers for their work and dedication to making a difference for children and young people. At a civic reception in the Town Hall hosted by Shetland Island's Council Convenor, Malcolm Bell, the contribution that local foster carers make through their care and commitment to our young people was celebrated. A few months later, Elinor Thompson, Team Leader Children and Families, was presented with a Social Work Award in Leadership by Children and Young People Minister, Aileen Campbell, at a national event.

Older People's Services were also inspected and performance considered strong with evidence of good outcomes being achieved. The flexibility and motivation of staff was commended, particularly those at the front line and older people and carers were generally happy with the services provided to them. The development of integrated teams and a structure to support locality planning were recognised as being at early stage. The main challenge was the need to develop more integrated ways of working and more joined up services, and to look for opportunities arising from integration to address capacity issues. The Engagement and Participation Strategy for integrated services was approved by the Integration Joint Board and is intended to support community capacity building. A Head of Planning post has been recruited to and more dedicated management support is planned to be put in place in 2016.

Over the year, key developments in Adult Services include the review and implementation of new With You For You pathway tools. Alongside this, a new risk assessment and risk management tool has been developed. The number of people who are delayed in hospital has reduced and the amount of time that people are delayed for has also reduced. Committing specific social work and administrative support to hospital liaison and intake work has helped improve communications and ensure assessments and care management is happening in a more timely way.

The number of people in Shetland with learning disability, autistic spectrum disorder, profound and multiple complex needs known to the Local Authority is slightly above the national average with just over 8 people per 1000 compared to the Scottish average of 6 people per 1000 (*ref: Scottish Consortium for Learning Disability Learning Disability Statistics Scotland, 2014*). At October 2015, this translates into 197 adults with either Learning Disability or Autistic Spectrum Disorder and a further 51 under 16's year olds in Shetland. As the population of people with a learning disability and autism spectrum disorder grows larger and people are reaching older age, it is increasingly important to consider what enables individuals to remain in their own homes and have meaningful lives in their communities. Additionally, it is recognised that the biggest challenge for the foreseeable future will be to maintain, with limited resources, both the level and quality of care the people of Shetland have come to expect.

A national redesign of 'community justice' is taking place in Scotland. From 1st April 2017 responsibility for local strategic planning and delivery of community justice will transfer from the eight Community Justice Authorities to Community Planning Partners in each local authority area. The new model seeks to deliver better outcomes for communities by promoting a collaborative approach to the planning and delivery of community justice services. Locally, responsibility for progressing work in this area has been delegated to a new Community Justice Partnership which will report directly to the Shetland Partnership Board. The development and submission of Shetland's Community Justice Transition Plan for 2016-17 was a key step in the transition process.

3 Partnership Structures/Governance Arrangements

The Social Work (Scotland) Act 1968 requires local authorities to appoint a single Chief Social Work Officer. It was established to ensure the provision of appropriate professional advice in the discharge of the local authority's statutory function, as set out in the 1968 Act. It also has a place in integrated arrangements brought in through the Public Bodies (Joint Working) (Scotland) Act 2014. The role of the Chief Social Work Officer is to provide professional governance, leadership and accountability for the delivery of social work and social care services. This applies both to services provided by the local authority and those purchased by the Council.

In July 2016, the Scottish Government issued revised Guidance on the Chief Social Work Officer role http://www.gov.scot/Resource/0050/00503219.pdf. It summarises the minimum scope of the role of the Chief Social Work Officer and will assist elected members in ensuring that the role is delivered effectively and that the local authority derives maximum benefit from the effective functioning of the role.

In Shetland, the Chief Social Work Officer sits with the Executive Manager Children and Families reporting directly to the Children's Services Director, with a line of accountability to the Council Chief Executive in relation to the Chief Social Work Officer function. As a member of the Corporate Management Team and Risk Management Board, the Chief Social Work Officer has the opportunity for involvement in corporate decision making, and provides the professional guidance, governance and scrutiny to ensure risks for the profession and local authority are managed.

There are five Directorates within the Council. Social services are delivered across two of these - Children's Services, reporting to Education and Families Committee and Community Health and Social Care, reporting to the Integration Joint Board. The Chief Social Work Officer is a member of the Integration Joint Board and its associated Audit Committee. To strengthen governance arrangements and support the delivery of integrated services, a Governance Framework was developed and the terms of reference for the Clinical Care and Professional Care Committee revised to include all social work and social care matters. The Chief Social Work Officer is a member of this Committee and also sits on the Integrated Children and Young People's Strategic Planning Group. These partners from across sectors provide leadership and direction to the Children's Forum, responsible for the delivery of the Integrated Children and Young Peoples Services Plan.

The Chief Social Work Officer is a member of the Chief Officer's Group, the remit of which is to provide strategic leadership and scrutiny to the public protection work of their respective agencies and to inter-agency work. The key areas overseen by the Chief Officers' Group are child protection, adult protection and offender management. The Chief Social Work Officer is also a member of Shetland's Child Protection and Adult Support and Protection Committees.

4 Social Services Delivery Landscape

Shetland is situated 338km north of Aberdeen and 360km west of Norway and consists of a group of 100 islands with 15 of these being inhabited. The mainland is the largest island and the third largest island in Scotland. Approximately 30% of the population live in Lerwick with the remained dispersed across a rural and island landscape, dependent on good transport links to access services, work, education and leisure.

The population of Shetland is just over 23,000, accounting for 0.4% of the total population of Scotland. 16.4% of the population are aged 16-29 years compared to the Scottish average of 18.2%. Persons aged 60 and over make up 25.1% of Shetland, whilst the Scottish average is 24.2%.

Although there was a slight decrease in population in 2015, the population of Shetland has risen overall since 1989. By 2037, the population of Shetland is projected to be 25,147. Over the 25 year period, the 75+ age group is projected to increase most in size. The population aged under 16 is projected to decline by 2.8% over the same period (*ref: National Records of Scotland, 2016*).

Unemployment in Shetland has been very low for three decades although some fragile island communities experience higher rates. In 2014, 70% of employment was estimated to be in the Service sector. Fishing, agriculture and oil are important industries with tourism also playing a part. Low unemployment and well paid jobs have contributed to the challenge of recruiting social services staff resulting in the use of agency staff in both children's and adults services over the past year.

Shetland is generally considered a good place to live but during 2015, Shetland's Commission on Tackling Inequalities, looked at evidence which indicated inequalities do exist, for example, households in fuel poverty, in work poverty and adults experiencing mental ill health (*ref: On Da Level, March 2016*). Improved local data collection and analysis will help develop the shape and structure of planning and delivering services within localities. Greater integration and collaboration will help Shetland realise its ambition to help people to remain in their own homes.

Most of our health and care services are provided by public services. For example, there are 66 services actively providing care within Shetland, 53 of which are provided by the Council (ref: Care Inspectorate data). There are few private providers, none in relation to adult services, and a total of 8 voluntary or not for profit services across children's and adults services.

The Children's and Families social work team is based within Children's Services, alongside a range of complimentary services in Children's Resources supporting families across Shetland. This includes:

- Isleshaven Nursery and Out of School Club;
- Bruce Family Centre;
- Early Intervention Team based at Hayfield House;
- Short Breaks Service provision through two residential services in Lerwick;
- Family Placement Services supporting foster carers and adopters and all aspects of recruitment; and,
- Residential Services supporting children and young people in three services in Lerwick.

At present Shetland is experiencing significant demand for placements as a result of factors affecting families in relation to neglect and drug and alcohol misuse. In order to respond to these pressures a further singleton resource in Lerwick was opened and a further three bed service will be operational later in the year. Alongside this, working is underway to put forward a business case to the Council to support the development of residential services over the longer term in 2016.

The Children's Resources management team are aware of the need to rebalance service provision away from residential services to support families in their own communities and as such will undertake reviews of services in 2016 to ensure they are in line with current best practice and are sustainable in the longer term. The Children and Families social work service is also recognising that we need to strengthen the way we work with families and over the next year this will be further explored.

Work is underway to develop of a Corporate Parenting Strategy as well as exploring the feasibility of introducing a Champions Board to promote the voice of children and young people in service delivery and design. This involves working with all partners across the agencies and provides the opportunity to improve the future of Shetland's looked after children and care leavers.

Adult Social Work sits in the Community Health and Care Directorate along with Criminal Justice and a wide range of social care services delivering supported accommodation and outreach services, care at home, day care, respite care and residential care across ten care/support centres. Whilst we need to ensure that there are services available when people need them, many services also are required to assess and manage risk, to proactively intervene to support people and to provide therapeutic interventions as well as care and support. Services continue to face challenge to meet the growing demand of complexity whilst continuing to deliver on early intervention and prevention, and still meet efficiency demands.

5 Finance

Shetland Islands Council Medium Term Financial Plan 2015/16-2020/21 provides the financial framework for the delivery of Council services to the people of Shetland. The plan takes account of the desired outcomes of the Council's Corporate Plan recognising the need to improve productivity and efficiency in order to maintain and improve the Services provided, as well as continue to prioritise its spending. In preparing the budget, the public are provided with the opportunity to participate in the process, this is known as 'Building Budgets'.

The 2016/17 budget set for Children's Services totals £41.2m and for Community Health & Social Care Services totals £20.4m. Included in these figures are savings of 3.3% before cost pressures, primarily in relation to pay award, were added in to the budget.

For future years, the MTFP identifies further year on year savings of 3.3% as being a requirement from each Directorate in order to continue to set a financially sustainable budget.

In 2015/16 Children's Services revised budget totalled £41.6m. £5.1m of this budget related specifically to Children's Social Work and showed a slight overspend at the year end, mainly due to the cost of implementing the Social Work Action Plan and increased demand within residential services. This was offset by savings due to staff turnover vacancies across the services.

It is recognised that going forward some service areas are experiencing growth, for example, children's residential and foster care. Whereas in other areas demand can fluctuate from one year to another, for example, off island placements and direct payments, and any unexpected demand for these services may be costly.

The Integration Joint Board (IJB) was established on 27 June 2015. The Council and the Shetland Health Board (the Parties), delegate the responsibility for planning and resourcing service provision of adult health and social care services to the IJB and its Strategic Plan specifies the services to be delivered by each Party. The IJB became live on 20 November 2015 when this Plan was agreed by IJB Members. Only part of the Council Community Health and Social Care budget was allocated to the IJB in 2015/16, as it was apportioned from the point the IJB became live.

The Community Health and Social Care Directorate set a budget of £19.7m for 2015/16. The budget was underspent by just over £2m, which was mainly due to underspends in employee costs across the Directorate, but also reflected the early closure of Viewforth Care Home in February 2014. The quality of service provision within Community Health and Social Care has remained at a high level, as evidenced in Care Inspectorate inspections, despite employee cost underspends.

Self-Directed Support legislation came into force on 1 April 2014, giving people a range of choices over how they receive their social care and support. An increase in demand for SDS packages has been seen during 2015/16 and continues into 2016/17. Most of the new packages being requested represent people approaching the Council for the first time for support.

In order to meet the challenges of changing demographics and shrinking resources, services must have the ability to change and adapt, including exploring different models of service delivery.

6 Service Quality and Performance

Adult Social Work Services

The Adult Social Work team has a wide remit and covers all social work and statutory functions in relation to adults over 16 years old (who have left school), apart from those functions which fall under Criminal Justice responsibility. This includes care management duties, which involves assessment and arranging services in line with Self-Directed Support legislation to meet individual's needs. It also involves periodically reviewing care packages and maintaining contact with people in receipt of Self-Directed Support, or if an adult is subject to Welfare Guardianship.

There is a dedicated duty Social Worker in the team who screens referrals and responds to urgent situations. The duty Social Worker role includes liaison with the hospital to ensure people have appropriate support, when required, to facilitate their timely discharge into the community. The post is an example of the more integrated collaborative approach between Acute Services and Community Health and Social Care Services. This post has played a key role in reducing the number of delayed discharges from hospital and reducing the number of bed days lost because of delays.

In the Adult Social Work Team, the number of cases allocated to Social Workers increased by 35 from 393 in 2014/2015 to 428 in 2015/2016. This increase is the equivalent to a full time Social Worker caseload and followed an increase of 26 cases from the year before. The four options of self directed support are routinely being offered to all those eligible for support. The number of people accessing Option 1 - Direct Payments, has increased slightly but overall spend increased from £585k in 2013/2014 to £643k. Option 3 - Council Provided Support, remains the most common form of support to people in Shetland.

Mental Health Officers are based in this team as is the dedicated Substance Misuse Social Worker who works as part of the Substance Misuse Recovery team and assesses people for rehabilitation where they have substance use issues.

Social Workers are responsible for assessing and managing risk in relation to vulnerable adults. Risk Assessment and Risk Management training was undertaken by the Adult Social Work team during this reporting year. Senior Social Workers subsequently developed a new risk assessment and management tool. Social Workers in the Adult Social Work team trained as Council Officers are able to carry out the full range of duties under the Adult Support and Protection (Scotland) Act 2007. Social Workers who have recently joined the team are to undertake Council Officer training in the near future.

Adult Support and Protection

The Adult Protection Committee is required to produce a Biennial Report for the Scottish Government on its work. Its third report was presented to Social Services Committee on 30 October 2014 http://www.safershetland.com/assets/files/APC-Biennial-Report-2014-Final.pdf. The Fourth Biennial Report will be submitted to Scottish Government on 31 October 2016 and presented to the Integration Joint Board.

Adults are considered to be at risk when they meet the 3-point test. This means they are:

- Are unable to safeguard their own wellbeing, property, rights or other interests;
- Are at risk of harm; and,
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

The table below shows the records held on referrals for Adult Support and Protection for the reporting period and the previous year:

Table 3: Adult Support and Protection Activity

Date	Referrals	No of Conferences	No who did not meet 3 point test	Police Investigations	Social Work Investigations
2014/15	223	01	215	0	01
2015/16	252	00	239	0	01

This evidences a significant increase in Adult Support and Protection referrals being received.

In 2015/16 there was an increase in referrals that raised concerns about the safety and well being of adults. 252 referrals were received of which 13 met the 3 point test. The majority of referrals came from Police Scotland (226), 1 from SIC Housing, 1 from the Community Mental Health team, 9 from Primary and Acute health services, 2 from NHS 24, 9 from Social Work, 1 from a member of the public, 1 from family member and 2 from unknown sources. There were a number of highly vulnerable individuals who were referred on more than one occasion - 71 referrals related to 56 people including one person who was referred on 9 occasions. For the 239 referrals which did not meet the 3 point test a range of other appropriate supports and interventions were put in place - 75 required no further action, 40 were passed on to social work services for assessments of need, 46 referrals were passed to a number of mental health services (CMHT, MHO, Annsbrae, CPN, Psychiatrist), 26 were passed to substance misuse services (Substance Misuse Social Worker, CADSS, Substance Misuse Recovery Service), 14 were referred to the Criminal Justice Service and the remaining 38 referrals were dealt with by a variety of local services (for example, Shetland Women's Aid, Maternity, Children and Families Social Work, Citizens Advice Bureau, SIC Housing Services, Dementia Care Services, etc.)

There were no Adult Protection Case Conferences held in 2015/16 as a result of the referrals received as noted above and no legal orders sought. One adult was subject to a protection plan until October 2015 and there were 2 review conferences to discuss this adult, but the original referral relating to this individual fell outside this reporting period. Agencies continued to meet to discuss referrals, although with good interagency contact and information gathering by Senior Social Work staff it has proved possible to deal with lower level adult concerns and hold more formal interagency meetings only when it was necessary to discuss higher risk situations.

Mental Health Officers

Mental Health Officers are registered Social Workers who have been qualified at least two years and undertake intensive post qualifying training at Master's level, to gain their Mental Health Award. The Chief Social Work Officer has a duty to ensure the appointment, and continued registration of Mental Health Officers who undertake duties as required by legislation. Currently, there are two full-time equivalent Social Workers and two Senior Social Workers who are qualified to act as Mental Health Officers. In addition, there are two Mental Health Officers employed on a relief basis in Aberdeen to undertake statutory duties when individuals are admitted to hospital there. This avoids Shetland based MHOs having to constantly travel to Aberdeen to undertake such work. The current Mental Health Officer staffing quota meets demand, but there has been an increase in work under the Adult's with Incapacity (Scotland) Act 2000 and to ensure adequate numbers of Mental Health Officers in the future it will be essential that Social Workers continue to undertake Mental Health Award training. There is one Social Worker due to start the Mental Health Officer Award training in September 2016. The Scottish Government is in the process of updating the Mental Health Act and it

is expected that amendments will be introduced during 2017. Mental Health Officers will require training in the new legislation when introduced.

