Shetland Islands Health and Social Care Partnership

Agenda Item

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Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	23 November 2016
Report Title:	Public Health Annual Report 2016	
Reference Number:	CC-78-16 F	
Author / Job Title:	Susan Webb, Director of Public Health NHS Grampian and NHS Shetland	

Decisions / Action required:

The IJB is asked to:

(i) receive the Public Health Annual Report.

(ii) continue to support efforts to improve the public health in Shetland through work on alcohol, drugs and tobacco.

(iii) continue to support the work of the Public Health Directorate in maintaining and progressing its wide range of work to improve and protect the health of the Shetland population.

High Level Summary:

The Public Health Annual Report for 2016 is split into two parts. The first is similar to previous reports where we have focused on a specific theme. This year the theme is 'substance misuse' which includes legal substances: alcohol and tobacco and illegal substances, drugs, and how they affect our health in Shetland. The second part provides a summary of the work of the Public Health Directorate over the past year. This is a more comprehensive overview of the work of the Directorate than has been included in previous years and aims to show the breadth and diversity of the work that we do.

In Part I of the report we look at the some of the key current issues in tackling alcohol, tobacco and drug use. Within these topic areas there are three consistent strands, prevention, protection and cessation. The alcohol chapter focuses particularly on understanding risk, with reference to the new alcohol guidelines, and how we can change attitudes and culture. This includes the local Drink Better campaign and work with the Licensing Board. It should be noted that some of the possible actions discussed in this report, around alcohol licensing in particular, could be potentially quite radical and have already attracted considerable local and national media interest.

The smoking chapter considers the challenges of prevention given that whilst health improvement work in schools appears to have a significant effect on children, this does not last through to the teenage years and young adulthood and people are still taking up smoking. The success of the local smoking cessation services is highlighted along with the challenges to maintaining this success and having a real impact on smoking prevalence. Finally, the impact of 'e-cigarettes' on both smoking behaviour and smoking cessation is considered. The chapter on drugs looks at the recovery model to help people

stop their drug taking behaviour and addresses the issue of stigma that affects drug users and their families. This is not only the stigma of drug use but also the potential consequences including blood borne viruses and a criminal record. The new challenge of dealing with 'novel psychoactive substances' is also considered.

Public Health staff work very closely with the Substance Misuse and Recovery Service on tackling alcohol and drug issues.

Part II of the report describes the overall work of the Public Health Directorate in the past year, including the Public Health and Health Improvement Teams. We have structured this part of the report to show the diversity of work that we do under a number of key areas ranging from influencing policy and using social marketing techniques for health improvement to developing individual's personal skills and working with communities. There is a focus on prevention and inequalities and also the areas where we know we can, and should, do more work including engaging and working with partners. However there is the ongoing challenge in the face of reducing resources to continually re-prioritise our efforts, and ensure we are continuing to work effectively and efficiently.

There is currently a considerable amount of preventative work done in primary care and community settings, which is achieving good outcomes that cannot be achieved by one service alone, but is under pressure from reduced resources.

Corporate Priorities and Joint Working:

The main priority of the Public Health Directorate is to improve and protect the health of the people of Shetland; and it works towards meeting all the National Health and Wellbeing Outcomes.

Joint working is essential for nearly all areas of public health and health improvement work. It is key in tackling alcohol, drugs and tobacco; primarily through the Drug and Alcohol Partnership.

Key Issues:

On alcohol, tobacco and drugs:

- Tackling substance misuse is a very complex issue requiring complex solutions.
- Alcohol use is a bigger problem on a population level than drugs, but hard to challenge because of cultural and social factors.
- Smoking is still an issue, despite the success of smoking cessation services.
- Partnership working and engaging with the community are key to tackling substance misuse.
- Services have to react and change to meet new challenges such as novel psychoactive substances or potential opportunities such as e-cigarettes.
- Some of the issues discussed in this report, particularly around alcohol licensing have already attracted considerable local and national media interest.

On the work of the Public Health Directorate:

- The Directorate carries out a huge range of work in a variety of settings across Shetland; with the move to locality working being very well received by Primary Care teams in particular.
- Much of the work of the health improvement team in particular is carried out within and alongside Integration Joint Board services such as Primary Care.
- The main areas of work are around weight management, physical activity,

substance misuse, mental health and inequalities.
- There is a need to continually evaluate, develop and improve services to ensure they are supporting the most vulnerable people and communities, that they focus on prevention and that they are effective: particularly within the context of diminishing resources.

Exempt and/or confidential information:
None

Implications :	
Service Users, Patients and Communities:	The function of the Public Health Directorate is to improve the health of the whole population of Shetland through prevention; early intervention; work on the determinants of health and tackling inequalities.
Human Resources and Organisational Development:	NHS Shetland and Shetland Islands Council have drug and alcohol and smoking policies. There is training available for managers on alcohol and mental health in the workplace context. There is a range of health improvement training available to staff in NHS Shetland, Shetland Islands Council and other partner organisations.
Equality, Diversity and Human Rights:	Inequalities, exclusion and poverty can be closely linked with the use of alcohol, drugs and tobacco; both as a risk factor and a consequence of substance misuse. Public health and health improvement work is increasing focused on supporting the most vulnerable and excluded in our communities; along with specific work on tackling health inequalities.
Legal:	Legislation is essential to reduce the harm caused by alcohol, tobacco and drugs at a national level. All public health and health improvement work is conducted within existing legislation.
Finance:	This work is done within current existing resources: there are some specific funding streams for substance misuse work including SDAP funding and the prevention bundle (for tobacco control work). Any further cuts to funding will result in a reduction in the work that can be done particularly where resources have already been reduced eg the Health Improvement Team. All other work of the Public Health Directorate is largely within existing resources although external funding is sought and has

	been secured for specific projects.	
Assets and Property:	There are no implications for major assets and property.	
ICT and new technologies:	There are no ICT issues arising from this report.	
Environmental:	There are no environmental issues.	
Risk Management:	If the work outlined in the first part of this report is not continued and developed, particularly relating to prevention and early intervention, there is a considerable risk of an increase in harm caused, the cost to society and number of people affected by alcohol, drugs and tobacco. Similarly, not continuing and not further developing all the work outlined in part two would result in a considerable risk of an increase in harm caused, the cost to society and number of people affected by a variety of health issues including obesity, inactivity, cancer, mental health problems, sexual health problems, gender based violence and communicable diseases.	
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 has authority to resource and direct the work of a number of services, such as Primary Care and Substance Misuse Recovery Team that work in partnership with the Public Health Directorate.	
Previously considered by:	NHS Shetland Board Meeting	4 October 2016

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Appendices:
Shetland Public Health Annual Report 2016

Background Documents:

Shetland Public Health Annual Report 2016

Focus on Substance Misuse

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FORWARD

Welcome to my first Public Health Annual Report for NHS Shetland. The main theme of this year's report is alcohol, smoking and drug use and how this affects our health in Shetland. Along with physical activity and diet (the theme of last two annual reports), alcohol and tobacco in particular are major factors which influence our community's wellbeing.