Mental Health Officers undertake statutory duties on behalf of the local authority under the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000, the Criminal Procedure (Scotland) Act 1995. Where an adult is at risk of harm and may have a mental disorder Mental Health Officers are also involved in Adult Support and Protection (Scotland) 2007 work. They work autonomously and have to make complex decisions independent of the local authority or NHS. These are decisions which reduce risk to individuals, and on occasion to the public. Statutory duties include: assessing, consenting or refusing consent to detention, making applications and providing reports to the Mental Health Tribunal for Scotland and the Sheriff Court. Depriving a person's of their liberty is a serious event and Mental Health Officers must ensure that any statutory intervention is lawful, and that all voluntary alternatives have been exhausted. They also work closely with the Community Mental Health Team and Annsbrae Support Services to support people in the community and avoid hospital admission.

A summary of activity over the past two years is illustrated in the table below:

Table 4: Mental Health Officer Activity

Category	2014/15	2015/16
MHO Contacts	82	63
Individuals subject to Compulsory Treatment Orders	5	7
Emergency Detentions	12	5
Short Term Detentions	16	13
Social Circumstances Reports	12	7
Other Mental Health Assessments	4	4
Assessment Order	0	1
Adults With Incapacity Reports	4	7
Mental Health Reviews	10	21
Mental Health Tribunals	8	7
Welfare Guardianship Reviews	10	21
Consultations under the Mental Health (Care and Treatment) (Scotland) Act 2003	5	5
Individuals subject to Welfare Guardianships	12	15
Individuals CSWO Guardianship	2	3
Compulsory Treatment Order Applications	1	2
Consultation under Adults with Incapacity (Scotland) Act 2000	6	11
Mental Health Officer report for Compulsory Treatment Order Extension / Variation	3	3

Criminal Justice

The management of sexual and violent offenders remains a priority for Criminal Justice Social Work. The Executive Manager Criminal Justice continues to report Multi Agency Public Protection Arrangements (MAPPA) to the Chief Officers' Group. The governance of MAPPA in relation to high risk offenders continues to be managed by the Public Protection Unit in Inverness.

Multiagency Risk Assessment Conferencing (MARAC) is established for people who are experiencing high risk domestic abuse. MARAC was run by the Adult and Child Protection team up until March 2016 then following formal agreements it was taken over by a full time Highland Coordinator, who is also providing this service for Western Isles and Orkney. A Highland and Island Operating Group has

been established and the Lead Officer for Adult and Child Protection represents Shetland as part of that group. In the reporting year, there were 26 MARAC referrals.

The Community Payback Order is the main community based sentence in Scotland and is a direct alternative to custody. The Criminal Justice service has been involved in the following community payback activity over the past year:

Table 5: Criminal Justice Service Activity

Category	2014/15	2015/16
Criminal Justice Social Work Reports/203's	70	114
Community Payback Orders	56	82
Offender Supervision Requirement	28	48
Unpaid Work Requirement	46	60
Other Requirements	8	12
Unpaid Work Hours Imposed	4615	6289
Unpaid Work Hours Completed	2965	4948
Total Number of CPO Requirements	138	202

From the table above, it is apparent that compared to 2014/15 there was a significant increase in all areas of work. This placed pressure on the service in meeting deadlines for court reports and other government benchmarks and social work staff had to work additional hours to meet these. The service has been unsuccessful in recruiting to the vacant part time community service post and has relied on the existing part time supervisor undertaking additional hours but this is unsustainable in the long term.

Unpaid Work Requirements enable offenders to do unpaid work to benefit communities. 4948 hours of unpaid work were carried out across Shetland including: painting and decorating of community premises in Scalloway, Ollaberry and Whiteness and environmental projects such as tree planting, grass cutting and beach road restorations. Feedback from beneficiaries is consistently positive with many saying that they would struggle to maintain community venues without unpaid work support.

Addressing offender behaviour is essential if individuals are to be helped to make changes to their lives and stop offending. All individuals subject to a Supervision Requirement have an individual plan to address their criminogenic need. Examples of the types of general work undertaken include offending behaviour, restorative justice, victim awareness, substance misuse and employability programmes. Specialised work included domestic violence and sex offender programmes.

The main challenge facing the service at present is the new model for Community Justice which is to be introduced throughout Scotland in April 2017. This sees Community Planning Partnerships being responsible for strategy, delivery and commissioning of Community Justice Services and will include Criminal Justice social work. The service has been working alongside community development and the Shetland Partnership to ensure a smooth transition to the newly formed Shetland Community Justice Partnership. Funding for Criminal Justice social work remains a concern as the Government has not yet announced what this may look like for 2017/18.

<u>Care Services</u>

Since the Regulation of Care (Scotland) Act 2001 came into effect, a range of services have been registered with the Care Inspectorate and inspected against National Care Standards. The inspections

are based on four quality themes and graded on a six point scale. Within each quality theme there may be two or three aspects inspected, with the final grade reflecting the lowest.

Inspection activity and the accompanying action plans are reported to the relevant committees for adults and children's services. The table below provides a summary of the 19 inspections that took place during 2015/16:

Table 6: Inspection Activity of Registered Services (April 2015 to March 2016)

Grade	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management and Leadership	Total	%
6 - Excellent	1	0	0	0	1	1
5 - Very Good	8	8	5	4	25	33
4 - Good	8	7	13	11	39	51
3 - Adequate	2	0	1	4	7	9
2 - Weak	0	0	0	0	0	0
1 - Unsatisfactory	0	0	0	0	0	0
Not Inspected	0	4	0	0	4	5

During the reporting period, a total of 19 services were inspected. The quality of our services are good with most (84%) graded as good and very good. Some are some consistently very good across all areas, for example, the Adoption Service, Nordalea Day Care, and Annsbrae, which was considered excellent for quality of care and support. There were no services with a grade mix of 1&2 in the reporting year but some services were assessed adequate, particularly in quality of leadership and management. In all areas, this represented shift from a previous grade of good. Some of the reasons provided for this are change in structures and vacant posts, but also the need to further develop quality assurance processes and strengthen leadership across management teams. The interim Executive Manager Community Care Resources is working with Team Leaders to focus on consistency within care services across Shetland in order to ensure that processes and structures remain robust and fit for purpose. Services inspected and grades for this year and the previous year are listed at **Appendix 1**.

Community Care Resources provide services direct to individuals who require assessed support to remain living within their own community. Although registered for individuals over the age of 16, the majority of people who receive support are over the age of 65 years. The number of people in care homes is below the national average (24 per 1000 of the population compared to 36 per 1000 across Scotland). In Shetland, 85 people per 1000 population receive care at home, compared to the Scottish average of 53 per 1000 population.

Adult Services comprises of a range of services to meet the assessed needs of adults over the age of 16 years with learning disability, autism spectrum disorder and complex needs. Services include Supported Living Service (SL) which works in close association with SIC Housing and Hjaltland Housing Association to provide supported tenancies. Some outreach support for people living in their own or family home is also delivered.

Supported Vocational Activity Service, the Eric Gray Resource Centre (EGRC), provides a needs led, day support service to adults with learning disabilities and autistic spectrum disorder that recognises the rights of the individual to participate as meaningfully and as independently as possible in everyday life. Assessed needs are met through a range of vocational, learning and recreational

opportunities and experiences to promote inclusion, choice and independence and encourage each person to fulfil their personal goals and aspirations.

Supported Employment opportunities are provided through third sector providers including: COPE, which offers a range of supported employment placements in their small businesses and works closely with EGRC; and the Moving On Employment Project (MOEP), which provides Job Brokerage and Tapered Support to sustain people into mainstream employment.

Short Break and Respite Service, Newcraigielea, is committed to supporting unpaid carers manage their caring role and be enabled to have a life outside of caring. Good quality and flexible support to meet the assessed needs of adults with a learning disability, autistic spectrum disorder and complex needs and those of the unpaid carer is provided. Newcraigielea also offers a day care service through the GOLD Group for older people with learning disability.

Children's Social Work Services

The Social Workers in Children's Social Work are predominately engaged in fulfilling statutory duties in relation to children and young people in need of protection or additional care, including permanent alternative care. They provide advice, guidance and direct support to children, young people and their families and carers, ensuring that the best interest of children are paramount in any decision making about their lives. Social Workers work closely with colleagues in other agencies to such as Schools, Health, Police, Children's Reporter and Voluntary Services, to promote good communication and collaboration, essential for Getting it Right for Every Child.

Child Protection

Shetland Child Protection Committee recently reported on the period 2015/16 http://www.safershetland.com/assets/files/CPC%202015-16%20Annual%20Report.pdf. During the year, the Inter-agency Child Protection procedures were revised and are now consistent with the National Guidance for Child Protection (2014). It also includes new protocols addressing the emerging issues of internet safety and self-harm and supporting vulnerable young people aged 16-18, where there is a risk that they may fall between gaps in services.

In the year 2015/16, there was a reduction in child protection referrals, 183 compared to 235 the previous year, and fewer joint police/social work interviews, 54 compared to 71 in 2014/15. There were fewer names recorded on the child protection register, 43 compared to 48 in 2014/15. Data is collected on the categories of abuse of children whose names are on the resister. In individual cases where domestic abuse or parental substance misuse is a recognised risk to children protection plans are drafted to ensure these issues are fully addressed and wherever possible risks reduced. Additionally, Shetland Child Protection Committee is working closely with social work staff and the Substance Misuse Team to look at ways of improving support to families where parents misuse substances, particularly those situations where a parent relapses and risks for children increase again. Shetland Child Protection Committee will give consideration to further work to address the issue of domestic abuse and look at any additional work that can be undertaken in partnership with local agencies Shetland Women's Aid and also Shetland Domestic Abuse Partnership.

In last year's Chief Social Work Officer report, the marked increase in child protection activity compared to previous years was discussed. Over this reporting year an Intake Service has been established within the Children and Families team, which has ensured consistency in the recording and management of all referrals, including those relating to child protection. This will provide better data for quality assurance activity.

The table below summarises child protection case conference activity over the past two years:

Table 1: Child Protection Case Conference Activity

Child Protection	No of children 2014/15	No of children 2015/16
Initial Child Protection Case Conferences	50	15
Review Child Protection Case Conferences	59	33
Number of children on the Child Protection Register	48	43
Number of children on the Child Protection Register on 31 March 2016	17	13

Looked After Children

Looked After Children are defined as those for whom the local authority has a responsibility for their care. Some of these children will remain at home but others are looked after away from home. National data indicates that Shetland has the lowest percentage of looked after children per population group aged 0-17. On 31 March 2016, there were 30 looked after children in Shetland.

Children with additional support needs, who access over night stays with the Short Breaks for Children service, are regarded as looked after for the period of time that they have the respite for. These children are not included in these figures. During the reporting period, a total of 35 children and young people had overnights. This service also provides day care, outreach and activity weekends to a further 63 children and young people.

Residential care is a positive choice for some children. There is one established full-time house for three children, but additional properties have been made available to meet need. In total, six children have been accommodated in this way over the past year. Off island placements are still considered for young people that have needs that are not being met locally. Some of these have placements are for the longer term, others are on a short term basis. On 31 March 2016, four young people were accommodated off island. Developing resources within Shetland and delivering more family focused interventions will ensure that more children in the future will have the opportunity to achieve their potential within their communities. No children have been in need of secure placements during this year.

When children are unable to remain safely within the family home, social work has a duty to explore placements with extended family relatives and friends in the first instance. This type of arrangement is known as kinship care. In Shetland, there are currently 19 kinship care households. Foster care is another way in which the care needs of children can be met. Between April 2015 and March 2016, 3,977 nights were provided for children and young people with foster carers. This is a decrease of 4.3% on last due mainly to children moving on into different long term placements, for example from fostering to adoption.

Families are supported to make the necessary changes to have children returned to their care but where this is not possible, planning for permanency should take place in a timely and child centred way. This can be achieved through kinship, foster care or residential options but for younger children especially, adoption is often the best route to secure permanence. There are 21 adoptive families in Shetland, 4 of which were approved over the past year.

Table 2: Adopters, Foster Carers and Kinship Carers Approved

Category	2014/15	2015/16
Adopters approved	2	4
Foster carers approved	2	3
Kinship placements approved	2	2
*Children adopted	1	1
Children approved for adoption, still not concluded	1	0

* This figure represents the number of children from Shetland who have been adopted. During the reporting period 2015/16, three children were adopted into Shetland.

Out of Hours Service

The Chief Social Work Officer has a duty to ensure that social work services are provided 24 hours per day. In larger authorities, this service is provided by dedicated Out of Hours social work teams. However, in Shetland all Out of Hours work is undertaken by Social Workers in addition to their contracted hours. This is a significant commitment, with the Out of Hours service required to cover 130.5 hours each week. Social Workers are required to respond to difficult and challenging situations working single-handed and responding to need across all social work services. On call Social Workers also undertake out of hours duties on behalf of Housing and Occupational Health services. They are supported by senior social work managers who also work a rota system and are essential to provide professional guidance and ensure safe decision making. Concerns have been raised by social workers regarding payment for out of hours. During 2016, priority will be given to working with Human Resources, in order to consider this further.

Mental Health Officers participate on a first contactable rota as there are insufficient to establish a paid on-call rota. Most requests for a Mental Health Officer out of hours relate to emergency situations. The majority of requests are responded to and appropriately dealt with due to their willingness to be contacted out with their contracted hours.

7 Delivery of Statutory Functions

The Chief Social Work Officer has statutory responsibilities that are specific to the role. These are referred to in legislation and Scottish Government guidance, and relate primarily to issues of public protection and the promotion of professional standards.

Registered Social Workers seek to promote the principles of social justice and social inclusion in their day to work. This is challenging as they find themselves often making decisions that impact on individual's liberty, for example, the compulsory detention of people with mental health problems, the restriction of liberty for offenders who may pose a risk and the removal of children from their parents care. These decisions call for a careful balance between risk, rights and needs both of and to the individual and the wider community. Social Workers are personally accountable for their professional decision-making. A governance framework is being developed which is intended to both clarify and strengthen the governance arrangements of the social work profession. This is particularly important at this time of increasing integration between health and social care.

Risk Management for key service user groups in Shetland is located primarily in three services areas: Community Care for Adult Protection, Children's Services for Child Protection and Criminal Justice for offenders. Reflecting the importance of joint working, the following multi agency mechanisms are well established in Shetland:

- Shetland Child Protection Committee (CPC)
- Shetland Adult Protection Committee (APC)
- Multi Agency Public Protection Arrangements (MAPPA)

The Chief Social Work Officer is a member of both APC and CPC and their respective quality assurance sub groups and sits on the Strategic Group for MAPPA. The Chief Officers Group provides strategic leadership and scrutiny to the public protection work of their respective agencies and to interagency work, and oversees the work of the three groups listed above. It is chaired by the Chief Executive NHS Shetland, and the Chief Social Work Officer is a member. These arrangements ensure that the Chief Social Work Officer has an overview of related risk management activity across agencies. The volume of activity relating to the discharge of statutory duties and decisions and public protection are outlined above at **Service Quality and Performance.**

In July 2015, the Scottish Social Services Council published the Standard for Chief Social Work Officers (http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/standard-for-chief-social-work-officers-2015). The Standard is based on the specific requirements of the role of the Chief Social Work Officer. Around the core of modelling social work values, there are four aspects of the standard: self-leadership, setting direction, achieving outcomes and working with others. As well as being a reference point for Chief Social Work Officers, the Standards underpins the new Postgraduate Diploma Chief Social Work Officer. Shetland's Chief Social Work Officer was part of the first cohort studying for the qualification.

8 User and Carer Empowerment

In Shetland, we have many good examples of how we are engaging with service users and gathering information on their experience of the services they receive. These are some examples that services have provided:

- The Stepping Out Club operating in Yell offers support and social activities to individuals and their carers. The Club is run by Voluntary Action Shetland and Isleshavn Care Centre and takes place in community halls across the island of Yell. It is well attended and feedback from those who attend is very positive.

- Day support and short term respite breaks has been increased specifically to support carers to maintain their caring role.

- Care experienced children in Residential Services gathered their views on what they need from their carers and this was shared with new staff. A care experienced young person also spoke at a training event for new foster carers.

- Families using Short Breaks for Children service, the Family Centre and Nursery regularly complete surveys which inform service improvements. Foster carers and adopters likewise complete annual evaluations that help with service improvement.

- Foster carers and adopters are involved in the recruitment of staff. Foster carers have met new prospective to share their views about the rewards and challenges of fostering. They also have been involved in training and mentoring carers, which been highlighted as good practice.

- Four young people went to Glasgow for an event organised by '*Who Cares?*' during care leavers week to share their experiences of being looked after. On their return, they wrote up their experiences, which were then used to improve the service.

The following two case examples provide insight into how legislation can be applied to support people in need.

- Tom (fictitious name) was thought to have learning difficulties, to be living in squalor and often appeared distressed in public. He refused the help of services over many years. There were concerns he was at risk. An assessment by a doctor established that Tom lacked the capacity to make significant decisions, for example about where he lived or the medical treatment he needed. A meeting of all agencies involved agreed that the local authority should make an application to become Welfare Guardian, as there was no family member who could undertake this. A Mental Health Officer carried out an assessment and prepared a report. The Sheriff approved the Welfare Guardianship order which meant that the Social Worker who was delegated welfare guardian, on behalf of the Chief Social Work Officer, was able to make decisions of Tom's behalf. Decisions included that Tom should move to supported accommodation where staff could help him with cooking, budgeting, attending appointments and other tasks which he had previously struggled with. It became apparent Tom had not known how to cook when he had lived alone; he had also struggled with managing his money and run up a massive amount of debt. Tom was reassured to have his Social Care Worker attend appointments with him. He had been afraid of attending these appointments in the past and his health had suffered as a result. Tom benefited from the Welfare Guardianship order in that it enabled him to receive the support he needed, it reduced risk and significantly improved his quality of life.

- Mike (fictitious name) was diagnosed with a mental disorder several years ago, but he disagreed with the diagnosis. He lived chaotically, abusing illegal substances and missing appointments with his psychiatrist and community psychiatric nurse. He informed his family that someone had planted hidden cameras in his house and was sending him threatening messages. He presented as frightened and was at risk. He had not been taking his medication for a long time. The Consultant Psychiatrist assessed that Mike needed treatment in hospital, however Mike refused this. A Mental Health Officer consented to Mike being detained in hospital under a Short Term Detention Certificate for a period of up to 28 days. There was no alternative to ensure his safety or that he received the medication he needed. During his hospital admission the MHO made an application for a Compulsory Treatment Order [CTO]. The admission to hospital and subsequent CTO ensured Mike received the care and treatment he needed. Medication stabilised his condition and he accepted that he needed to continue to take the medication to avoid a recurrence of the symptoms he had been experiencing. When Mike returned home he felt safer and more relaxed. He was able to engage with treatment to begin addressing his substance misuse.

9 Workforce

The Chief Social Work Officer has a responsibility to have an overview of workforce development across social services. Workforce planning and development is fundamental to ensuring that we have both the capacity and the skills to meet the care and protection needs of our population. We want our workforce to be competent, confident and valued.

The social work and social care workforce is regulated with an emphasis on continuing professional development in order to meet the registration requirements of the Scottish Social Services Council (SSSC). Social Care Workers working in Support at Home are not yet required to be registered although managers and supervisors are required to be registered by 2017. Failure by an employee to achieve or maintain compulsory registration will result in their removal from a post, in line with employer responsibilities. This has the potential to impact on our capacity to deliver services. A new level 9 qualification requirement for the residential child care workforce was announced in November 2015. Managers and supervisors will be the first groups required to hold this award, which is to be phased in from October 2017.

Managers in social work and social care, working closely with Workforce Development, have ensured effective staff training and development programmes are in place for staff groups as well as individuals. Increasingly, there is a need to maintain strong links with Workforce Development staff in health and social care, both in Council and NHS in order to ensure there are properly joined up approaches that can meet the needs of integrated teams. Important too is the need for flexibility to ensure swift responses to emerging need. A draft Joint Organisational Development Strategy has been developed in order to direct the activities of the joint workforce of the Integrated Joint Board.

Recruitment and retention of qualified staff still poses difficulties in some areas. Some social worker posts have been successfully recruited to over the past year, mainly through a well established process of 'growing our own'. However, where experienced social workers are required either to deliver specialist services or to undertake higher duties, recruitment is problematic with services having to use agency staff to fill gaps. Later in 2016, there will be work undertaken by Human Resources and the Chief Social Work Officer to explore more fully some of the recruitment and retention issues.

10 Improvement Approaches

Learning from Complaints

The Council is committed to improving social work services for people in Shetland and recognises that complaints are an important source of customer feedback. The Social Work (Scotland) Act 1968, as amended by the National Health and Community Care Act 1990, requires Local Authorities to publish information on complaints received and action taken, in relation to services either provided or purchased by the Social Work Service.

During the period, 1 April 2015 to 31 March 2016, one formal complaint was investigated under the Social Work Complaints Procedure. This related to a Children and Families matter. The timescale for responding to this complaint was extended with the agreement of the complainant. There were three aspects to the complaint, one was upheld and two were not upheld. There is always learning from complaints and in this case, recommendations for improvement were made and implemented. The particularly low number of complaints over the reporting year may in part reflect the work in progress to resolve complaints at an earlier stage, in line with Council policy.

Where a complaint had not been resolved to the complainants satisfaction they may have the matter referred to a Complaints Review Committee. During the reporting period, one Complaint Review Committee was held in relation to an historic complaint. The Committee did not uphold the complaint but made some recommendations for improvement. All recommendations relating to the service have been fully responded to and where action has been required, this has been taken.

It is recognised nationally that the social work complaints system is in need of reform in order to ensure that there is alignment across health and social care. Presently there is a four stage process with local resolution, an investigation stage, Complaints Review Committee, and then complaints about maladministration can be investigated by the Scottish Public Services Ombudsman. In 2015, the Scottish Government launched a consultation on changes to remove the Complaints Review Committee stage entirely and extend the powers of the Scottish Public Services Ombudsman to allow them to investigate complaints about social work including around the professional judgment of social work professionals. In due course our procedures will change to reflect the new model.

Health and Social Care Integration

Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015 with the inaugural meeting held the following month. The Standing Orders, Scheme of Administration and Financial Regulations have been approved and an Audit Committee for the IJB has been established. The IJB Participation and Engagement Strategy is in place and informs the way in which communities will be actively engaged in decision making about services. An important strand relates to supporting capacity building for locality planning and this will be a key feature in 2016. Across Shetland, seven planning localities have been identified. Multi-disciplinary teams for health and social care is not a new concept and already some projects, such as the recent success of an intermediate care team, have demonstrated the potential that greater integration and coordination can bring. This will require greater clarity about professional governance and accountability and to this end a paper on Governance for Social Work and Social Care Practice in Shetland, is being prepared by the Chief Social Work Officer. Developing a matrix of management could provide clarity around operational and professional supervision and help support the progress of locality planning.

Integrated Childrens Services

Although not formally integrated, Children's Services in Shetland work collaboratively to deliver services to children, young people and their families driven by the Integrated Children and Young People's Strategic Planning Group. The work is supported by a Quality Assurance Group which combines the function of quality assuring the work of Child Protection Committee as well as the delivery of the Integrated Children's Services Plan. It remains the aspiration of Children's Services to be co-located and share space to work with children and families as well maximising the benefits that working in closer proximity can bring.

Going forward, it will be important to give deeper consideration to the impact of the developing health and social care integration agenda on Children's Services and, particularly in relation to social work and social care, how to strengthen rather than fragment services across both Directorates, in order to ensure that we remain focused on our overall objective to deliver excellent social services and achieve improved outcomes for the people of Shetland.

11 Contact Details

Further information can be obtained from:

Martha Nicolson
Chief Social Work Officer
Shetland Islands Council
Hayfield House
Hayfield Lane
Lerwick
Shetland
ZE1 0QD

martha.nicolson@shetland.gov.uk

Social Work Inspection Grades **Appendix 1**

Service	Quality of Care & Support		Quality of Environment		Quality of Staffing		Quality of Leadership & Management	
	2015/16	Previous Grade	2015/16	Previous Grade	2015/16	Previous Grade	2015/16	Previous Grade
Adoption	5 Very Good	5 Very Good	N/A	N/A	5 Very Good	5 Very Good	5 Very Good	4 Good
Fostering	4 Good	4 Good	N/A	N/A	5 Very Good	4 Good	5 Very Good	4 Good
Children's Residential	5 Very Good	5 Very Good	5 Very Good	5 Very Good	5 Very Good	4 Good	4 Good	4 Good
Short Breaks for Children	5 Very Good	5 Very Good	5 Very Good	4 Good	4 Good	5 Very Good	3 Adequate	4 Good
Short Breaks for Children Support Service	5 Very Good	5 Very Good	5 Very Good	5 Very Good	4 Good	5 Very Good	3 Adequate	5 Very Good
Eric Gray Resource Centre		5 Very Good		5 Very Good		5 Very Good		5 Very Good
Edward Thomason & Taing	4 Good	4 Good	5 Very Good	4 Good	4 Good	4 Good	4 Good	4 Good
Fernlea	4 Good	4 Good	5 Very Good	5 Very Good	4 Good	4 Good	4 Good	4 Good
Fernlea Day Care		5 Very Good		5 Very Good		4 Good		4 Good
Isleshavn	3 Adequate	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good
Mental Health Support Service	6 Excellent	5 Very Good	N/A	N/A	5 Very Good	5 Very Good	5 Very Good	4 Good
Montfield Support Service	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	3 Adequate
Newcraigielea	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	3 Adequate
Nordalea	5 Very Good	4 Good	5 Very Good	4 Good	4 Good	4 Good	4 Good	4 Good
Nordalea Day Care	5 Very Good	5 Very Good	5 Very Good	5 Very Good	5 Very Good	5 Very Good	5 Very Good	5 Very Good
North Haven	3 Adequate	4 Good	4 Good	4 Good	3 Adequate	4 Good	3 Adequate	4 Good
North Haven Support Service		4 Good		4 Good		3 Adequate		3 Adequate
Overtonlea	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good
Overtonlea Support Service	5 Very Good	5 Very Good	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good
Support at Home Shetland	4 Good	4 Good	N/A	N/A	4 Good	4 Good	4 Good	4 Good
Taing House Support Service		4 Good		4 Good		4 Good		4 Good
Wastview	4 Good	4 Good	4 Good	4 Good	4 Good	4 Good	3 Adequate	4 Good
Wastview Support Service	5 Very Good	5 Very Good	5 Very Good	5 Very Good	4 Good	5 Very Good	4 Good	4 Good

Agenda Item

2

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Scottish GP Patient Experience Survey
Reference Number:	CC-74-16 F
Author / Job Title:	Lisa Watt / Service Manager Primary Care

Decisions / Action required:

The purpose of this report is to provide information on the results of the 2015/16 Scottish GP Patient Experience Survey and ask that the IJB NOTE and COMMENT on the attached results.

High Level Summary:

This paper presents the "Top 5 and Bottom 5" responses for the Shetland Community Health Partnership and also gives information on the areas of care and help provided by Local Authorities. These results are an amalgamated total for Shetland and it should be noted that individual health centres will have specific areas that have been raised as areas requiring action.

Corporate Priorities and Joint Working:

The survey included other areas of care and help provided by local authorities and other organisations to support the National Outcomes for Health and Wellbeing as well as questions aimed specifically at carers about their experiences of caring and support. The continued integration of services and creating seamless pathways is a priority for the IJB.

Key Issues:

The survey shows differences in results between 2013/14 and 2015/16 in percentage points, as well as comparing Shetland results with the rest of Scotland. Overall, the results mainly show improvement in the survey results, particularly in relation to carers feeling supported to continue caring. There are also clear opportunities for improvement, and these will need to be built into the strategic planning process for 2017/18-20, with specific actions identified at an operational level.

Implications :	
Service Users, Patients and Communities:	The survey will be presented to the Public Participation Forum for discussion and comment.
Human Resources and Organisational Development:	There are no HR issues arising from this report.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications in this regard. The scope of the patient survey supports and promotes equalities, health and human rights.
Legal:	There are no Legal issues arising from this report.
Finance:	There are no Finance issues arising from this report.
Assets and Property:	There are no Asset and Property issues arising from this report.
Environmental:	There are no Environmental issues arising from this report.
Risk Management:	Embedding a culture of continuous improvement and customer focus are key aspects to meeting the aspirations of the IJB. Failure to promote and embed a continuous improvement culture increases the risk of the Council and NHS Shetland working inefficiently, failing to focus on customer needs and along with the IJB being subject to negative external scrutiny.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility for the planning of integrated services. The Chief Officer is responsible for the operational management of integrated services

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Scottish GP Patient Experience Survey
Reference Number:	CC-74-16 F
Author / Job Title:	Lisa Watt / Service Manager Primary Care

1. Introduction

1.1 The purpose of this report is to provide information on the results of the 2015/16 Scottish GP Patient Experience Survey and ask that the IJB NOTE and COMMENT on the attached results

2. Background

2.1 The 2015/16 Scottish GP Patient Experience Survey is the successor to the 2013/14 Patient Experience Survey of GP practices and other local NHS services.

2.2 Questionnaires were sent out to randomly selected patients across Scotland, using a postal questionnaire, and patients were asked to only respond to the survey if they had had contact with their GP surgery in the last 12 months. The survey asked patients about their experience of accessing their GP Practice, making an appointment, visiting reception, seeing either a nurse and/or doctor at the surgery, receiving prescribed medicine and care provided overall by the practice. The survey also includes other areas of care and help provided by local authorities and other organisations to support the national outcomes for health and wellbeing.. It also included questions aimed specifically at carers about their experiences of caring and the support to them.

2.3 The survey focuses on access to GPs and Nurses, as well as looking at care and help provided by Local Authorities. At the present time, the survey does not ask for feedback on access to Advanced Nurse Practitioners or other healthcare staff, nor does it differentiate between different types of appointment systems e.g. triage. The survey does not therefore cover the different types of appointment options available to patients in Shetland.

3. Conclusion

3.1 This paper presents the "Top 5 and Bottom 5" responses for the Shetland Community Health Partnership and also gives information on the areas of care and help provided by Local Authorities. These results are an amalgamated total for Shetland and it should be noted that individual health centres will have specific areas that have been raised as areas requiring action. Each health centre has been asked to submit an action plan for their own individual set of results.

3.2 Overall, the results mainly show improvement in the survey results, particularly in relation to carers feeling supported to continue caring. Questions on caring experiences were introduced in 2013/14 and given ongoing work on supporting carers it is good to note the improvement of this result.

3.3 There are also clear opportunities for improvement, and these will need to be built into the strategic planning process for 2017/18-20, with specific actions identified at an operational level. These actions will need to be built into service and Directorate plans in order to particularly address areas where Shetland has a significant negative variance to the national averages. Action planning will be undertaken through the Joint Acute and Health & Social Care Strategic Group to ensure that patient/client pathways continue to be developed to be seamless.

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

Appendices:
Appendix 1: Health and Care Experience Survey 2015/16

Shetland Community Health Partnership / Shetland Islands Council

This report gives a summary of the results of the Health and Care Experience Survey 2015/16 for NHS Shetland.

The survey was sent to 5,081 people registered with GP practices in the area; this was an increase from the previous survey in 2013/14 when the survey was sent to 3,936 people registered in Shetland.

The survey asks about people's experiences of accessing and using primary care services and was widened in 2013/14 to include aspects of care, support and caring to support the principles underpinning the integration of health and care in Scotland outlined in the Public Bodies (Joint Working) (Scotland) Act 2014.

A copy of the survey is available at:
www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16

1,069 patients of NHS Shetland sent in feedback on their experiences at the practice, just slightly higher than the response rate of 2013/14, when 1,015 patients responded. Of the patients that answered questions about themselves:

- 41% were male and 59% were female;
- 9% were aged 17-34, 18% were aged 35-49, 33% were aged 50-64 and 40% were 65 and over;
- 66% did not have any limiting illness or disability.

The survey was commissioned by the Scottish Government as part of the Scottish Care Experience Survey Programme, which aims to use the public's experiences of health and care services to improve those services. The survey was managed by the Scottish Government in partnership with Information Services Division (ISD) of NHS National Services Scotland. The survey was carried out by a patient survey contractor, Quality Health Ltd.

The results of the survey will be used by GP practices, Health Boards, Health and Social Care Partnerships and the Scottish Government to improve the quality of health and care services in Scotland.

National results for this survey and further details on the methods used to generate this report are available at:
www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16

Top Five and Bottom Five Results

The tables below show the top 5 responses (highest percent positive scores in green) and bottom 5 responses (highest percent negative scores in red) for patients at this NHS Board.