Protecting the population from harms due to the misuse of substances is complex. Some substances such as alcohol and tobacco are perfectly legal for adults to buy and use within some constraints, whilst others are not. There are common factors between substances whether legal or illegal: they can have psychological effects (which is why people use them); they can all be bad for our health; they can be addictive and their use can seriously affect other individuals and communities, either directly or indirectly. There are huge cultural and social influences on why and how people drink, smoke and take drugs; as well as individual ways of thinking and behaving. However, there are also a variety of legal factors which can significantly influence behaviour and consequences.

In Part I of this Report we consider these issues and where possible provide local data on alcohol, smoking and drug use and highlight local action. Whatever the substance there are three key strands to our public health efforts:

Prevention: creating an environment where people choose not to misuse substances

Protection: protecting people for harms of others misuse of substances, for example creating smoke free environments

Cessation: helping people who are using substances to stop: 67% of those who smoke wish to quit.

Whatever your personal views of substance misuse there is a good chance that others will have a different view from you. I hope the information presented in this report stimulates discussion in communities and partnerships around future action to tackle substance misuse in Shetland.

In Part II of the report there is a summary of the work of the Public Health Directorate over the last year. Many of the achievements would not have been possible without the strong collaboration of a range of partners. This demonstrates the huge range of work that the

public health and health improvement colleagues are involved with; highlighting both the successes and the continued challenges in improving the health of the people in Shetland.

Acknowledgments

My thanks for all their hard work in the production of this report go to Elizabeth Robinson, Dr Susan Laidlaw, Elsbeth Clark, Karen Smith, Wendy Hatrick, Kim Govier, Andy Hayes, David Kerr and Emma Fletcher.

Susan Webb

Director of Public Health

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EXECUTIVE SUMMARY

The Public Health Annual Report for 2016 is split into two parts. The first is similar to previous reports where we have focused on a specific theme: this year the theme alcohol, smoking and drug use and how this affects our health in Shetland. The second part summarises the work of the Public Health Directorate over the past year (excluding communicable disease control and emergency planning for which there are separate annual reports).

Part I

We know that too much alcohol is bad for us, but it is completely legal for adults to buy and drink alcohol. Most adults drink alcohol, if not regularly then occasionally, and many people enjoy a drink quite safely. But many others regularly suffer the short term consequences of too much alcohol, and some develop serious illness. The effects of alcohol problems on relationships, families and communities can be devastating; including accidents, violence and other criminal behaviour due to alcohol. Alcohol can directly and indirectly affect mental health, and we know that alcohol has played a significant role in suicides in Shetland. How do we change the cultural norms around alcohol to reduce the harmful effects on individuals, families and communities? 'Drink Better' is our local campaign to try and influence and change people's drinking habits to reduce the risk to their health and other consequences. However, a campaign alone cannot change behaviour and needs to be supported through legislative and environmental changes such as reducing the availability of alcohol. The alcohol chapter focuses particularly on understanding risk, with reference to the new alcohol guidelines, and how we can change attitudes and culture. This includes the local Drink Better campaign and work with the Shetland Area Licensing Board.

We also know that smoking is really bad for our health, being a leading cause of heart disease and cancer, but again tobacco is completely legal for adults to buy and use. 15% of us in Shetland still smoke regularly, despite the cost, increasing social pressure to stop and limitations on where we can smoke. In fact two thirds of smokers say they want to give up: so why is it so hard to quit? We have an excellent smoking cessation service which achieves high quit rates; but is very resource intensive to run, and we are now finding that the people who attend are those who find it the most difficult to quit. And we know that

there are still young people who start smoking, despite seemingly very successful educational approaches in schools. And how do we deal with the new fashion for 'vaping': are electronic cigarettes the safe way to smoke or do they cause more harm than good?

The smoking chapter considers the challenges of prevention given that whilst health improvement work in schools appears to have a significant effect on children, this does not last through to the teenage years and young adulthood and people are still taking up smoking. The success of the local smoking cessation services is highlighted along with the challenges to maintaining this success and having a real impact on smoking prevalence. Finally, the impact of 'e-cigarettes' on both smoking behaviour and smoking cessation is considered.

Often, the general public view drugs as the biggest concern in terms of substance misuse and addiction, but the reality is that smoking and alcohol cause far more health and other problems in our community. Within our society it is really quite acceptable to get drunk and behave in a way we wouldn't normally, making ourselves ill and causing bother to other people. However, most people view 'drugs' in a completely different way; people who take drugs are criminals and second class citizens (whether or not their drug taking affects anyone else) and there is often a perception that people who use drugs will inevitably get ill, and will die from their addiction. However on a population level, alcohol and smoking cause far more ill health and premature deaths that illegal drug taking. And on an individual level, people can reduce the health risks associated with drug taking, such as overdose and infections like HIV and hepatitis. Frequently it is the legal implications of taking illegal drugs that cause more problems for the individual taking them than the effects of the drugs themselves.

Drug taking is now increasing complex to tackle with the wide availability of novel psychoactive substances (NPS). Previously known as 'legal highs', these substances are now illegal but freely available on the internet in particular. The problem with them is that the effects on individuals are extremely unpredictable. One tablet may give a pleasant 'high' or it might kill you.

The other element of drug use that is complex to deal with is the misuse of legal prescription drugs. Although a prescribed drug, such as morphine, may be perfectly safe to use in the right circumstances under medical supervision, it can also be extremely addictive and may end up being used in the same way as its illegal counterpart, heroin.

The chapter on drugs looks at the recovery model to help people stop their drug taking behaviour and addresses the issue of stigma that affects drug users and their families. This is not only the stigma of drug use but also the potential consequences including blood borne viruses and a criminal record. The new challenge of dealing with 'novel psychoactive substances' is also considered.

The three main approaches to tacking substance use and misuse are highlighted in each of the chapters: prevention; protection and cessation. Throughout the report we also consider the complex relationship between substance misuse and inequalities, poverty and social exclusion.