Top 5 Responses (highest % positive scores)

Question	% positive
Patients know enough about how and when to take their medicines	100%
The receptionists are helpful	98%
It is explained to patients why they need a test	98%
Nurses listen to patients	98%
Patients have enough time with nurses	98%

Bottom 5 Responses (highest % negative scores)

Question	% negative
Overall rating of how mistakes are dealt with	62%
Caring has had a negative impact on carers' health and wellbeing	33%
Carers have a say in the services provided for the person they look after	28%
Can usually see preferred doctor	25%
Able to book a doctors appointment 3 or more working days in advance	24%

Summary of Results

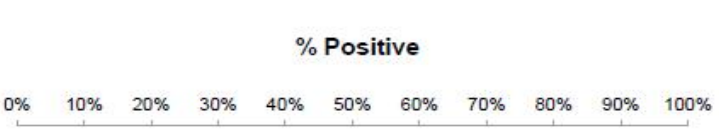
This section provides the results for those questions which align to the Health and Social Care Indicators.

The difference between the percent positive score for the NHS Board and the Scottish average is shown in the final column. Differences which are statistically significant are marked with an S. Where a comparison has not been tested due to small numbers, this is marked with an NT.

I am able to look after my own health	95%	+1 *
Service users are supported to live as independently as possible	78%	-6
Service users have a say in how their help, care or support is provided	80%	+2
Service users' health and care services seem to be well coordinated	60%	-15 S
Rating of overall help, care or support services	79%	-2
Rating of overall care provided by GP practice	89%	+2
The help, care or support improves service users' quality of life	84%	-0
Carers feels supported to continue caring	54%	+13 S
Service users feel safe	79%	-5

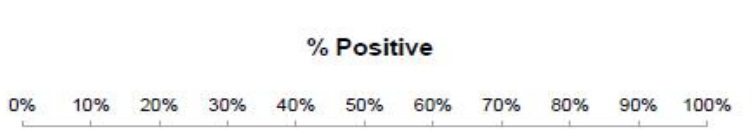
*Please note that measure "I am able to look after my own health" has not been subject to significance testing.

Care, support and help with everyday living



	NHS Board	NHS Scotland
People take account of the things that matter to service users	91%	85%
Service users have a say in how their help, care or support is provided	80%	79%
Service users are aware of the help, care and support options available	74%	76%
Service users are treated with respect	91%	90%
Service users are treated with compassion and understanding	86%	87%
Service users' health and care services seem to be well coordinated	60%	75% [s]
Service users are supported to live as independently as possible	78%	84%
Service users feel safe	79%	84%
The help, care or support improves service users' quality of life	84%	84%
Rating of overall help, care or support services	79%	81%

Caring responsibilities



	NHS Board	NHS Scotland
Carers have a good balance between caring and other things in their life	65%	68%
Caring has had a negative impact on carers' health and wellbeing	45%	40%
Carers have a say in the services provided for the person they look after	50%	50%
Local services are well coordinated for the people carers look after	58%	42% [s]
Carers feels supported to continue caring	54%	41% [s]

Your GP Practice: getting to see or speak to someone

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
It is easy to get through on the phone	952	54% / 36% / 9%	82%	88%	91%	+3%	+8% [S]
Person answering the phone is helpful	951	76% / 21%	95%	94%	96%	+2%	+2% [S]
Can see or speak to a doctor or nurse within 2 working days	757	74% / 19%	96%	89%	94%	+4% [S]	+9% [S]
Able to book a doctors appointment 3 or more working days in advance	761	76% / 24%	62%	73%	76%	+3%	-0%
Can usually see preferred doctor	758	75% / 25%	72%	75%	75%	-0%	-6% [S]
Overall arrangements for getting to see a doctor	951	37% / 31% / 16% / 16%	69%	68%	68%	-0%	-4%
Overall arrangements for getting to see a nurse	884	55% / 37% / 8%	85%	84%	92%	+8% [S]	+10% [S]

Your GP Practice: referrals

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Arrangements for getting to see other health and care services	511	36% / 42% / 18%	-	79%	78%	-1%	+1%

At your GP Practice

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
The receptionists are helpful	962	68% / 30%	97%	94%	98%	+4% [S]	+5% [S]
Time waiting to be seen at GP practice	949	82% / 18%	88%	75%	82%	+8% [S]	-4% [S]

At your GP Practice - doctors

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Doctors listen to patients	868	57% / 37%	94%	94%	94%	+0%	-1%
Patients feel that doctors have all the information they need to treat them	864	46% / 40% / 11%	87%	86%	86%	-0%	-3%
Doctors take account of the things that matter to patients	860	50% / 38% / 9%	-	87%	87%	+0%	+1%
Doctors talk in a way that helps patients to understand their condition and treatment	868	54% / 36%	87%	90%	90%	+0%	+0%
Patients have confidence in doctors' ability to treat them	860	55% / 34% / 8%	85%	86%	88%	+2%	-1%
Patients have enough time with doctors	864	54% / 37%	88%	89%	91%	+2%	+2%

At your GP Practice - nurses

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Nurses listen to patients	800	66% / 32%	98%	98%	98%	+0%	+2% [S]
Patients feel that nurses have all the information they need to treat them	794	57% / 38%	94%	95%	95%	-0%	+2% [S]
Nurses take account of the things that matter to patients	790	59% / 33% / 7%	-	96%	92%	-4% [S]	+2%
Nurses talk in a way that helps patients to understand their condition and treatment	791	63% / 32%	92%	96%	95%	-1%	+3% [S]
Patients have confidence in nurses' ability to treat them	792	64% / 31%	95%	98%	95%	-3%	+1%
Patients have enough time with nurses	797	64% / 33%	99%	96%	98%	+1%	+2% [S]

At your GP practice - care and treatment

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Patients are involved as much as they want to be in decisions about their care and treatment	935	65% / 32%	-	64%	65%	+1%	+3%

Tests arranged by your GP practice

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
It is explained to patients why they need a test	724	60% / 38%	-	95%	98%	+3% [S]	+2% [S]
Patients are satisfied with the length of time they wait for results	715	47% / 39% / 9%	-	81%	87%	+6% [S]	+2%
Patients are satisfied with the way they receive results	711	45% / 35% / 11% / 10%	-	80%	79%	-0%	-1%
Test results are explained to patients in a way they can understand	714	45% / 36% / 14%	-	81%	81%	-0%	-0%

At your GP Practice - medicines

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Patients find it easy enough for them to get their medicines	821	64% / 32%	97%	93%	95%	+2%	-1%
Patients know enough about what their medicines are for	818	62% / 35%	98%	98%	97%	-0%	+1%
Patients know enough about how and when to take their medicines	819	66% / 33%	99%	100%	100%	-0%	+1% [s]
Patients know enough about side effects of medicines	815	47% / 39% / 11%	83%	85%	85%	+0%	+3%
Patients know what to do if they have any problems with their medicines	816	52% / 40%	91%	90%	92%	+2%	+3%
Patients take their prescription as they are supposed to	821	68% / 29%	97%	99%	97%	-1%	-1%

At your GP practice - dealing with mistakes

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Patients believe a mistake was made in their treatment or care by their GP practice	940	95%	-	94%	95%	+2%	+2% [s]
Overall rating of how mistakes are dealt with	41	38% / 62%	-	14%	38%	+25%	-8%

At your GP practice - overall experience

	Number of responses	Very Positive / Positive / Neutral / Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Patients are treated with respect	959	62% / 32%	94%	93%	94%	+1%	+3% [S]
Patients are treated with compassion and understanding	934	57% / 33% / 9%	90%	86%	90%	+4%	+5% [S]
Rating of overall care provided by GP practice	961	50% / 38% / 10%	84%	82%	89%	+7% [S]	+2%

Out of hours healthcare

	Number of responses	Very Positive	Positive	Neutral	Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
The time patients wait for out of hours services is reasonable	219	33%	40%	9%	17%	76%	71%	73%	+2%	-0%
Patients feel that people have all the information they need to treat them	216	35%	46%	11%	8%	77%	79%	81%	+2%	+3%
Patients feel that they are listened to	215	43%	49%			83%	87%	92%	+6%	+8% [s]
Things are explained to patients in a way they can understand	214	43%	45%	8%		85%	88%	88%	+0%	+2%
Patients feel that they were treated by the right people	215	43%	43%		8%	-	-	86%	-	+5%
Patients feel they get the right treatment or advice	214	43%	41%	11%		75%	82%	84%	+2%	+4%
Patients feel that people take account of the things that matter to them	214	42%	41%	11%		-	80%	83%	+3%	+7% [s]
Rating of overall care provided out of hours	218	33%	44%	15%	9%	70%	76%	76%	+0%	+5%

Care, support and help with everyday living

	Number of responses	Very Positive	Positive	Neutral	Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
People take account of the things that matter to service users	79	41%	49%			-	84%	91%	+6%	+5%
Service users have a say in how their help, care or support is provided	75	31%	50%	11%	9%	-	80%	80%	+0%	+2%
Service users are aware of the help, care and support options available	75	25%	49%	18%	7%	-	-	74%	-	-1%
Service users are treated with respect	77	44%	47%			-	93%	91%	-1%	+1%
Service users are treated with compassion and understanding	74	42%	44%		8%	-	88%	86%	-2%	-1%
Service users' health and care services seem to be well coordinated	77	16%	44%	26%	14%	-	64%	60%	-4%	-15% ^{S}
Service users are supported to live as independently as possible	77	48%	30%	14%	8%	-	68%	78%	+10%	-6%
Service users feel safe	76	39%	41%	12%	9%	-	75%	79%	+4%	-5%
The help, care or support improves service users' quality of life	79	33%	50%	10%	7%	-	80%	84%	+3%	-0%
Rating of overall help, care or support services	88	35%	44%	10%	11%	-	81%	79%	-2%	-2%

Caring responsibilities

	Number of responses	Very Positive	Positive	Neutral	Negative	% Positive 2011/12	% Positive 2013/14	% Positive 2015/16	Change from 2013/14	Difference from Scotland
Carers have a good balance between caring and other things in their life	147	28%	37%	15%	20%	-	65%	65%	-0%	-4%
Caring has had a negative impact on carers' health and wellbeing	135	12%	32%	22%	33%	-	58%	45%	-13%	+4%
Carers have a say in the services provided for the person they look after	133	12%	38%	22%	28%	-	49%	50%	+1%	+0%
Local services are well coordinated for the people carers look after	134	20%	38%	19%	23%	-	52%	58%	+6%	+16% [S]
Carers feels supported to continue caring	133	17%	37%	23%	23%	-	41%	54%	+13%	+13% [S]

Care, support and help with everyday living

Q33 - In the last 12 months have you had help or support with everyday living?

All Patients	n	%
Yes, help for me with personal and/or household tasks	70	**7.1**
Yes, help for me with adaptations and/or equipment for my home	54	**4.9**
Yes, help for me for activities outside my home	34	**3.3**
Yes, help to look after someone else	24	**2.2**
No, not had any help but I feel that I needed it	18	**2.1**
No, not had any help	856	**79.4**
	1069	

Q34 - Did you get help from services provided by, for example, the Council, NHS, voluntary organisations, or private agencies – including services you paid for?

People who have received help or support with everyday living in the past 12 months	n	%
Yes	81	**63.8**
No	42	**36.2**
	123	

Q35 - Which of the following applies to you and how your social care is arranged?

People who have received help or support with everyday living in the past 12 months	n	%
I had a choice in how my care is arranged	58	**72.4**
I was not offered any choices	7	**10.8**
I had no choices due to medical reasons	3	**5.0**
I did not want a choice in how my care was arranged	4	**3.0**
Can't remember / don't know	7	**8.7**
	79	

Q36a - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? People took account of the things that matter to me

	People who have received formal help and care services in the past 12 months	n	%
*	Strongly agree	33	**41.4**
*	Agree	37	**49.3**
	Neither agree nor disagree	6	**5.8**
	Disagree	2	**2.3**
	Strongly disagree	1	**1.2**
	Percent Positive - This Board 90.8 %	79	

Q36b - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I had a say in how my help, care or support was provided

	People who have received formal help and care services in the past 12 months	n	%
*	Strongly agree	24	**30.9**
*	Agree	34	**49.6**
	Neither agree nor disagree	10	**10.7**
	Disagree	5	**6.7**
	Strongly disagree	2	**2.2**
	Percent Positive - This Board 80.5 %	75	

Q36c - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I was aware of the help, care and support options available to me

	People who have received formal help and care services in the past 12 months	n	%
*	Strongly agree	25	**25.0**
*	Agree	35	**49.3**
	Neither agree nor disagree	9	**18.4**
	Disagree	4	**4.1**
	Strongly disagree	2	**3.1**
	Percent Positive - This Board 74.3 %	75	

Q36d - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I was treated with respect

	People who have received formal help and care services in the past 12 months	n	%
*	Strongly agree	35	**44.4**
*	Agree	36	**46.9**
	Neither agree nor disagree	3	**4.7**
	Disagree	3	**4.0**
	Strongly disagree	0	**0.0**
	Percent Positive - This Board 91.3 %	77	

Q36e - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I was treated with compassion and understanding

	People who have received formal help and care services in the past 12 months	n	%
*	Strongly agree	33	**42.2**
*	Agree	32	**44.1**
	Neither agree nor disagree	5	**5.8**
	Disagree	3	**6.0**
	Strongly disagree	1	**1.8**
	Percent Positive - This Board 86.3 %	74	

Q36f - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? My health, support and care services seemed to be well coordinated

	People who have received formal help and care services in the past 12 months	n	%
*	Strongly agree	20	**16.1**
*	Agree	34	**43.9**
	Neither agree nor disagree	15	**25.9**
	Disagree	6	**8.9**
	Strongly disagree	2	**5.1**
	Percent Positive - This Board 60.1 %	77	

Q36g - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I was supported to live as independently as possible

People who have received formal help and care services in the past 12 months	n	%
* Strongly agree	38	**48.2**
* Agree	24	**29.6**
Neither agree nor disagree	10	**14.5**
Disagree	3	**4.9**
Strongly disagree	2	**2.8**
Percent Positive - This Board 77.8 %	77	

Q36h - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I felt safe

People who have received formal help and care services in the past 12 months	n	%
* Strongly agree	33	**38.6**
* Agree	29	**40.7**
Neither agree nor disagree	9	**11.6**
Disagree	2	**2.2**
Strongly disagree	3	**6.9**
Percent Positive - This Board 79.3 %	76	

Q36i - How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? The help, care or support improved or maintained my quality of life

People who have received formal help and care services in the past 12 months	n	%
* Strongly agree	30	**33.4**
* Agree	38	**50.1**
Neither agree nor disagree	7	**9.6**
Disagree	2	**4.0**
Strongly disagree	2	**2.8**
Percent Positive - This Board 83.6 %	79	

Q37 - Overall, how would you rate your help, care or support services – excluding the care and help you get from friends and family?

	People who have received formal help and care services in the past 12 months	n	%
*	Excellent	33	**34.8**
*	Good	36	**43.9**
	Fair	10	**10.4**
	Poor	7	**9.4**
	Very poor	2	**1.5**
	Percent Positive - This Board 78.7 %	88	

Caring responsibilities

Q44 - Do you look after, or give any regular help or support to family members, friends, neighbours or others because of either long-term physical / mental ill-health / disability or problems related to old age?