Part II

This describes the work of the Public Health Directorate in the past year, including the Public Health and Health Improvement Teams. We have structured this part of the report to show the diversity of work that we do under a number of key areas:

1. Formulating, implementing and monitoring healthy public policy;
2. Re-orienting public services to become health-promoting;
3. Implementing programmes to improve health for individuals and communities, and across a range of settings, such as workplaces;
4. Encouraging environmental measures to improve health;
5. Incorporating community development approaches, so that communities are empowered;
6. Developing people's personal skills by enabling them to identify their own needs and involving them in planning and evaluation processes;
7. Encouraging appropriate service utilisation, including screening and immunisation services; and
8. Delivering health information and education, including the use of social marketing techniques
9. Tackling inequalities

There is a focus on prevention and inequalities and also the areas where we know we can, and should, do more work including engaging and working with partners. There is a need to continually evaluate, develop and improve services to ensure they are supporting the

most vulnerable people and communities, that they focus on prevention and that they are effective: particularly within the context of diminishing resources.

Within the appendices there are more detailed evaluations for two specific pieces of work ('Beating the Blues' Computerised Cognitive Behavioural Therapy; and the Otago Strength and Balance exercise programme) and also a summary of the results of a survey with primary care teams on the Health Improvement Team's shift into locality working.

PART I

FOCUS ON SUBSTANCE MISUSE

CHAPTER 1 INTERPRETING THE FACTS & FIGURES

There are numerous ways to measure the extent and the impact of substance misuse within communities. But it can be difficult to interpret what the results actually mean and how they can help us to tackle the problems of alcohol, drug taking and smoking.

Why do we need this information? We need to understand the size of the problem so that we know where to target our limited resources. And to see if things are getting better or worse: particularly how successful are the things that we are doing to prevent and reduce substance misuse and the effects of substance misuse.

The information that we can collect can be divided into the following broad categories:

- Prevalence – how many people smoke / drink alcohol / take drugs
- Availability of the substance
- Crime related to substance misuse
- Social effects of substance misuse
- Economic effects of substance misuse
- Health effects of substance misuse
- Treatment services

Prevalence

It is very difficult to find out the exact number of people who smoke, drink alcohol or use drugs: that could only be done by asking every person in a population if they use these substances, and assuming that they answer it truthfully; or by testing every person for evidence of tobacco, alcohol or drug use. Both these options clearly have major logistical, cost and ethical implications. We therefore tend use information that has already been collected, for example in GP medical records, or proactively survey a representative sample of the populations, or use a 'proxy' measure.

In Shetland we measure smoking prevalence both using GP data and figures from national surveys that include a sample of the Shetland population. There are pros and cons with both sets of data. The Scottish Health Survey and Scottish Household survey both ask a sample of people in every Health Board area in Scotland a set of questions including about smoking status. The most recent results from the Health Survey (covering 2012-15), which samples about 100 people each year in Shetland, showed that 23% of people smoked.[1] However the Household Survey showed the rate to be 16% in 2013.[2] Because these are small samples, the rates may not be statistically significant. Data from GP practices however could theoretically include the whole population. In practice it does not, as not every patient has their smoking status recorded, although this is improving. Another problem with this data is that they can be out of date: so a patient may be recorded as a smoker who has since stopped and is now a non-smoker but that information has not been updated. Local GP data shows that 15% of adults in Shetland smoke.

With smoking we tend to classify people as smokers or non smokers, and possibly ex-smokers but do not often look at how much tobacco people smoke. However with alcohol consumption we tend to categorise according to how much they drink and how regularly , rather than simply being a drinker or non-drinker. But self reporting of alcohol consumption can be very inaccurate, with people usually underestimating what they drink especially if pouring out 'home' measures. Medical students used to be told that whatever a patient says they drink then the doctor should double it! There has been a lot of work put into raising people's awareness of how much alcohol they drink, and trying to explain how to calculate the amount using units of alcohol. Information from the most recent Scottish Health Survey (2012-15) showed that 51% of men in Shetland were drinking up to 14 units a week, and 35% over 14 units; along with 63% of women up to 14 units and 18% over 14 units.

However, surveys are known to underestimate the prevalence of drinking: a Scottish Public Health Observatory report looked at the differences in estimated prevalences between different surveys and measures of alcohol sales. But sales figures also

[1] Scottish Health Survey results by Board available at: www.gov.scot/Resource/0050/00505568.xlsx

[2] Scottish Household Survey results by Board available at: www.gov.scot/Resource/0048/00486916.pdf

underestimate prevalence because of alcohol obtained from abroad ('duty free'), illegal 'black market' purchases and home-brewed drink.[3]

Assessing the prevalence of drug use is even harder, because drug users may be unwilling to tell anyone about their drug use, and so it has to be estimated from other data sources. These can include from surveys (e.g. in the general adult population, older school pupils, prisoners), from drug offences and drug seizures recorded by the police, from drug testing in prisons, from drug users coming into contact with health care providers because of their drug use or coming forward for treatment. It is estimated that 2.2% of the population in Shetland use drugs: although this proportion does fluctuate from year to year because of the small numbers involved.[4]

There is a survey of alcohol and tobacco use in school pupils: the Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS) which is done in school with pupils aged 13 and 15. Some of the results are shown below on page 27. This survey covers all teenagers in Shetland in these age groups rather than just a sample. Although the survey is done anonymously, there is potential for pupils to either exaggerate or play down substance misuse in front of their peers.

Availability of the substance

There are a number of ways to assess availability. At a local level, the number of shops selling tobacco and the number of licensed premises in an area can indicate availability, and can be compared with other similar areas. Research has shown that there is a link between the number of licensed premises in an area and the level of alcohol consumption: with increased availability leading to increased levels of drinking.[5]

Figure 2.1 on page 26 shows how much alcohol is sold in the UK, which gives a good indication of how much is being consumed on a national level. In the UK, during 1995, an average of nine litres of pure alcohol was sold per head of population aged 15 and over,

[3] Catto S.(Scottish Public Health Observatory) *How much are people in Scotland really drinking?* Edinburgh: ScotPHO, 2008. Available at: www.scotpho.org.uk/downloads/scotphoreports/scotpho080526_alcoholsurveys_rep.pdf

[4] Information Services Division (ISD) of National Services Scotland.

[5] Babor T, Caetano R, Casswell S, et al. *Alcohol: No Ordinary Commodity*. Oxford: Oxford University Press, 2010.

the equivalent of 18 units per week. By 2005, this had increased to 11 litres per head of population: the equivalent of 22 units per week.[6]

On a national level, the income generated by tobacco and alcohol sales and the resultant tax raised gives an indication of availability (see Page 14).

However, for illegal drugs, and illegally produced or imported alcohol and cigarettes, then police intelligence would be the main way to assess availability. In Shetland, the availability of illegal drugs tends to vary, which leads to drug users often using a number of different drugs, or changing their drug of choice. Novel psychoactive substances in particular have a range of physical and psychological effects which vary from drug to drug. Knowing which drugs are available helps to predict what effects we might see in drug users, and helps services to better respond to the needs of drug users.

Crime

There is a wide range of crimes associated with substance use including:

- Drug crimes
- Underage alcohol and tobacco sales
- Drink driving
- Alcohol related incidents including violent crime
- Smoking ban incidents

Crimes can be measured in a number of ways including reported crime; arrests; detections; convictions and number of fines. There are local alcohol related crime figures reported on page 29-30 below.

Crime figures need to be interpreted with care, especially if making comparisons with other areas or over time. An increase in reported crime may be due to a genuine increase in crime or due to increased awareness and reporting. If police resources are increased, then an increase in detection of crime would be expected and vice versa. Furthermore, laws

[6] Catto S.(Scottish Public Health Observatory) *How much are people in Scotland really drinking?* Edinburgh: ScotPHO, 2008. Available at: www.scotpho.org.uk/downloads/scotphoreports/scotpho080526_alcoholsurveys_rep.pdf

and the interpretation of the law change over time and between different areas, so it can be difficult to make international comparisons for example.

Social effects of substance misuse

These include the effects on relationships, families and communities. Alcohol and drugs can have devastating consequences for families in particular. In Scotland, parental substance misuse is identified in 36% of child protection cases on the Child Protection register. In Shetland, in 2015-16, there were 25 children who had specific issues identified at the initial case conference; parental alcohol misuse was identified in six cases, and drug misuse in five cases.[7] Alcohol and drugs are also often factors in domestic abuse and other violence.

Economic measures of substance misuse

Alcohol and tobacco are huge industries worth billions across the world. Scotland exports around £4 billion worth of whisky each year.[8] Governments can raise significant sums of money through taxation of alcohol and cigarettes; although the argument for high taxes is that they fund the healthcare and other costs of cigarette and alcohol use. The UK Government was forecast to have received £9.9 billion in tobacco duty and around £10.4 billion in alcohol duty in 2014-15.[9] So trying to reduce the quantity of alcohol consumed or tobacco smoked could have a detrimental effect on this revenue. We would argue that this would be offset by the decrease in Government expenditure needed for services such as healthcare, police, social care etc.

Substance use has a wide range of economic effects. At an individual level, the cost of alcohol, cigarettes and drugs can be a significant percentage of an individual or household expenditure. A potential (and unwelcome) consequence of increasing the tax and therefore

[7] Shetland Child Protection Annual Report 2015-16 available at www.safershetland.com/assets/files/CPC%202015-16%20Annual%20Report.pdf

[8] DEFRA. UK Food and drink International Action Plan. London: UK Trade and Investment, 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329486/UKTI_Food_and_Drink_strategy_brochure_June_2014_spreads.pdf

[9] Institute for Fiscal Studies. A Survey of the UK Tax System.IFS Briefing Note BN09. London: IFS, 2013. Available at: www.ifs.org.uk/bns/bn09.pdf

the price of alcohol and cigarettes, in order to reduce the quantities people consume can cause people to seek illegally imported cigarettes and alcohol that are not subjected to tax.

The use of illegal drugs in particular is associated with people turning to crime to 'fund their addiction'; whether this is through illegal activity to make money to pay for drugs or to obtain essential commodities that they cannot afford, for example through shoplifting. The effects of drug and alcohol use can cause problems with work and employability, further exacerbating the financial burden. Problems with employment do not only affect the individual but also businesses and employers in terms of low productivity, sick leave and potentially the costs of having to replace staff. But some people who abuse alcohol or drugs can afford to buy them, can still function at work and do not overtly exhibit the behaviour associated with drug and alcohol misuse.

The cost to society of the effects of drugs and alcohol, and also tobacco, is huge when taking into account health services, crime and social consequences. It is estimated that in Shetland the total cost of alcohol use to our community is between £6.8 and £10.8 million a year.

Assessing the scale of the drug market in Scotland is even more difficult given its illicit nature, although a study published in 2009 provides initial estimates of the size and value of the illicit drugs market and estimates of the social and economic cost of illicit drug use in Scotland for the year 2006.[10] The total value of the illicit drugs market was estimated at around £1.4bn. Heroin held the largest share of the market with 39% of the market, with cannabis holding a 19% share, the second largest. Problem drug users held the largest percentage share of the total market (63%).

Health effects of substance misuse

The health effects of substance misuse are wide ranging, costly for the health service and can exacerbate financial and social problems. There are a number of ways to measure health effects including the prevalence of specific conditions directly or indirectly related to substance use; health service usage and treatment and deaths due to alcohol, drugs or tobacco.

[10] Casey J, Hay, G, Godfrey C, Parrot S. *Assessing the Scale and Impact of Illicit Drug Markets in Scotland*. Scottish Government. 2009. Web only available at: www.gov.scot/Publications/2009/10/06103906/0

There are certain conditions that are specifically related to substance use including for example alcoholic liver disease; lung cancer (86% is caused by smoking[11]); alcohol and drug withdrawal; or drug induced psychosis. Others are indirectly related, for example people who are infected with blood borne viruses such as HIV and hepatitis C because of their drug taking behaviour, rather than the effects of the drugs themselves, or injuries caused by violence or accidents due to alcohol.

The number of people who are admitted to hospital is a measure of how many people are drinking so much that it is harming their health. This includes people with liver disease and other medical problems due to alcohol and also those who have accidents and injuries due to excess alcohol. This indicator is in fact based on diagnosis on discharge, because the diagnosis may not be clear on admission**;** and it is presented as a rate per 100,000 population so that we can compare ourselves with other areas and from year to year. In Shetland hospital admissions is one of our key indicators for measuring the burden of alcohol misuse. In 2009-10 there were 770.3 /100,000 population alcohol related admissions to the Gilbert Bain hospital. This has dropped to 677.1 /100, 000 by 2013-14 and then to 588.7 by 2014-15. This drop in the number of people being admitted could be due to a number of factors: a genuine decrease in alcohol related illnesses and injuries; a change in the way conditions are recorded; fewer people being admitted to hospital, but potentially being cared for in the community. There is further information on alcohol related admissions, and also deaths due to alcohol on page 28.

Treatment services

The number of people requiring healthcare services because of smoking or drug or alcohol use is another way of measuring the impact of substance misuse**.** This can include generic services such as A&E and hospital admission, along with dedicated services including the Substance Misuse Recovery Service (SMRS), the needle exchange (community pharmacy) and the smoking cessation service delivered by the Health Improvement Team.

Measuring waiting times for services is done frequently for performance management, however it also helps with the overall picture of substance misuse. Generally 100% of patients are seen within three months by the Substance Misuse Recovery Services.