All patients	n	%
No	866	**85.8**
Yes, up to 4 hours a week	55	**5.0**
Yes, 5 - 19 hours a week	39	**4.2**
Yes, 20 - 34 hours a week	4	**0.3**
Yes, 35 - 49 hours a week	5	**0.6**
Yes, 50 or more hours a week	45	**4.1**
	1014	

Q45a - How much do you agree or disagree with the following about how you feel as a carer most of the time? I have a good balance between caring and other things in my life

	People who act as carers	n	%
*	Strongly agree	48	**27.9**
*	Agree	53	**37.0**
	Neither agree nor disagree	24	**15.3**
	Disagree	17	**15.2**
	Strongly disagree	5	**4.7**
	Percent Positive - This Board 64.8 %	147	

Q45b - How much do you agree or disagree with the following about how you feel as a carer most of the time? Caring has had a negative impact on my health and wellbeing

	People who act as carers	n	%
	Strongly agree	12	**8.0**
	Agree	32	**24.9**
	Neither agree nor disagree	30	**22.5**
*	Disagree	39	**32.2**
*	Strongly disagree	22	**12.4**
	Percent Positive - This Board 44.6 %	135	

Q45c - How much do you agree or disagree with the following about how you feel as a carer most of the time? I have a say in services provided for the person(s) I look after

	People who act as carers	n	%
*	Strongly agree	22	**11.7**
*	Agree	42	**38.4**
	Neither agree nor disagree	41	**22.1**
	Disagree	16	**18.4**
	Strongly disagree	12	**9.3**
	Percent Positive - This Board 50.2 %	133	

Q45d - How much do you agree or disagree with the following about how you feel as a carer most of the time? Local services are well coordinated for the person(s) I look after

	People who act as carers	n	%
*	Strongly agree	27	**19.9**
*	Agree	49	**37.9**
	Neither agree nor disagree	36	**19.3**
	Disagree	14	**18.3**
	Strongly disagree	8	**4.6**
	Percent Positive - This Board 57.8 %	134	

Q45e - How much do you agree or disagree with the following about how you feel as a carer most of the time? I feel supported to continue caring

	People who act as carers	n	%
*	Strongly agree	28	**16.9**
*	Agree	39	**37.3**
	Neither agree nor disagree	39	**22.8**
	Disagree	22	**19.1**
	Strongly disagree	5	**3.8**
	Percent Positive - This Board 54.3 %	133	

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Financial Recovery Plan 2016/17 Update- *Cover*
Reference Number:	CC-75-16 F
Author / Job Title:	Simon Bokor-Ingram, Director Community Health & Social Care

Decisions / Action required:

The Integration Joint Board is asked to NOTE:

- The progress and the work that is in hand on the Financial Recovery Plan and the actions being taken
- Further update reports on progress against the overall savings target will be brought to the IJB

High Level Summary:

The Financial Recovery Plan Update sets out the financial pressures for the IJB which relate to pressures within the NHS Shetland budgets for directly managed and set aside services for 2016/17. The IJB budget is made up of two allocations. The Council budget is balanced. NHS Shetland (NHSS) budget has a financial gap where savings need to be generated. Based on current information, there is a combined gap of £1.777M in the directly managed and set aside budget for NHSS, and this is the focus of the recovery plan.

Corporate Priorities and Strategic Aims:

In order to fulfil the statutory duties with regard to the functions delegated to the IJB by the Council and NHSS, the IJB must consider and address the challenges and risks of planning for and directing the provision of services. The IJB will aspire to deliver on the Strategic Plan but this will need to take into account the available resources. The financial gap for 2016/17 in the NHSS allocation needs to be addressed as the efficiency target is not being met.

Key Issues:

This recovery plan update is being presented because there is a high risk that the savings schemes for the NHSS budget allocation will not deliver the expected amounts and there is an overspend position which is likely to deteriorate further with the cost pressures emerging.

Implications :	
Service Users, Patients and	Any significant service changes as a result of the shortfall in the NHSS allocation will need a separate process for public and

Communities:	user engagement, and a change to the Strategic Plan.
Human Resources and Organisational Development:	Where there is a need for service change, this may potentially have an impact on staff, and will be planned and delivered in partnership with staff and through due process. This would involve engagement with the Joint Staff Forum and with other consultative forums. The challenge of the vacancy factor generating £166k saving in social care will be carefully monitored to ensure that existing staff are well supported and to avoid an impact on individuals and service delivery.
Equality, Diversity and Human Rights:	No equalities issues have been identified to date. An impact assessment will be undertaken for any redesign of how we deliver services.
Partnership Working	There are well established processes in place to engage with the public; third sector and other statutory agencies. There are established forums for engagement with unions and staff. The Strategic Planning Group which reports to the IJB brings together key stakeholders and this group would advise the IJB on changes to the Strategic Plan.
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 Council and NHSS and for the preparation of the Strategic Plan. The Strategic Plan specifies the services to be delivered by the parties. Where there is a forecast overspend against an element of the operational budget then a recovery plan shall be subject to the approval of the IJB.
Finance:	The NHSS has a statutory responsibility each year to reach an in-year break even position on its finance. Up until now NHSS has achieved this each year. Should a year end deficit become likely in 2016/17, NHSS will need to begin discussions with the Scottish Government Health and Social Care Directorate. Any year-end deficit will put further pressure on budgets in following years.
Assets and Property:	There are no implications for major assets and property i.e. buildings and equipment at this stage. Any proposals identified through service redesign will be presented to the IJB. Assets and property remain the respective property of the Council and NHSS.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	The IJB has agreed a Risk Management Strategy and Risk Register which includes risks associated with the delivery of the Strategic Plan. Key risks relate to failure to deliver service change including the achievement of recurring savings within some services. Savings scheme have been developed to cover the financial gap in the NHSS allocation, but these are not enough to meet the financial gap that exists. The risks around staff recruitment and retention in social care are being carefully managed, with staff overtime reducing significantly in Q4 in 2015/16.
Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In

	exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions.
Previously considered by:	This report has not been presented at any formal meeting.

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Financial Recovery Plan Update 2016/17
Reference Number:	CC-75-16 F
Author / Job Title:	Simon Bokor-Ingram, Director Community Health and Social Care

1. Introduction

1.1 The budget setting process for 2016/17 identified a financial challenge for the IJB in the NHS Shetland (NHSS) budget, where savings of £1.777M in total for directly managed services and the set aside were required to be generated in order for NHSS to be able to balance its overall budget. The savings that are required amount to 8% of the total NHSS allocation.

1.2 There is a requirement to develop a recovery plan for the IJB where an overspend is generated or predicted. The Shetland Islands Council (SIC) budget was balanced from the start of the year, and continues to operate within budget, and so the recovery plan focuses entirely on NHSS budgets. A recovery plan for 2016/17 was presented to the IJB on the 29 February 2016, with an update presented on the 28 June 2016.

1.3 Both Community Health and Social Care and Acute and Specialist Services, are expected to deal with any in-year cost pressures before seeking further financial support from either the SIC or the NHSS, depending on which organisation is funding the particular service where the cost pressure has arisen.

For 2016/17, an efficiency target has been given to the Social Care budget, of £166,000, as a non-recurrent sum to be generated by vacancies. This has been achieved through the vacancy factor generated between people leaving the service and new recruits starting. The SIC part of the Directorate budget is balanced and information has previously been reported and agreed by IJB members.

1.4 For NHSS, efficiency schemes had been identified which would need to deliver in-year in 2016/17. For the NHSS allocation to the IJB it was clear that a number of schemes would not deliver from the 1 April 2016. This has been factored into the NHSS financial plan for 2016/17, however, overall this means that NHSS would continue to rely significantly on non-recurrent savings in order to achieve a break-even position at year end.

1.5 The Shetland Islands Health & Social Care Partnership Scheme of Integration is clear on how financial pressures must be dealt with:

"Where there is a forecast overspend against an element of the operational budget, the Chief Officer, the Chief Financial Officer of the Integration Joint Board will work with the LPFT [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.

If the recovery plan is not successful the Chief Officer and the Chief Financial Officer will work with the LPFT to develop options to address the overspend which may include the option of making interim funds available with repayment in future years on the basis of a revised recovery plan agreed by the Parties and the IJB."

1.6 This recovery plan has been developed because it is evident that the delays in implementing the savings schemes for NHSS budgets will not deliver the predicted in year value. There is thus a gap between the savings required to achieve balance and the amount schemes are anticipated to generate.

1.7 In addition, cost pressures in both the set-aside Acute Services and in the directly managed Community Health and Social Care primary from locum costs to cover essential medical staff posts have compounded the overspend position..

2. Background

2.1 The Scottish Government financial strategy has required NHS Scotland to achieve year on year recurring efficiency savings of around four percent in 2016-17. The funds released from the achievement of efficiencies are retained locally to address local cost pressures, demographic pressures, new drug costs and to deal with the impact of inflation.

2.2 NHS Shetland financial plan for 2016-17 required to deliver an in year saving target of 8.7%. This is due to a delay in implementing recurring savings proposals primarily in clinical areas to ensure proposal developed were both clinically safe and sustainable long-term. This process includes lengthy discussions with clinical stakeholders.

2.3 The current NHSS efficiency savings plan was set to cover the five years from 2012/13 to 2016/17. That plan sets NHSS Corporate and Support Services an ambitious efficiency saving target over the five years that was equivalent to 25% of their 2011/12 baseline budgets. The balance of the efficiency targets was assigned to Clinical Services, which at that time consisted of a single directorate. Clinical Services was subsequently divided into two directorates - Acute and Specialist Services and Community Health and Social Care. The combined target for clinical services required achievement of £4.1 million efficiencies over the five year period. At the end of 2015/16, after the first four years, clinical efficiency target have a £1.4m shortfall on realised savings. As whole the Board had a shortfall of £1.5 on realised savings to plan.

2.4 NHSS efficiency savings plan for delivery of 2016-17 required saving was agreed as part of the budget setting process and is outline in Appendix 1.

2.5 Appendix 2 outlines the current position in respect of the savings target for both directly managed services and the set aside budget, with unachieved savings to be carried forward, the savings target for next year, and the total accumulated target for 2016/17.

2.6 Plans have been developed that describe how savings projects will be taken forward; timescales; and the phasing in of savings during the year. Appendix 3 shows the principle NHSS clinical projects that are in place, with detail on what progress is being made and what remedial action is being taken. The Directorate and IJB Risk Registers include the risk of failing to operate within the available budget. Other than property sales are unlikely to generate forecast surplus non clinical schemes are expected to be delivered to budget in 2016-17.

2.7 The financial position to date for the NHSS presented to their Board meeting in October shown in table below is just under £0.9m over spent and sits entirely within clinical service areas:

Shetland NHS Board Financial Position as at the end of August 2016	**Variance (Over) / Under**	**Narrative Explanation**
Acute and Specialist Services	(785.5)	Medical and Anaesthetics consultant locums covering sickness and maternity leave, Junior Doctor locums required to fill rotas, nursing acuity pressures, agency cover in Laboratory plus shortfall in achieved efficiency
Community Health and Social Care	(354.6)	Salaried GP practices locum cover for Lerwick, Unst and Yell plus shortfall in efficiency savings.
Off Island Clinical Services	(38.7)	NHSG Mental Health SLA plus Cardiac activity with NHS Grampian.
Dir Public Health	8.9	Non pay under spend year to date in Health Promotion
Dir Finance	45.2	Achieved efficiency savings ahead of target plus short-term staff vacancies
Reserves	58.3	Board wide efficiency savings achieved.
Medical Director	(1.3)	Medical staff training costs.
Dir Human Res & Support Svs	68.4	Primarily short-term staff vacancies.
Head Of Estates	82.0	Non pay cost reductions in Estates and staff vacancies in Facilities
Office Of The Chief Executive	19.8	Over achieved savings target in 2016-17 plus short-term staff vacancies
Overall Financial Position	**(897.5)**	

2.8 In year for 2016/17 the potential for a budget overspend has been recognised by NHSS as an issue that requires addressing and managed to ensure the Board complies with statutory financial obligation under section 85 of the National Health Services (Scotland) 1978.NHSS is developing a financial recovery plan for the Board to approve. However that plan will requires the services covered by the IJB to be managed within existing resources for the remainder of 2016-17.

2.9 Where possible efforts are being made to limit spend. Whilst non-recurrent savings will contribute to the budget, this is not a sustainable long term solution. In the short term, directly managed services and acute services in the set aside budget will need to limit discretionary spends; delay recruitment and use vacancies that arise as an opportunity to redesign delivery. Appendix 4 describes the measures that will be needed in order to generate what will mostly be non-recurrent savings to support the year-end position of NHSS.

3. Impacts

3.1 The NHSS has a statutory responsibility each year to reach an in-year break even position on its finances. Up until now NHSS has achieved this each year.

3.2 At present there are a number of factors which are putting pressure on budgets, including substantial locum costs to cover sickness absence and vacancies. Detail is shown in Appendix 5. Whilst there has been much work carried out to redesign services over the years, redesign has not kept pace with the time parameters set to deliver these and are now causing underlying pressure on the NHSS budget. Non-recurrent funding, including surplus generated on the sale of properties, has been used in increasing amounts in the last few years to balance the overall budget at year end.

3.3 Non-recurrent savings will need to be identified not just within directly managed services and the set aside but also across NHSS to support an in-year break even position for 2016/17, particularly as the clinical savings schemes set out in Appendix 1 and 3 will not deliver the in year plan in many cases. As those actions are not likely to be adequate to meet the predicted financial gap, and create a forecast year-end deficit the IJB will need to consider how it wishes the NHSS to amend service delivery to live within the financial resources available to the IJB.

3.4 There will need to be a continued focus on budget positions and the efficiency and redesign agenda. Services will need to consider all opportunities in-year to generate further non-recurrent savings; control discretionary expenditure levels; and to plan for schemes beyond 2016/17 that will restore recurrent financial balance.

3.5 There will need for an ongoing IJB programme of work to develop detailed savings schemes, with clear timeframes, that will create sustainability for 2016/17 and beyond. This will need to be done in conjunction with the work being undertaken by NHSS to meet the same objectives. Part of the IJB's consideration in making decisions will need to be the balance between quality, cost and time.

3.6 The Financial Regulations for the Integration Joint Board, which are in line with the Finance Guidance for the Public Bodies (Joint Working) (Scotland) Act 2014 sets out the options for the IJB on virement between the two arms of the Operational Budget. The Local Partnership Finance Team (LPFT) will support the Chief Officer and Chief Finance Officer so that any options for virement are set out for the IJB.

4. Conclusions

4.1 With such a focus on finances, it is important that the commitment to safety and quality in delivering care is maintained, and the full governance structure of NHSS is used to ensure that. The Joint Clinical Care and Professional Governance Committee for NHSS, SIC and the IJB has recently been established and this Committee will be key to ensuring safety and quality. At the same time, it is imperative that the services operate within the available resources allocated to them.

4.2 Monitoring and reporting maintains the audit trail of where spend is made against budget for both SIC and the NHSS, and delineates between each organisations budget and expenditure.

4.3 Whilst the financial situation is very challenging, NHSS has a long history of delivering within its financial budget each year. The NHSS is fully committed to creating a sustainable position for the long term.

For further information please contact:
Simon Bokor-Ingram
Director of Community Health and Social Care
E-mail: simon.bokor-ingram@nhs.net
Telephone: 01595 743087
10 October 2016

Appendices:
Appendix 1 - NHSS Efficiency Saving Delivery Plan 2016-17
Appendix 2 - Current position in respect of the savings target for both Services
Appendix 3 - NHSS Savings Schemes 2016/17
Appendix 4 - Further Measures to Recover Year-End Position
Appendix 5 - NHSS Cost Pressures

Background Documents
Finance Guidance for the Public Bodies (Joint Working) (Scotland) Act 2014
http://www.gov.scot/Resource/0048/00480494.pdf

NHS Shetland Local Delivery Plan 2016-17
http://www.shb.scot.nhs.uk/board/meetings/2016/May/20160524-16_18.pdf

NHS Shetland Financial Plan 2016-17
http://www.shb.scot.nhs.uk/board/meetings/2016/May/20160524-16_19.pdf

Shetland Island Council Corporate Plan 2016-20
http://www.shetland.gov.uk/documents/OurPlan2016-20final.pdf

Shetland Island Council The Council Budget Book 2016-17
http://www.shetland.gov.uk/about_finances/documents/2016-17BudgetBook.pdf

Appendix 1

NHS Shetland Financial Plan 2016-17 Efficiency Savings Delivery Implementation Plan