[11] www.cancerresearchuk.org/about-cancer/type/lung-cancer/about/lung-cancer-risks-and-causes

Alcohol Brief interventions (ABIs) is another key indicator which is measured against a target set by the Government for the purposes of performance management. However, the number of ABIs does also give us another estimate of the number of people in the population who drink enough alcohol for it to be potentially harmful to their health.

Other useful data that we can collect includes the number of needles being given out in the Needle exchange: i.e. monitoring the number of needles being given out. Changes in the numbers of people using the needle exchange, or big increases or decreases in the numbers of needles being used or returned gives an indication of changes in drug taking behaviour, and potentially different drugs being used or in different ways.

In summary, there is a wide range of information and data that can be used to describe a picture of alcohol and drug use and smoking, and to monitor progress over time. However care must be taken to avoid misinterpreting data, particularly because of the small numbers involved, which can make it hard to detect trends and make comparisons with other areas.

CHAPTER 2 ALCOHOL

Understanding the risk

The UK Independent Scientific Committee on drugs, reporting in 2010, showed that while heroin, crack cocaine, and metamfetamine were the most harmful drugs to individuals, alcohol, heroin, and crack cocaine were the most harmful to others. Overall, ***alcohol was the most harmful drug***, with heroin and crack cocaine in second and third places.

However, they noted, the findings correlate poorly with present UK drug classification, which is not based simply on considerations of harm. [12]

The UK Chief Medical Officers have recently published updated alcohol consumption guidelines, following a two- year, expert review of the scientific evidence[13]. Their guidance makes it clear for the first time that there is no "safe" level of alcohol consumption. Any level of drinking raises the risk of developing a range of cancers including breast, bowel and mouth cancer. Although we have known that alcohol is a carcinogen (cancer causing substance) since the 1980s, the full extent of the link was not recognised in the previous recommended limits which were set out in 1995. There is also now no justification for recommending drinking on health grounds as previous evidence is likely to have over-estimated the protective effects of alcohol for the heart.

Organisations that are concerned about alcohol and public health have welcomed the new guidelines and in particular that attention has been drawn to alcohol-related cancer. Alcohol is responsible for around 12,500 cancer cases a year in the UK, yet only around half of us are aware of the link.

It is well recognised that excessive consumption of alcohol can result in a wide range of health problems, not just cancer. Some may occur after drinking over a relatively short period, such as acute intoxication (drunkenness) or poisoning (toxic effect). Others can

[12] Nutt, David J et al.Drug harms in the UK: a multicriteria decision analysis, *The Lancet* 2010; **376:** 1558 - 1565

[13] www.gov.uk/government/uploads/system/uploads/attachment_data/file/489795/summary.pdf

develop more gradually, only becoming evident after long-term drinking, such as damage to the liver and brain. In addition to causing physical health problems, excessive alcohol consumption can lead to mental health problems, including dependency.

Why is NHS Shetland interested in this?

The new Government Guidelines are that neither men nor women should drink more than 14 units per week. If people do drink up to this limit it is best that they spread it evenly across the week. It is the longer term affects of moderate alcohol consumption of alcohol that impact on the work of NHS Shetland as well as potential damage from drunken assaults or falls.

- Around 11% of attendances at A&E are estimated to be alcohol related
- Around 190 out of every 1000 primary care (GP surgery) presentations have alcohol related problems
- 15% of psychiatric admissions are due to alcohol misuse and alcohol is considered to be one of the three main risk factors in suicide.[14]

Many people are unaware that they routinely drink above these limits and are at increased risk of long term damage to themselves: mentally, physically and socially. The more often that daily limits are exceeded, and the greater the amount exceeded by, the greater the risk of harm.

The UK Chief Medical Officers alcohol consumption guidelines are based on the following premises:

- People have a right to accurate information and clear advice about alcohol and its health risks.
- Government has a responsibility to ensure this information is provided for the public in a clear and open way, so they can make informed choices.

Consequently the guidelines have been developed so that the known health risks of different levels and patterns of drinking, particularly for people who want to know how to keep long term health risks from regular drinking of alcohol low, are both accurate and expressed in an understandable way.

[14] *Cost of Alcohol Use & Misuse*. Scottish Government, 2008.Web only publication. Available at: www.gov.scot/resource/doc/222103/0059736.pdf

The Governments felt that it is for individuals to make their own judgements as to the risks they are willing to accept when they drink alcohol, including whether to drink alcohol at all, and how much and how often to drink. They believe that these guidelines should help people to make those choices.

The low risk drinking guidelines are based on average risks. Individuals can also take account of other individual factors that could potentially increase their personal risks from drinking or from drinking at particular times. This could include taking account of any previous negative effects experienced from alcohol, the possible interaction of alcohol with any medications they are currently taking, whether they have any other relevant physical or mental health problems that could be made worse by drinking, or other factors that could be relevant such as low body weight or worries about falling.

There will also be situations when individuals will want to avoid the short term performance limiting effects of alcohol, for example, when they are planning to drive, operate machinery, or take part in risky activities.

20

Weekly Drinking Guidance

This applies to adults who drink regularly or frequently i.e. most weeks

The Chief Medical Officers' guideline for both men and women is that:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.
- If you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days. If you have one or two heavy drinking episodes a week, you increase your risks of death from long term illness and from accidents and injuries.
- The risk of developing a range of health problems (including cancers of the mouth, throat and breast) increases the more you drink on a regular basis.
- If you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.

Single Occasion Drinking Episodes

This applies to drinking on any single occasion (not regular drinking: use the weekly guideline)

The Chief Medical Officers' advice for men and women who wish to keep their short term health risks from single occasion drinking episodes to a low level, is to reduce them by:

- limiting the total amount of alcohol you drink on any single occasion
- drinking more slowly, drinking with food, and alternating with water
- planning ahead to avoid problems e.g. by making sure you can get home safely or that you have people you trust with you.

The sorts of things that are more likely to happen if you do not understand and judge correctly the risks of drinking too much on a single occasion can include:

- accidents resulting in injury, causing death in some cases
- misjudging risky situations, and
- losing self-control (e.g. engaging in unprotected sex).

Some groups of people are more likely to be affected by alcohol and should be more careful of their level of drinking on any one occasion. For example those at risk of falls; those on medication that may interact with alcohol; or where it may worsen existing physical or mental health problems.

If you are a regular weekly drinker and you wish to keep both your short- and long term health risks from drinking low, this single episode drinking advice is also relevant for you.

Pregnancy and drinking

The Chief Medical Officers' guideline is that:

- If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
- Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy.