	Total	April	May	June	July	August	September	October	November	December	January	February	March	Total
Recurrent														
Summary Scheme Narrative														
Specialist and rehabilitation services	202.8							33.8	33.8	33.8	33.8	33.8	33.8	202.8
Pathways / Patient Travel	250.0							41.7	41.7	41.7	41.7	41.7	41.7	250.0
Hospital Management Team	20.0	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	20.0
Community Nursing	62.5							10.4	10.4	10.4	10.4	10.4	10.4	62.5
Lerwick Health Centre	50.0	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	50.0
Out Of Hours (OOH) Vehicle	9.2	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	9.2
Prescribing	200.0	5.0	5.0	5.0	5.0	22.5	22.5	22.5	22.5	22.5	22.5	22.5	22.5	200.0
Primary care Redesign	30.0										10.0	10.0	10.0	30.0
Public Health	50.0	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	50.0
Estates & Facilities	122.0	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2	122.0
Chief Executive	10.0	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	10.0
Finance	29.8	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	29.8
HR	75.0	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	75.0
Procurement	140.0	11.7	11.7	11.7	11.7	11.7	11.7	11.7	11.7	11.7	11.7	11.7	11.7	140.0
NHS SLAs	208.0	17.3	17.3	17.3	17.3	17.3	17.3	17.3	17.3	17.3	17.3	17.3	17.3	208.0
Highland and Island Travel Scheme (HITS)	450.0	37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5	450.0
Bundles Efficiencies met directly	402.0	33.5	33.5	33.5	33.5	33.5	33.5	33.5	33.5	33.5	33.5	33.5	33.5	402.0
Net SubTotal Recurrent	**2,311.2**													
Recurrent Shortfall	**1,401.1**													
Financed By:														
Non - Recurrent.														
Summary Scheme Narrative														
Income and Productivity gains	291.2							48.5	48.5	48.5	48.5	48.5	48.5	291.2
CHSC NR	100.0	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	8.3	100.0
Technical Accounting Issue 1	188.0									47.0	47.0	47.0	47.0	188.0
Technical Accounting Issue 2	396.0									99.0	99.0	99.0	99.0	396.0
Properties Sale Surplus	200.0						200.0						0.0	200.0
MH SLA Under spend	147.0												147.0	147.0
Band 1 redesign	4.9	0.8	0.8	0.8	0.8	0.8	0.8						0.0	4.9
Finance	74.0	6.2	6.2	6.2	6.2	6.2	6.2	6.2	6.2	6.2	6.2	6.2	6.2	74.0
Net SubTotal Non-Recurrent	**1,401.1**													
In- year Gap still to Address	0.0													

2016/17 Savings Requirement Feb 2016

	IJB 'Set Aside'	IJB Joint Budgets	Total	NHS Total
	£000s	£000s	£000s	£000s
Unachieved recurring savings brought forward	171	747	919	1,462
2016-17 Savings Target	124	368	492	1,194
Additional savings required as a result of agreed cost pressures	30	241	271	654
Additional savings required as a result of 7.5% reduction in 'bundled' allocations	95	0	95	146
Total	420	1,357	1,777	3,456

Savings as a percentage of overall funding for IJB Services	10.9%	7.3%	8.0%

Set Aside figures above are 26% of total Acute Services Directorate efficiency target

NOTE: The Savings target relate solely to the NHS Shetland part of the IJB Budgets

Community Health & Social Care

Project	Estimated Full Year Effect £	Achievable in 2016/17 £	By When	Detail	Risks	Progress
Lerwick Health Centre costs	100,000	50,000	Oct-16	The ANP model is now in place. Patient list number has fallen. Activity and capacity being reviewed. More work required on self-management.	Demand for service continues at current rate, or increases.	Non-recurrent efficiencies offset by locum costs. Work ongoing to secure recurrent savings.
OOH Vehicle configuration	10,000	5,000	Oct-16	2nd out of hours vehicle in place to reduce need for moving single asset to next on call clinician	Vehicle in place and efficiency being generated.	Project completed. Late implementation as one vehicle not usable for a period of time.
Community Nursing capacity to match demand	240,000	63,000	Mar-17	Full review of capacity and demand across Shetland of the Community Nursing Service. Will include options for extending out of hours provision and advanced practice.	Communities not engaging with plans for future service delivery. Ageing population with increase in demand.	Fact finding visits to localities and remote areas. Data analysis prepared. Capacity to complete project reduced with Chief Nurse support to Mental Health Service. Non-recurrent government funding available to support redesign. Meridian Productivity procedure from 17 October for initial two week period to provide capacity and expertise.
Pharmacy Challenge	200,000	200,000	Mar-17	Prescribing initiatives commenced. Pharmacists supporting practices with efficient prescribing.	Prescribing continues to increase, and above national trends. Pharmacists unable to engage clinicians in programmes.	Projects underway. Evidence of impact of pharmacy intervention to be quantified.
Primary Care Redesign	200,000	30,000	Mar-17	Implementation of Primary Care Strategy. Options need to be developed to create resilience and sustainability.	Unable to engage local clinicians. Communities not engaging with plans for future service delivery.	Behind trajectory because of sickness absence. Project Board established. Support from National Primary Care Directorate secured - visit to Shetland in Q3. Engagement with clinicians in North Isles to develop sustainable model.
Off Island Mental Health Activity	44,630	0	Mar-17	More responsive local service that results in less people having to go off-island for in-patient mental health provision.	Local service's ability to meet complex needs. Ability to respond out of hours to acute presentations. Increased patient activity at Cornhill in first quarter of 2016-17.	Trend of reduced transfers to Cornhill continues - strong local hospital liaison service in place. 3 year rolling average Service Level Agreement with savings therefore not achievable in year.
Public Dental Service	182,009	182,009	Mar-17	Redesign of service to meet reduced allocation from Scottish Government for salaried dental service. Revised confirmed allocation is now a reduction of £138,009.	Transfer of activity in Lerwick from salaried service to independent contractors not happening quickly enough. Lack of access in some areas of Shetland.	Number of vacancies in service allowed a redesign in year to meet financial challenge. Service will need to shift resources to areas where no independent practices likely to establish.
Non recurrent savings	0	100,000	Mar-17	Seeking all opportunities to create efficiency, through pay and non pay budgets.	Prolonged vacancy factor could affect capacity of services. Reducing non pay expenditure may build pressure for future years.	Savings accumulated in month removed from budgets to secure. Continuing to capture non-recurrent opportunities.
PROJECTED SUB TOTAL	**976,639**	**630,009**				

Acute & Specialist Services

Projects	Estimated Full Year Effect £	Achievable in 2016/17 £	By When	Detail	Risks	Progress
Acute services redesign	475,000	0 (or up to 169,000)	Oct-17	Match hospital capacity to demand for bed base. Incorporate factors including shifting balance of care; reduced delayed discharges and shortening lengths of stay. Level of efficiency will depend on when a decision is made.	Ability of community services to build capacity. Maintaining low rates of delayed discharges.	Proposal developed to implement community based rehabilitation model to shift the balance of care. Proposal under consideration by the IJB and Board so delivery of savings will be aligned to outcome of the decision making process.
Increasing the use of telehealth and redesigning patient pathways	250,000	208,333	Mar-17	Repatriation of services to Shetland, resulting in less spend on off island activity and less spend on patient travel.	Ability to engage NHS Grampian in shifting care to Shetland. Confidence of clinicians to utilise and increase technology enabled care provision.	Project ongoing to increase tele-health pathways
Hospital management team restructuring	20,000	20,000	Mar-17	Redesigning job roles and aligning capacity to service need.	Ability to recruit to posts.	Sucession planning is being progressed and savings released through appropriate changes in skill mix
Non recurrent savings	0	159,316	Mar-17	Seeking all opportunities to create efficiency, through pay and non pay budgets.	Prolonged vacancy factor could affect capacity of services. Reducing non pay expenditure may build pressure for future years.	Short term measures in place.
PROJECTED SUB TOTAL	**745,000**	**387,649**				

26% of acute budget assigned to IJB set aside

Further Measures to Recover Year-End Position

Scheme	Detail	Risk	Achievability
Reduce non-pay expenditure	Largest non-pay budget is pharmacy where savings schemes already in place. Some areas have small non-pay budgets.	Pressures may build and expenditure transfers to future years. Holding non-pay expenditure may create inefficiencies.	Some smaller savings may be achievable.
Vacancy freeze	Number of vacancies appear each month with turn-over rate above 10% for the Health Board.	Holding vacancies may impact on access to services and pressure may appear elsewhere in the system. Existing staff could experience higher levels of pressure in maintaining service delivery with fewer staff.	With turnover rate there will be some areas where holding vacancies for longer would be achievable. Careful monitoring of impacts would need to be in place.
Reduce expenditure on travel	Curtail off island travel, which would also impact positively n associated accommodation costs.	Some travel linked to training courses which are ncessary to deliver services. Missed opportuities to influence at a national level.	VC is well used already but all travel to be closely examined which could yield some savings.
Reduce use of locum staff	Number of key posts covered by locums, with significant premium over the budget cost of psots.	Limited access to services. Increased waiting times. In more remote areas limited or no access to alternatives.	Limited scope for reducing locum spend where needed is deemed as being critical to service delivery. Risk assess limiting cover and how existing staff can provide more continuity.

Service Issue	2016-17 Year to Date at Month 5
Lerwick Health Centre	In terms of pay costs the use of locums for filling vacancies was in balance at month 5. Additional recruitment now required for further vacancies.
Yell Health Centre	From June principle and associate GP positions were in post. Additional costs incurred slightly below anticipated cost. However in September the principle GP post will become vacant.
Unst Health Centre	NHS Shetland became responsible for the day to day management of the practice from 1 August 2016 and will now do so for the foreseeable future.
Junior Doctors	Due to vacancies in the Junior Doctor rota locums costing £115k more than budget were used to the end of August. Following the Junior doctor rota change in August 2016 there are now 4 post vacant which means 40% of Junior Doctor slots are vacant and covered by agency locums.
General Medicine	Locum use in the first 4 months have caused a year to date over spend of £74k.
High Cost On Island Drugs	As at August, costs in 2016 are in-line with 2015 actual costs. However limited data does not allow a more informed forecast on 2016-17 likely out turn value projections.
New Medicine Fund	Scottish Government is still to advise allocation methodology for 2016-17. Costs incurred are as advised by NHS Grampian. Nil variance declared as at month 5 as assumed funding and allocation will at worst match. There was an under spend in 2016-17.
GP Prescribing	Actual costs for April to June are the only true real data. This data currently shows no significant change between 2015 and 2016 as increase is within inflation uplift assumed. However this data is not necessary representative of what the whole year movement.

Appendix 5

Assumption regarding 2016-17
Plan in place is now delivering the service in-line with available monthly resource set aside. The GP recruitment will take place during the summer of 2016.
The principle GP moved to another practice in Shetland on 1 November 2015. There is an associate GP in place who will cover part of the period the post is likely to be vacant. New substantive GP started at Yell in June 2016 however there were periods covered by locum GPs at start of 2016-17. Cost anticipated at £30k for first two months.
Practice would continue to be managed and ran as an Independent Contractor practice through out 2016-17.
There will be a need to employ locums in 2016-17. There may be vacancies to the rota in 2016-17 however locums will be required to cover gaps created by Junior Doctor maternity leave and phased return to work from maternity leave in 2016-17. NES remove funded from Junior Doctors post that are part filled.
There will be locum cover costs incurred in General Medicine during 206-17. Recruitment for a permanent appointment to the 4th Consultant Physician post is currently in progress.
The balance set aside in the reserve of £124.6k to cover the costs of Hep C and increase in high cost drugs will remain in a specific drug contingency reserve in 2016-17. Funds allocated to the High Cost on Island Drug service in 2015-16 will remain with that service in 2016-17 and inflation will be added at 4.0% to the service in-line with LDP plan.
In LDP planning for 2016-17 the planning assumption is that expenditure and funding match for new medicines. Scottish Government guidance is that 2015-16 under spend should be reprovided in 2016-17 for expenditure incurred on new medicines covered by the scheme.
In LDP planning for 2016-17 the planning assumption was that an additional £300k was required to be added to the budget to offset increased costs in 2015-16. In addition to that inflation uplift was added at 4.0% plus £50k for unspecified higher costs drugs entering the market in 2016-17.

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Winter Plan for Ensuring Service Sustainability including the Festive Period 2016-17
Reference Number:	CC-76-16 F
Author / Job Title:	Kathleen Carolan / Director of Nursing & Acute Services Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

That the Integration Joint Board:
(1) APPROVE the Winter Plan 2016-17
(2) NOTE that planning is a dynamic process and any emerging issues will need to be addressed. Any significant changes will be brought to the IJB's attention.

High Level Summary:

The Scottish Government directs winter planning, and in their letter of 7 October 2016 it is clear that the expectation is that within integrated services there must be robust planning to ensure that safe and appropriate capacity is available during winter. Shetland has a good history of joint working between health and social care, and the winter plan for 2016/17 follows a format that has been well tried and tested in previous years.

The Winter Plan 2016-17 describes the health and social care service provision and special arrangements that will be put in place during the festive season by NHS Shetland and Shetland Islands Council and through the winter period.

The Plan has been developed jointly by the Director of Nursing & Acute Services and the Director of Community Health & Social Care with input from the Scottish Ambulance Service (SAS) and Third Sector.

The Winter Plan will be communicated/enacted by both the Council and NHS and sits alongside the national winter campaigns co-ordinated by NHS 24, which will be locally advertised to ensure our residents know what services are available over the festive season, and how to access them.

Corporate Priorities and Joint Working:

The Strategic Plan for the IJB is the Commissioning Strategy for Shetland's Health and Social Care Partnership. The objectives of the Strategic Plan are to deliver on the National Health & Wellbeing Outcomes, and the Winter Plan is designed to ensure that this continues throughout the year. The Scottish Government directs winter planning through health boards for care and health services, and it is the responsibility of services

to ensure that there are robust and effective plans in place to ensure the continuity of service provision over the winter months, and especially over the festive season.

Key Issues:

- There is a particular emphasis on ensuring that elective services are sustained through the winter months and there is forward planning in January 2017 to deal with any backlog from the festive period (e.g. increasing surgical capacity, outpatient services, diagnostics, availability of patient transport, and care packages to support timely discharge). The plan describes the arrangements over the festive period and notes the need to monitor demand for services and develop plans to address them (e.g. using the patient flow protocol).

- Enhanced monitoring of service performance has been in place since April 2015 as part of the unscheduled care improvement work, which is being undertaken locally – the daily measures to support effective service delivery and patient flow also meet the requirements set out in the winter planning guidance issued in August 2016.

- The plans for unscheduled care, delayed discharges, use of the integrated care fund and waiting time's allocations are already congruent to the support required for the delivery of the winter plan.

- That the plan meets the requirements set out in DL (2016) 18.

Implications :	
Service Users, Patients and Communities:	Successful implementation of the Winter Plan will ensure continuity of delivery for service users, patients and the community.
Human Resources and Organisational Development:	Planning ensures that individuals and teams are clear about their roles and responsibilities and the organisations involved are able to respond to a range of situations.
Equality, Diversity and Human Rights:	The Council and Health Board are required to ensure that systems are monitored and assessed for any implications in this regard.
Legal:	The Winter Plan fits with the service plans in the Joint Strategic Plan and is consistent with the statutory duties and functions of the Council and the Health Board ensuring resilience
Finance:	Provision has been made to record the cost pressures of any increase that is needed for health and social care capacity over the festive season particularly.
Assets and Property:	There are no issues arising from this report
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Embedding a culture of continuous improvement and customer

	focus are key aspects of the Council's and Health Board's improvement activity. Effective performance management is an important component of that activity and requires the production and consideration of these reports. Failure to promote and embed a continuous improvement culture increases the risk of the Council and NHS Shetland working inefficiently, failing to focus on customer needs and being subject to negative external scrutiny.

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

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	19 October 2016
Report Title:	Winter Plan for Ensuring Service Sustainability including the Festive Period 2016-17
Reference Number:	CC-76-16 F
Author / Job Title:	Kathleen Carolan / Director of Nursing & Acute Services Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The Scottish Government directs winter planning through health boards for health and care services, and it is the responsibility of services to ensure that there are robust and effective plans in place to ensure the continuity of service provision over the winter months, and especially over the festive season. The Scottish Government letter of 7 October 2016 (Appendix 1) is clear that the expectation is that within integrated services there must be robust planning to ensure that safe and appropriate capacity is available during winter. Shetland has a good history of joint working between health and social care, and the winter plan for 2016/17 follows a format that has been well tried and tested in previous years. The Director of Nursing and Acute Services is the lead for Winter Planning, and has created the plan with the input from Acute and Community Health and Social Care services.

2. Background

2.1 Christmas and New Year fall at the end of a working week, creating in effect 4 day holiday periods (including weekends), which increase the risk of inflating unscheduled demand.

3.2 Planning ensures that individuals and teams are clear about their roles and responsibilities, and the Directorates are able to respond to a range of situations. Winter planning has been a regular agenda item at both Directorate meetings, and will be a standing item from now throughout the winter period to ensure that any changing dynamics are responded to.

3.3 The Winter Plan will be communicated through both the Acute Directorate and the Community Health and Social Care Directorate, and to our partners. Alongside the national winter campaigns will be local advertising co-sponsored by Community Health and Social Care and Acute Services to

ensure our residents know what services are available over the festive season, and how to access them.

3. Conclusions

3.1 Acute Services and Community Health and Social Care Services continue to collaborate effectively through the Joint Health and Social Care Strategic Group, and the initiatives that are directed from that Group, for the benefit of the community.