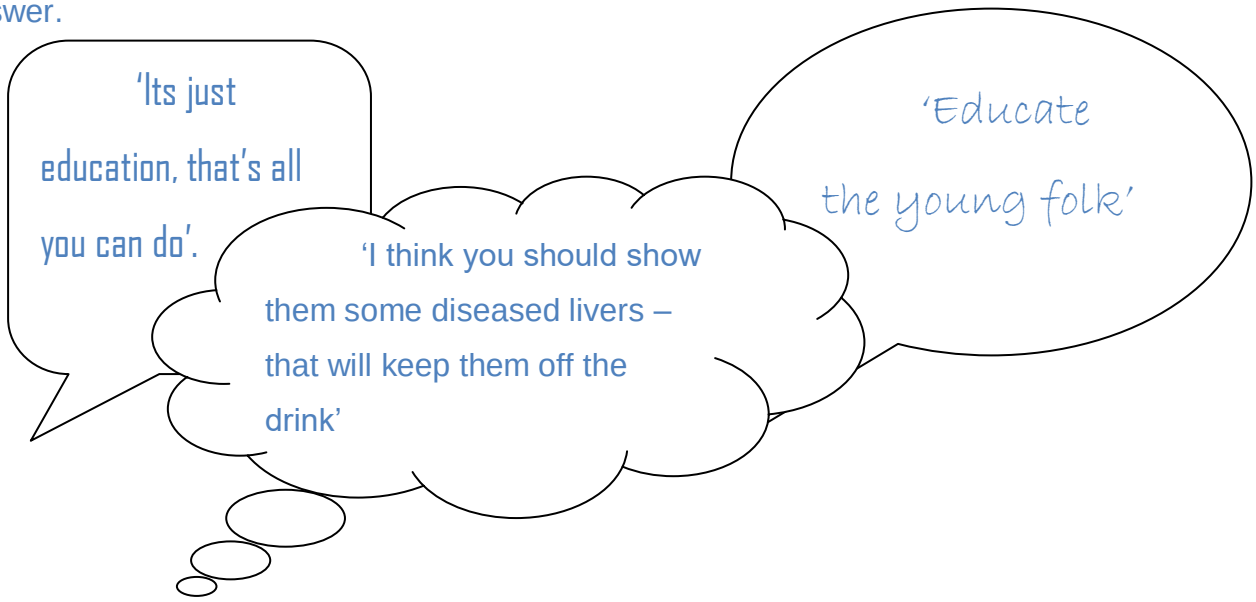
If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. Be aware that it is unlikely, in most cases, that your baby has been affected. But if you are worried about alcohol use during pregnancy do talk to your doctor or midwife.

The UK Governments and Chief Medical Officers have tried to makes these guidelines as clear as possible, but they are not simple messages; and they rely on people having the knowledge, skills, ability and understanding to put them into practice.

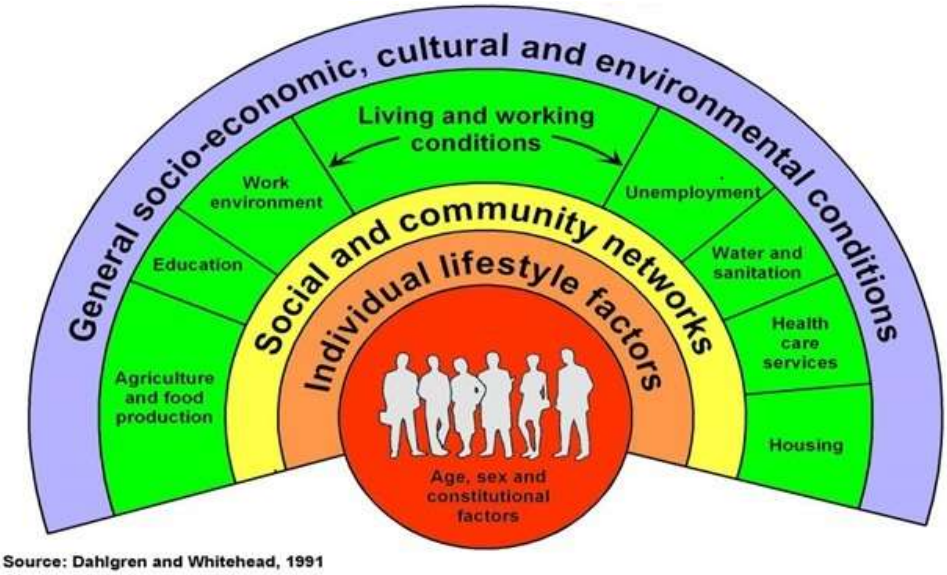
At a recent Shetland Area Licensing Forum, there was debate about the relative responsibilities of education and Licensing Boards in tackling alcohol misuse. The next section looks at the strengths and weaknesses of each approach.

Education, culture change or the law?

Often, when we talk about alcohol misuse in society, we are told that education is the answer.



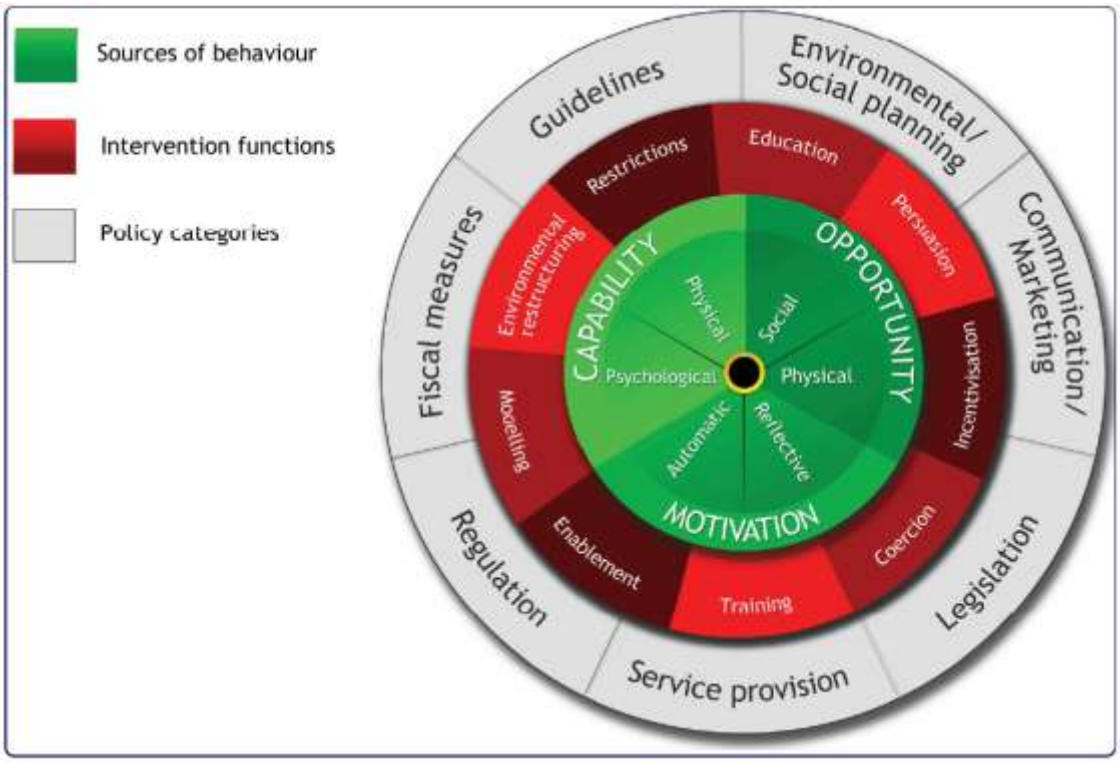
During the 1970s and 80s Health Education became all the rage. It was at this time that the Health Education Board for Scotland was established, and the focus was very much on education in order to help people increase control over their health and their environment. Since then, more and more evidence has emerged about health and the influences on health, illustrated by the diagram below.[15]