3.1.1 Planning is a dynamic process, and any emerging issues will need to be addressed promptly. The Joint Health and Social Care Strategic Group will be the forum for addressing emerging issues in the first instance, with more immediate issues addressed at an operational level with oversight from the 2 Directors.

Contact Details:

For further information please contact:
Kathleen Carolan, Director of Nursing and Acute Services
Tel: 01595 743000 (ext 3188) – email kcarolan@nhs.net

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

Appendices

Appendix 1 – Scottish Government Letter
Appendix 2 – Winter Plan for Ensuring Service Sustainability including the Festive Period 2016-17

NHSScotland Chief Operating Officer
John Connaghan

Health Finance Directorate
Christine McLaughlin, Director

Director for Health and Social Care Integration
Geoff Huggins

Scottish Government
Riaghaltas na h-Alba
gov.scot

NHS Chief Executives
IJB Chief Officers
Local Authority Chief Executives

7 October 2016

Dear Colleagues

We wrote to you in August with guidance to help ensure appropriate preparations are made for health and social care services this winter. Winter planning is important across the whole system of health and social care. It enables us, collectively, to provide safe and effective care for people using services, ensure effective levels of capacity and funding are in place to meet expected activity levels and to reassure the public.

Thank you for lodging your draft winter plans as requested. We will write separately to individual Health Boards and IJBs with any specific feedback on your plan before final submission at the end of this month. As plans are being finalised, we are writing to you now to reinforce the important principle of working together – across the statutory and non-statutory sectors – to make sure people have access to the right care, at the right time, in the right place, and to maintain sustainability across the system.

Our reading of the draft winter plans suggests that some shared funding and jointly agreed capacity decisions, across health and social care, have yet to be agreed for this winter. It is our expectation that Boards will take full account of winter planning within their financial plans for 2016-17, making best use of targeted funding for unscheduled and social care. From previous experience, and in light of arrangements now in place for integration, we strongly encourage you to finalise such decisions soon. Doing so will help ensure that you are well-placed to deliver safe and appropriate capacity over the coming months, and should help mitigate any need for remedial action during winter.

A joint approach is key, and we have been reassured to hear from local systems about effective planning and risk-sharing processes now in place between Health Boards, IJBs and Local Authorities. It will be important that plans take account of the whole pathway of care, provided in communities, care homes and hospitals via social care, primary care and acute hospital care, and by the full range of providers – the contribution of public, third and independent sectors must all be taken into account. Winter plans should also of course be congruent with other planning mechanisms within the Health Board and IJB, including the latter's strategic commissioning plan.

If you have not already done so, you will find it helpful to put in place tracking mechanisms for health and social care resource use and activity during winter, to provide clarity on local performance throughout the period. We have some examples of good practice and are happy to share these and/or support partnerships and Boards to develop tracking methodologies where they don't already have them in place/aren't comprehensive.

Your final winter plan should therefore demonstrate the delivery of an optimal service and should reassure your respective Boards and, ultimately the local population, that you can deliver a safe and effective service throughout winter.

You are due to publish final plans, based on the currently available resource, by the end of this month and we look forward to working with you over winter, and beyond, to support the continued provision of safe and effective care.

Yours sincerely

John Connaghan

Christine McLaughlin

Geoff Huggins

NHS Shetland

WINTER PLAN

CAPACITY MANAGEMENT PLANS FOR THE PROVISION OF SERVICES OVER

THE WINTER PERIOD 2016-17

Version 5.0 created 25/09/2016

Table of Contents

1. Introduction

NHS Shetland, along with its statutory agency partners in Shetland, coped well during the winter of 2015-16. Whilst there were events of extreme weather elsewhere in Scotland, there were not the heavy or prolonged snow conditions in Shetland which have been experienced in some previous winters. Winter 2016-17 has the potential to be challenging, with increased activity through elective and emergency services noted in 2015, planned changes to specialist hospital service provision and the threat of severe weather creating service disruption.

This winter plan for 2016-17 has been developed from critically appraising what went well and what lessons were learnt from previous winters, both from within the organisation and from debriefing with other health boards as part of the Scottish Government Health Directorate's winter planning programme for the NHS which also includes representation from local authorities.

2. Primary Care Services

a) <u>Shetland non OOH Co-operative – 4 practices – 3,500 patients</u>

The OOH arrangements for the 4 practices (Unst, Yell, Whalsay and Hillswick) shall be as per normal over the winter and festive period, with each individual practice providing their own out of hours cover. No additional resources or capacity is planned. Each practice will have in place their own contingencies for any increased demand over the coming months with Board level support offered if services become overwhelmed due to epidemic or staff absence. Those areas would then be covered by the OOHs GP Co-operative, locums and patients transferred to the Gilbert Bain Hospital.

On the islands of **Yell, Unst and Whalsay** the Community Nursing services will continue to provide a service over the winter and festive periods as noted below:

Date	Day	Daytime Provision	OOHs Provision
December 24th 2016	Saturday (Weekend)	On call and Essential visits by one nurse can be contacted via health centre answer phone for information	One nurse On-call on each island via health centre answer phone
December 25th 2016	Sunday (Weekend)	On call and Essential visits by one nurse can be contacted via health centre answer phone for information	One nurse On-call on each island via health centre answer phone

Date	Day	Daytime Provision	OOHs Provision
December 26th 2016	Monday (PH)	On call and Essential visits by one nurse can be contacted via health centre answer phone for information	One nurse On-call on each island via health centre answer phone
December 27th 2016	Tuesday (PH)	On call and Essential visits by one nurse can be contacted via health centre answer phone for information	One nurse On-call on each island contact via health centre answer phone
December 28th 2016	Wednesday (Normal business day)	Normal Working day	One nurse On-call on each island contact via health centre answer phone
December 29th 2016	Thursday (Normal business day)	Normal Working day	One nurse On-call on each island contact via health centre answer phone
December 30th 2016	Friday (Normal business day)	Normal Working day	One nurse On-call on each island contact via health centre answer phone
December 31st 2016	Saturday (Weekend)	On call and Essential visits by one nurse can be contacted via health centre answer phone for information	One nurse On-call on each island contact via health centre answer phone
January 1st 2017	Sunday (Weekend)	On call and Essential visits by one nurse can be contacted via health centre answer phone for information	One nurse On-call on each island contact via health centre answer phone
January 2nd 2017	Monday (PH)	Essential visits by one nurse working normal shift can be contacted via GBH switchboard	One nurse On-call on each island contact via GBH switchboard

Date	Day	Daytime Provision	OOHs Provision
January 3rd 2017	Tuesday (PH)	Essential visits by one nurse working normal shift can be contacted via GBH switchboard	One nurse On-call on each island contact via GBH switchboard

b) <u>Shetland Out of Hours Co-operative Area – 6 practices – 18,750 patients</u>

The Board's normal OOH arrangements will continue throughout the winter period for 6 practices (Bixter, Brae, Walls, Lerwick, Levenwick and Scalloway) with a single GP on call for home visiting, dual response and GP advice for the co-operative area.

The Community Nursing service provides a 24/7 service via a shift based system. Community Nursing staff will be available from the central base at the Gilbert Bain Hospital throughout the out of hours time period.

A&E continues to be available 24/7 with normal staffing levels. Patients will be encouraged to see their primary care practitioner where that is appropriate.

The resources available to the Board will match the predicted demand forecast by NHS 24 and our own forecasts based upon last year's activity levels.

Arrangements for the Festive Holidays for the Out of Hours Co-operative

All items in **bold** are additional provision that the Board is intending to put in place locally to help manage the situation. All these additions are agreed locally and all GP shifts have now been filled.

(N.B. Out of Hours arrangements run from 5.30pm to 8.00am the following day 365 days per year and during the day at weekends and public holidays).

Date	Day	Daytime Provision	OOHs Provision
December 24th 2016	Saturday (Weekend)	Walk in clinic 1000-1200 at Gilbert Bain	24 hour cover by OOH GP
December 25th 2016	Sunday (Weekend)	24 hour cover by OOH GP	24 hour cover by OOH GP

Date	Day	Daytime Provision	OOHs Provision
December 26th 2016	Monday (PH)	Walk in clinic 1000-1300 at Gilbert Bain	24 hour cover by OOH GP
December 27th 2016	Tuesday (PH)	Walk in clinic 1000-1300 at Gilbert Bain	24 hour cover by OOH GP
December 28th 2016	Wednesday (Normal business day)	Practices open 0830-1700	24 hour cover by OOH GP
December 29th 2016	Thursday (Normal business day)	Practices open 0830-1700	24 hour cover by OOH GP
December 30th 2016	Friday (Normal business day)	Practices open 0830-1700	24 hour cover by OOH GP
December 31st 2016	Saturday (Weekend)	Walk in clinic 1000-1200 at Gilbert Bain	24 hour cover by OOH GP
January 1st 2017	Sunday (Weekend)	24 hour cover by OOH GP	24 hour cover by OOH GP
January 2nd 2017	Monday (PH)	Walk in clinic 1000-1300 at Gilbert Bain	24 hour cover by OOH GP
January 3rd 2017	Tuesday (PH)	Walk in clinic 1000-1300 at Gilbert Bain	24 hour cover by OOH GP

3. Patient Transport & Ambulance Services

Patient Transport (General)

Date	Day	Daytime Provision	OOHs Provision
December 24th 2016	Saturday (Weekend)		
December 25th 2016	Sunday (Weekend)		
December 26th 2016	Monday (PH)		
December 27th 2016	Tuesday (PH)		
December 28th 2016	Wednesday (Normal business day)		

Date	Day	Daytime Provision	OOHs Provision
December 29th 2016	Thursday (Normal business day)		
December 30th 2016	Friday (Normal business day)		
December 31st 2016	Saturday (Weekend)		
January 1st 2017	Sunday (Weekend)		
January 2nd 2017	Monday (PH)		
January 3rd 2017	Tuesday (PH)		

Patient Transport (Renal Service)

Date	Day	Daytime Provision	OOHs Provision
December 26th 2016	Monday (PH)		
December 27th 2016	Tuesday (PH)		
December 28th 2016	Wednesday (Normal business day)		
December 29th 2016	Thursday (Normal business day)		
December 30th 2016	Friday (Normal business day)		
January 2nd 2017	Monday (PH)		
January 3rd 2017	Tuesday (PH)		

Should the hospital reach alert status, then patient transport to discharge patients from hospital can be requested through the normal channels by contacting the Scottish Ambulance EMDC (Emergency Medical Dispatch Centre) to organise.

There is also a primary care service being supplied by our Facilities Department using a vehicle to collect and return patients to and from the Hospital if no access to transport is available.

There will be no reduction in the provision of emergency ambulance services over the holiday period. The 24/7 365 service includes a retained technician crewed ambulance to augment the paramedic response. There is one fully equipped A&E ambulance vehicle with 4x4 capability based in Lerwick as well as other 4X4 equipped vehicles on the islands of Skerries and Fetlar.

4. Dental Services

The Board delivered Emergency Dental Service will continue to operate throughout the winter including the holiday period. This provides 24/7 access to emergency dental care every day of the year in conjunction with the normal weekday service.

Over the festive season normal and emergency services will be provided as follows:

Date	Day	Daytime Provision	OOHs Provision
December 24th 2016	Saturday (Weekend)	On Call via NHS 24	On Call via NHS 24
December 25th 2016	Sunday (Weekend)	On Call via NHS 24	On Call via NHS 24
December 26th 2016	Monday (PH)	On Call via NHS 24	On Call via NHS 24
December 27th 2016	Tuesday (PH)	On Call via NHS 24	On Call via NHS 24
December 28th 2016	Wednesday (Normal business day)	Normal Working Day	On Call via NHS 24
December 29th 2016	Thursday (Normal business day)	Normal Working Day	On Call via NHS 24
December 30th 2016	Friday (Normal business day)	Normal Working Day	On Call via NHS 24
December 31st 2016	Saturday (Weekend)	On Call via NHS 24	On Call via NHS 24

Date	Day	Daytime Provision	OOHs Provision
January 1st 2017	Sunday (Weekend)	On Call via NHS 24	On Call via NHS 24
Date	Day	Daytime Provision	OOHs Provision
January 2nd 2017	Monday (PH)	On Call via NHS 24	On Call via NHS 24
January 3rd 2017	Tuesday (PH)	On Call via NHS 24	On Call via NHS 24

5. Pharmacy Services

The local pharmacies will be open for extended hours over the festive season. The opening hours will be advertised in the local press as part of the Health Board's advertising campaign. The pharmacy opening hours will be coordinated with the walk-in primary care services operating times.

As part of the pre Christmas publicity campaign NHS Scotland is undertaking, advice for patients on how to best utilise their community pharmacists will be provided.

The Accident & Emergency Department will also increase its stock level over the period to ensure that all patients are supplied with the medicines they require as treatment for presenting conditions.

The supplies of hospital oxygen cylinder supplies will be increased over the festive season. Dolby Medical supply all domiciliary oxygen and high use patients have oxygen concentrators.

6. Clinical Support Services

(a) Laboratory Services

The Laboratory service

Date	Day	Daytime Provision	OOHs Provision
December 24th 2016	Saturday (Weekend)	0900-1200	On Call
December 25th 2016	Sunday (Weekend)	0900-1200	On Call

Date	Day	Daytime Provision	OOHs Provision
December 26th 2016	Monday (PH)	0900-1600	On Call
December 27th 2016	Tuesday (PH)	0900-1600	On-Call
December 28th 2016	Wednesday (Normal business day)	0830-1700	On-Call
December 29th 2016	Thursday (Normal business day)	0830-1700	On-Call
December 30th 2016	Friday (Normal business day)	0830-1700	On-Call
December 31st 2016	Saturday (Weekend)	0900-1200	On Call
January 1st 2017	Sunday (Weekend)	0900-1200	On Call
January 2nd 2017	Monday (PH)	0900-1600	On Call
January 3rd 2017	Tuesday (PH)	0900-1600	On-Call

(b) Medical Imaging

The Medical Imaging service will be limited to an on call service for the four public holidays over Christmas and New Year (26th & 27th December 2016 and 2nd & 3rd January 2017) and the weekend over the Christmas and New Year period. There will be the usual service on the normal business days.

(c) Other Clinical Support Services

Physiology and Audiology will be closed from December 24th 2016 to January 3rd 2017 (inclusive), bar the normal business days.

As part of the routine review of waiting times we will look at the level of capacity that will be required in January 2017 in order to ensure that the

impact of a prolonged shut down does not impact on patient flow and access to services.

7. Community Mental Health Services

The Community Mental Health Team will ensure arrangements are in place to manage mental health needs during the festive period and that psychiatric emergencies are actively managed. Consultant Psychiatrist cover will be provided with assistance from Royal Cornhill Hospital in Aberdeen (access through switchboard).

The local team will have clear protocols in place for the management of mental health presentations to the hospital and in the community. The team will extend their day time operating hours to include on call during the weekends, so in effect providing a 7 day service. The acute liaison by the Associate Specialist will prioritise decision making to reduce any hospital occupancy, and when appropriate aim to care for clients as early as possible in a community setting with the CPN team.

Community Psychiatric Nurses (CPNs)

Date	Day	Daytime Provision	OOHs Provision
December 24th 2016	Saturday (Weekend)	On call	Nil – access to duty MHO
December 25th 2016	Sunday (Weekend)	On call	Nil – access to duty MHO
December 26th 2016	Monday (PH)	Duty CPN	Nil – access to duty MHO
December 27th 2016	Tuesday (PH)	Duty CPN	Nil – access to duty MHO
December 28th 2016	Wednesday (Normal business day)	Normal service	Nil – access to duty MHO
December 29th 2016	Thursday (Normal business day)	Normal service	Nil – access to duty MHO
December 30th 2016	Friday (Normal business day)	Normal service	Nil – access to duty MHO
December 31st 2016	Saturday (Weekend)	On call	Nil – access to duty MHO
January 1st 2017	Sunday (Weekend)	On call	Nil – access to duty MHO

Date	Day	Daytime Provision	OOHs Provision
January 2nd 2017	Monday (PH)	Duty CPN	Nil – access to duty MHO
January 3rd 2017	Tuesday (PH)	Duty CPN	Nil – access to duty MHO

8. Hospital Bed Provision including Day Case Beds

The Gilbert Bain Hospital currently has 42 acute beds, 3-4 high dependency beds, 5 maternity beds and 6 rehabilitation beds[1]. We do not have plans to employ extra staff to cover the winter period, although we have the facility to utilise extra clinical and non-clinical staff as required through flexible working and bank arrangements. Rosters will be scrutinised at least 2 months ahead of shifts throughout winter.