Source: Dahlgren and Whitehead, 1991

[15] Dahlgren G., Whitehead M., *Tackling Inequalities in Health: What Can We Learn from What Has Been Tried? Working Paper Prepared for the King's Fund International Seminar on Tackling Inequalities in Health.* London: The King's Fund, 1993.

This Behaviour Change Wheel below represents an attempt to describe all the components that go into effective behaviour change, and shows what a very complex process this is:[16]



Drink Better is a local initiative aimed at changing the alcohol culture from one of drinking for intoxication, to drinking responsibly, and for enjoyment. It is an example of 'communication and marketing' in the behaviour change model.

Many social occasions and events in Shetland (as elsewhere) revolve around entertaining, having a good time, and often, having a few drams. Up Helly Aa, the Simmer Dim Bikers' Rally and the Folk Festival are Shetland traditions that are enjoyed immensely by Shetland residents and visitors alike, that can involve alcohol as an integral part of the festivities.

Rather than focussing on negative aspects of alcohol consumption, Drink Better aims to embrace the positive culture of drinking; we want a culture where people '*drink better*', where the 'good stuff', the 'nectar of the gods', is celebrated and not demonised.

[16] Michie et al.: The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science.* 2011; **6**:42.

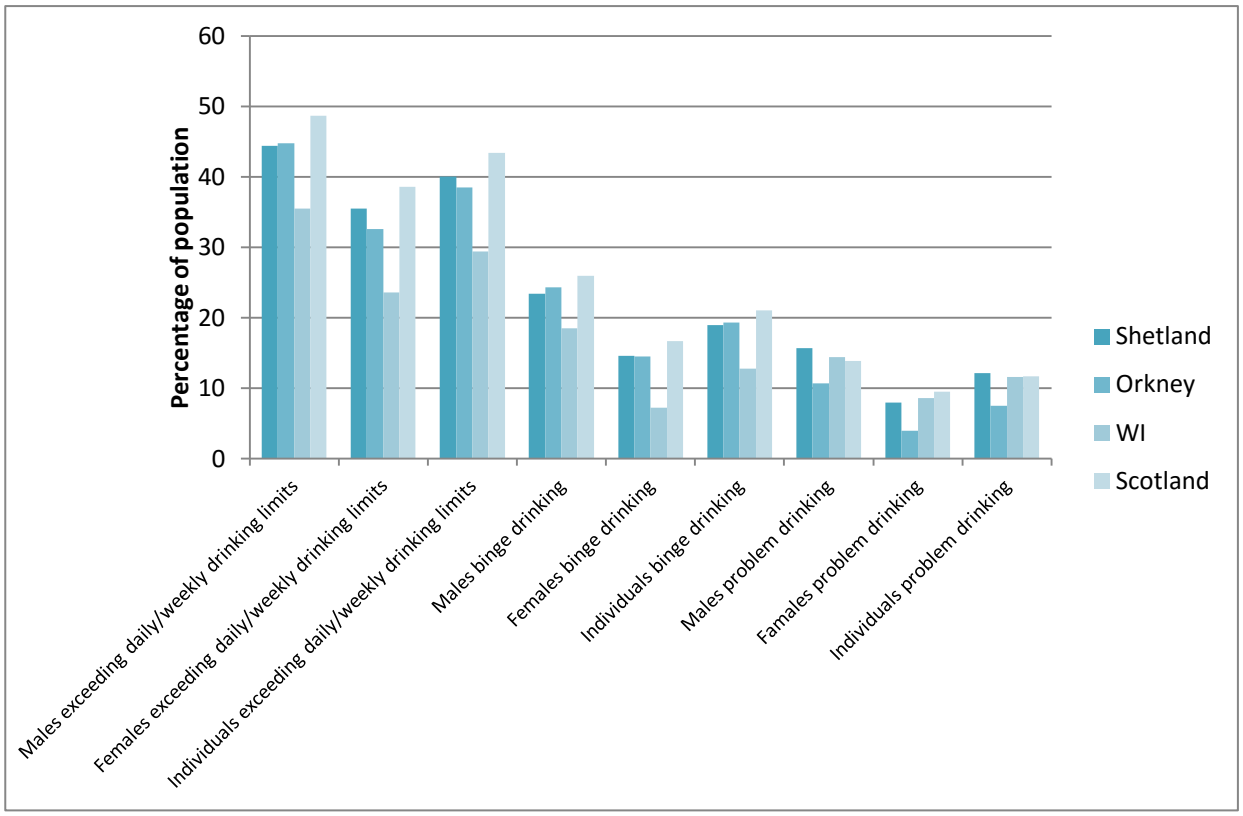
Drink Better's objectives include work to:

- Educate the public, including adults and young people, about drinking, challenging unhealthy relationships with alcohol
- Prevent and speak out against the damage caused by alcohol misuse
- Promote the enjoyment that comes from drinking moderately and reasonably: the culture of taste versus the culture of drunkenness

Why do we need the campaign?

In the previous chapter we talked about costs to the health service of alcohol misuse. The following charts show further detail on this, but also the costs to police and other public services in Shetland.