We look to use all of our beds flexibly as and when required and medical and surgical clinical staff co-operate in this type of arrangement. A patient flow escalation plan is in place to ensure that we effectively manage emergency and elective admissions throughout the hospital, which is shown in Appendix A.

Bed occupancy is reviewed at least twice daily, with known elective demands and estimated dates of discharge (EDD) identified when services are on amber/red, so that managers can ensure that elective activity can continue safely throughout the period. Severe weather reports are cascaded to all Heads of Department.

Waiting times monitoring meetings will take place on December 22nd and December 29th 2016 to ensure that appropriate monitoring of shared services and pathways will continue seamlessly, including the organisation of cancer pathways.

It must be noted that we 2016-17, we have continued to note an increase in the number of referrals for elective services e.g. Out Patients and Surgical Specialties (see Waiting Times report) but we have seen a down turn in bed occupancy, particularly where it is associated with people delayed in hospital waiting for respite, residential or care at home packages (which peaked at the beginning of 2015, but steadily reduced through 2015-16 and has been maintained into the first two quarters of 2016-17).

It is critical that we initiate all of the programmes to support community based services in parallel with the changes which are taking place in hospital so that we have a 'whole system' approach to older peoples care.

We are closely monitoring patient flow, particularly as we move into winter planning activities to ensure that we have the capacity available to provide hospital

[1] The provision of inpatient rehabilitation beds is currently under review.

based care, including intensive rehabilitation. Addressing delays and inefficiencies in the system will be a key priority. The daily measures which are collected on an ongoing basis as part of our unscheduled care improvement work, service monitoring arrangements and daily communication plan are shown in Appendix B.

If demand for inpatient services exceeds the bed base available, then the senior manager on call will be contacted to consider options available, including calling a major alert and setting up contingency plans to staff outpatient areas e.g. Day Surgical Unit (DSU), Maternity and surge capacity beds X 4, to provide 24 hour care if that is deemed necessary.

There is a multi-agency group that looks at discharge planning and there is close collaboration with the Council to try to prevent any undue delays occurring.

9. Community Care Services

Hospital staff will continue to work closely with local authority partners, and through the H&SCP will meet the needs of patients in the community and ensure that hospital in patients are discharged appropriately in a timely manner back into the community with proper support. The single shared assessment process "With You For You" is now embedded into practice for health and social care staff.

(a) Social Work Service

The Social Work Offices will be closed for the four public holidays over Christmas and New Year (26th & 27th December 2016 and 2nd & 3rd January 2017). A duty Social Worker (contactable via the main hospital reception) will be available to deal with **emergencies**.

(b) Care Centres for Adults

All care centres will be open as usual and can be contacted directly using the contact details in the Shetland Directory. During the festive season, the Social Care Service will use any spare capacity within the care centres to support the provision of emergency residential short breaks required throughout this period. This resource can be accessed by General Practitioners or Community Nurses by contacting the centre directly by phone or via the duty social worker in the out of hours period.

Work is ongoing to make best use of resources to either avoid an unnecessary hospital admission, or to expedite a speedy discharge from hospital. There is a daily bed state for care centre bed capacity, which is shared across community and acute services.

(c) Care at Home

This will operate at a reduced level as many service users get support from their families over the public holidays. It will be available for those without family support. Some meals on wheels kitchens will not be open at all during the festive period. Additional Care at Home will be provided to those for whom this will be a problem. Any queries or requests for unplanned Care at Home during the festive period (excluding public holidays) should be addressed to the local Care Centre. **Contact on public holidays should be via the duty social worker.**

In the central area, Care at Home staff are contactable at the Independent Living Centre on 744313. All requests for assessments should be made to the duty social worker.

(d) Mental Health Community Support Service, Annsbrae House

Annsbrae's services for adults with mental health problems will be provided in line with individual service users' care plans during the festive period. Tenants can contact staff out of hours by using their Community Alarm. Annsbrae out of hours service can be contacted via duty social work on 01595 695611.

(e) Adult Services

Newcraigielea The Short Break and Respite service at Newcraigielea will continue over the Christmas and New Year period with the usual booking system in operation. Any emergency requirement should be referred to the Duty Social Worker on 01595 744400 or 01595 695611.

Newcraigielea Day Service GOLD Group will be closing at the normal time on Wednesday 23rd December 2016 and reopening on Wednesday 4th January 2017

Supported Living and Outreach
Supported Living and Outreach services will be provided in line with individual service users' care plans during the festive period.

Vocational Activity
Eric Gray Resource Centre. The centre will be closing at the normal time on Friday 23rd December 2016 and reopening on Wednesday 4th January 2017

f) Day Care – Community Care Resources
Over the festive period Day Care services may reduce or cease. Individual service users will be consulted about their plans. Alternative services will

be made available depending on the level of demand, e.g. Care At Home or short breaks.
When Day Care is closed enquiries about existing service users should be directed to the relevant care centre (Newcraigielea for adults with Learning Disabilities). Enquiries about emergency Day Care for people who are not known to a service should be made by contacting the local care centre directly or via the duty social worker.

(g) Customer Relations Function at CAB

The Customer Relations Function will not be available over the festive period. All enquiries should be directed to local care centres or the duty social worker.

10. Access to Clinical Information

The Key Information Summary (KIS) system is in place, replacing Special Patients Notes (SPNs) and enhances the level of information which was previously available from the Emergency Care Summary (ECS). The eKIS should provide key information to partner agencies e.g. Scottish Ambulance Service (SAS), as well as to NHS employees in primary and secondary care in the out of hours period and therefore will support the delivery of more appropriate care for individuals in the out of hours period.

All eKIS records should contain current information relating to the patients:

- Medical condition and treatment
- Main carer - their name and contact number
- Wishes which they may have about their care and treatment; and
- Preferred place of care

11. Bad Weather Contingencies

In the case of severe weather, which may restrict patient and/or staff movement, the primary care services will be managed locally with each individual practice covering their own area and patients. Care at Home is already managed on a locality basis with Care Centres acting as hubs.

Community Nursing Services also operate a locally based service in times of severe weather with staff working from their local Health Centre and providing essential visits as weather and staffing numbers permit. This would continue for the duration of the adverse weather.

Hospital based staff will be provided with accommodation, and would travel when able to do so. Staff wishing to remain in Lerwick who reside out with the town for

the duration of a shift pattern will be entitled to the provision of accommodation and meal tokens[2], which will be managed by the Facilities Manager.

A decision whether to invoke the Board's Inclement Weather Policy will be taken by the senior manager on call. For council employees the SIC Adverse Weather Policy should be followed.

Business continuity plans are in place for all key Clinical Services. Decisions would be taken to invoke multi-agency support via Shetland Multi-agency Response Plan or to deal with pressures beyond normal local capacity in the NHS via the Board's Major Emergency Plan.

Council and NHS staff are reminded before each winter to ensure that their vehicles are prepared for inclement weather, and all Council and NHS owned vehicles are prepared in the same way. The cost of winter tyre replacement should be identified by Heads of Service and discussed with the respective Directors responsible that that service area.

12. Preparation and Implementation of Norovirus Outbreak Control Measures & Influenza Planning

The HPS Norovirus Outbreak Guidance refreshed in September 2016 has been fully distributed by NHS Shetland. The Health Protection Team (HPT) is supporting the advance planning which care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in care homes.

The HPS Norovirus Control Measures and support the 'Stay at Home Campaign' message are easily accessible to all staff on the Intranet via the Infection Control Portal. In addition posters and leaflets have been distributed to all wards in the Gilbert Bain Hospital. These same materials have also been distributed to the community.

There is an Outbreak Folder containing all current guidance, protocols and flowcharts to be used in the management of an Outbreak available via the Infection Control Portal on the Intranet.

Staff have been reminded of the need to remain absent for 48 hours post last symptom of diarrhoea and vomiting. This message will be reiterated at the daily Hospital Huddle over the winter period to ensure all staff continue to adhere to this guidance.

[2] Staff will be provided with basic provisions and access to the emergency snack vending machine as required.

The public will be informed about any visiting restrictions which might be recommended as a result of a norovirus outbreak. The IPCT will organize debriefs following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks.

Weekly Norovirus Reports are received from the HPS Infection Control Team which keep NHS Shetland up to date regarding the national norovirus situation.

Before the norovirus season started the IPCT reviewed the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge. Procedures will be updated immediately if additional advice is received from HPS or other agencies that improve the management of such outbreaks.

Adequate IPCT cover across the whole of the festive holiday period will be in place with an OOH Public Health On Call Rota also in place.

NHS Shetland is prepared for rapidly changing norovirus situations and this will be assessed on a daily basis at the Hospital Huddle with additional bed management meetings put in place in conjunction with the IPCT/ HPT as and when required e.g. the closure of multiple bays/ a ward.

Influenza Planning

The Board has the following in place relevant to influenza and winter planning:

- A local emergency plan which contains a general contingency plan which covers capacity to meet winter flu if it reaches epidemic proportions
- Local plans for influenza vaccination
- Encouraging staff to have the vaccination with support from the Occupational Health team
- A winter flu campaign which includes media coverage
- A local Pandemic Influenza Plan in place, modeled on, and continually updated in the light of national guidance

Local plans include:

- Business continuity planning (both for NHS Shetland and other Community Planning partners) which includes consideration of staffing in the event of high absences
- Emergency vaccination arrangements
- Communication and media handling
- Surge capacity agreements

Tabletop exercises have been undertaken to test key procedures for Healthcare Associated Infection (HAI).

13. Disaster Recovery Plans

There are business continuity plans for each area of health board business, designed to ensure that services continue to deliver and support patient care. IT disaster recovery plans have been reviewed in 2016. The Emergency Plan for the Council has been updated in 2016.

14. Escalation Procedures & Management Control

The Board has in place a senior manager on call who is able in real time to instigate any of the above contingencies. The senior manager on-call will be the first point of contact for local or national escalation procedures and will provide real-time feedback to partner organisations on the service delivery capacity locally. Contact details for the senior manager on-call will be made available to all partners and staff and clinicians working locally over the holiday period.

In the case of a sudden unpredicted surge in demand or unexpected absence of medical staff in the hospital setting, the shifts will be covered by the other doctors available within the hospital with support from consultant colleagues and/or leave would be cancelled.

If activity levels increase to such an extent that the usual patient flow management arrangements in the hospital are exceeded then we will move to major alert planning which would facilitate the cancellation of leave for nursing and management staff as well as medical staff as noted above.

15. Publicity

The Council and NHS, in conjunction with its service partners will undertake a publicity campaign. This will describe the arrangements for over the festive period as well as specific information for patients on how best to use the out of hours services. It will include details on when to use the emergency services and when and how to use NHS 24. Our website, which includes information about access to services and health information 'Know Who to Turn to' will also, be included in promotional materials.

The publicity will include a full-page advertisement in the local press for the week prior to Christmas; press releases; information at health centres; dental clinics and community pharmacies. Local public health messages are also given out through the media and our local media diary content will reflect the run up to the festive season. In addition to this, NHS24 will contract with the local press and media to run a pre-festive publicity campaign.

Patient Flow Escalation Plan – NHS Shetland

Time	Bed State	Assessment	Action
08:00	Bed state is on Amber OR Red	The SCN* of each ward, identifies the EDD for all patients and key issues (e.g. vulnerable/high risk patients, inter hospital patient transfers, impact of elective work, patients delayed in hospital and likely discharges that day). This is passed to the Hospital Co-ordinator** so they can take an overview.	If the assessment shows that there will be flow issues, then the information should be captured on the ward EDD templates by the Nurse in Charge of the Hospital and stored on the senior nurse drive for ease of access. If bed state is Red for the Hospital, then the Hospital Co-ordinator should take remedial actions immediately e.g. alert Consultants and consider current staffing levels, consider if elective work can go ahead etc
13:00	Bed state is ON Red	Hospital Co-ordinator reviews the situation post ward round. If the bed state remains on red then the SCN of each ward will be asked to consider which patients would be suitable for decant to other wards if necessary.	The <u>SCN for the ward contacts the Consultants to agree which patients can be transferred to another ward if necessary</u>* SCN notifies Nurse in Charge of the Hospital which patients can transfer if required. Hospital Co-ordinator decides if a bed planning meeting is necessary (to agree patient transfers/discharges etc). If yes, then the SCNs, Patient Flow Manager, Consultants on call (as necessary) and the Duty SW will be asked to attend to plan next steps. Options are considered/agreed at the meeting include: accelerated discharge, cancellation of elective work, additional staffing, transfer of patients to other wards or fast track into community care etc Plan is communicated back to clinical teams to action (e.g. organise patient transfers and discharges before 5pm where possible)
16:00	Bed state is ON Red	Hospital Co-ordinator reviews the current situation with the action plan agreed at 13:00 (e.g. progress of patient transfers, accelerated discharges etc).	If the plan is working and pressures are alleviating then keep a watching brief on patient flow through the evening and overnight. If patient flow issues are not alleviating (at 4pm) then the Hospital Co-ordinator will: • Contact the Consultants on call • Contact Director of Nursing & Acute Services OR Senior Manager on call if DNAS is unavailable, in order to agree contingency plans to be enacted for the rest of the day/night

*If the SCN is not on duty then it is the responsibility of the Nurse in charge of the ward for the shift.

** The Hospital Co-ordinator is denoted on the Nurse Management rota held in the Clinical Portal – and is available 24/7. At weekends this is the Nurse in Charge of the Hospital

NB Individual wards may be on RED
Trigger for actions is as follows:

Ward 3 = only 1 female, 1 male bed and 1 SR available
Ward 1 = only 1 female, 1 male bed

^Specific consideration should be given to patient care needs e.g. only transfer patients with confusion/dementia/high falls risk/complex discharge plans/palliative or terminal care if there are no other patients suitable for inter-ward transfer.
The Consultant must ensure that patients who are transferred to another ward continue to receive appropriate medical review.
Patients who have complex discharge requirements will remain the responsibility of the admitted ward.

Out of Hours/Weekends
Nurse in Charge of the Hospital <u>only</u> needs to contact the Senior Manager on Call IF:

- Beds are on RED and patient transfers are required and there is a need to move patients to beds not usually staffed e.g. decanting to Maternity Unit or Ronas

NB: Consultants must be made aware if a patient is being considered for transfer to another ward before the move is completed

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Appendix B
Daily Performance Metrics to Support Effective Patient Flow[1]

Beds Available
Number of Delayed Discharges*
Deaths (in previous 24 hours)*
Planned Admissions*
Planned Theatre Lists*
Planned Clinics Morning Session (e.g. OPD, Child Health, Visiting)*
Planned Clinics Afternoon Session (e.g. OPD, Child Health, Visiting)*
Planned Clinics/Visits - Obstetric (e.g. Antenatal clinics)*
Planned Discharges Before 12 MD*
Planned Discharges After 12 MD*
Monitoring Safe Patient Transfer
Patient Transfers in to GBH (Air Ambulance)*
Patient Transfers to Mainland Hospitals (Air Ambulance)*
Patient Transfers in to GBH (other route - not retrieval)*
Patient Retrievals – Adult*
Patient Retrievals – Child*
Monitoring Patient Dependency/Acuity
Number of Level 2 Patients*
Number of Acute Mental Health Patients*
Number of Children*
Number of Patients with Confusion (e.g. Dementia)*

Number of Patients with Protection Plans (e.g. GIRFEC, CP, PoA etc)
Number of Patients who are receiving End of Life Care
Monitoring Patient Safety
Number of Medical Patients Decanted to another Ward*
Number of Surgical Patients Decanted to another Ward*
Number of Obstetric Patients Decanted to another Ward*
Number of Dementia/High Risk Patients Decanted after 5pm
Number of Patients with Falls Risk (e.g. Previous falls)*
Number of Patients who have Fallen (previous 24 hours)
Number of Patient Falls with HARM*
Number of Patients with GRADE 2/3 Pressure Sores
Number of Patients with an Infection/Requiring Barrier Controls*
Monitoring Safe Staffing Levels
General Staffing Issues*
AA Nurse Status*
Theatre On Call Team/HDU On Call Team Status*
[i]Midwife On Call Status*
A&E On Call Status*
General Safety Issues
Environmental/Equipment Issues*

[i] All of these metrics are discussed at the daily huddles, some items are recorded for ongoing monitoring and others are reported by exception or formally through other routes e.g. patient safety programme. So for instance, we would note if a patient has a significant adverse event such as a fall with harm or a pressure sore but this would be discussed at the huddle as an exception, as it is not part of the core dataset for the huddle discussion. The metrics with an asterix against them are part of the core dataset for the daily huddles.