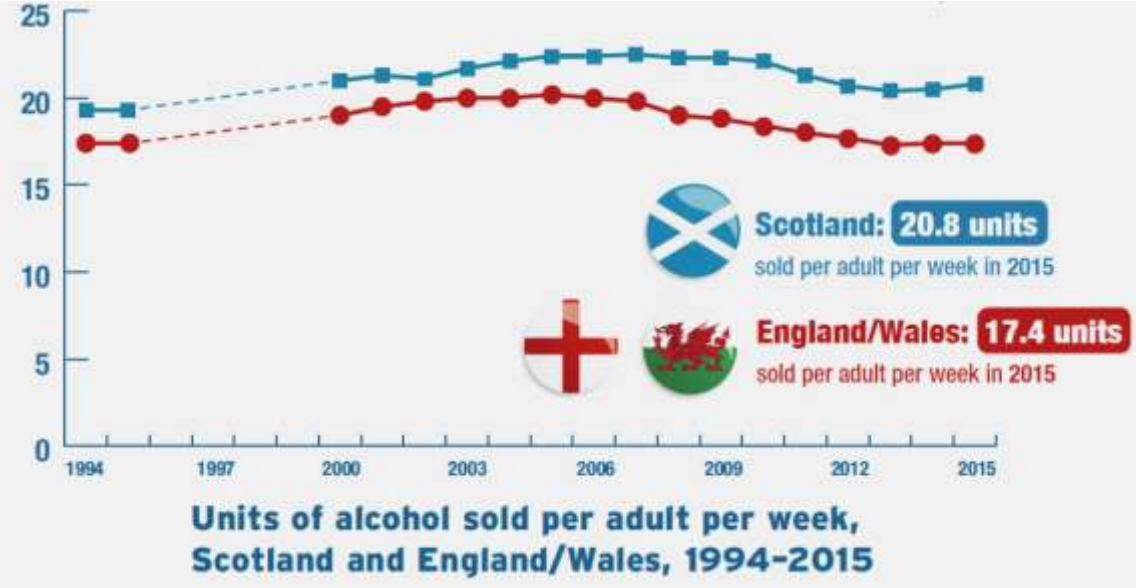
Figure 1.1: The percentages of adults drinking at harmful levels in Shetland, Orkney, Western Isles and Scotland. The figures are taken from the ScotPHO Alcohol Profiles[17]



[17] ScotPHO Alcohol Profiles available at: https://scotpho.nhsnss.scot.nhs.uk/scotpho/profileSelectAction.do

Shetland appears to be the worst of the island boards on a number of measures, although not as bad as Scotland as a whole. (It should be noted that the UK is amongst the worst in the world for dangerous drinking patterns)[18]. Alcohol sales in Scotland were 20% higher than in England and Wales in 2015. This was mainly due to higher sales of lower priced alcohol through supermarkets and off-licences, particularly spirits. More than twice as much vodka was sold off-sales per adult in Scotland than in England and Wales.[19]

Figure 1.2: Units of alcohol sold per adult per week, Scotland and England/Wales, 1994-2015



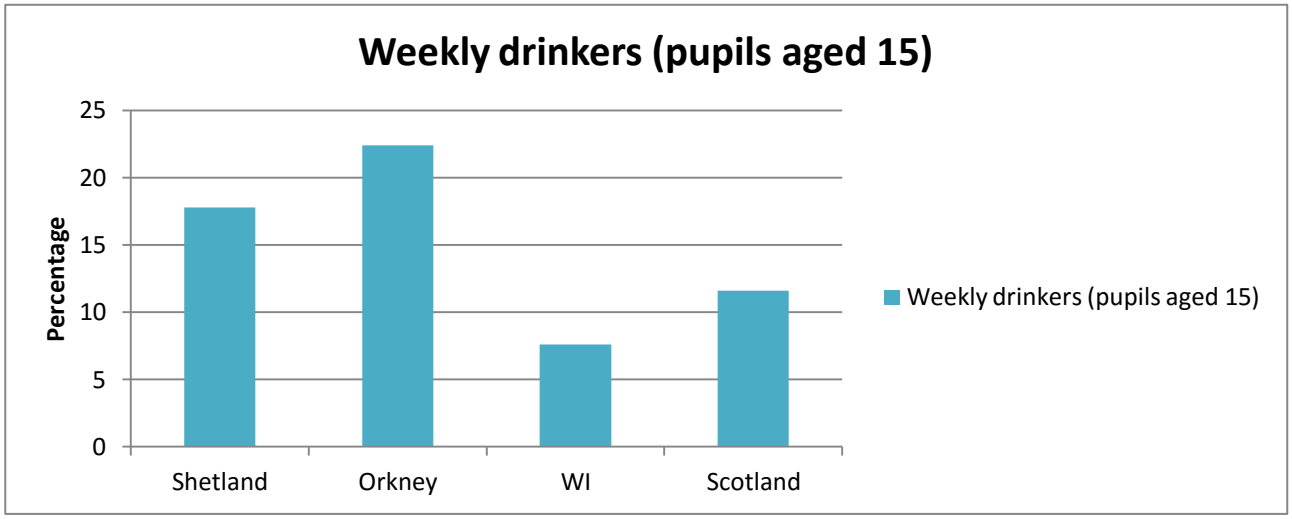
Children & Young People

National surveys are conducted every three to four years to understand the drinking patterns of school children in Scotland. We are able to break these figures down into island areas.

[18] WHO. *Global Status Report on Alcohol and Health 2014*. Geneva: WHO; 2014. Available at: www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua=1

[19] www.healthscotland.com/news-articles/news-article.aspx?ID=96

Figure 1.3: Number of pupils aged 15 in Shetland who report drinking alcohol weekly: The Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS)



In terms of Scotland wide data, SALSUS 2013 reports the following[20]:

The majority of 13 and 15 year old pupils who had ever had an alcoholic drink[21] reported that they are more likely to obtain alcohol from a relative or a friend;

- Thirteen year olds who had drunk alcohol were most likely to say that they usually obtained alcohol from a relative (38%) whilst 15 year olds were most likely to get their alcohol from a friend (46%).
- Almost four out of ten 13 year olds (39%) and almost six out of ten 15 year olds (58%) who had ever drunk alcohol said they had got someone else to buy alcohol for them in the last four weeks.
- Thirteen year olds most commonly asked their mother, father or carer (33%) to buy them alcohol, followed by an older friend (18%).
- Among 15 year olds, the most popular response was an older friend (28%), followed by their mother, father or carer (24%).

SALSUS data on the alcohol consumption of teenagers is often interpreted as increasing the need to prevent children from entering pubs or buying alcohol. It is far more likely that the figures are a sign of the availability and affordability of alcohol, given that most of the

[20] SALSUS 2013 reports available at: www.isdscotland.org/Health-Topics/Public-Health/SALSUS/Latest-Report/

[21] Pupils were asked whether they had 'ever had a proper alcohol drink – a whole drink, not just a sip'.

alcohol that young people are drinking comes from the off-sales trade (via a legal purchase by an adult).

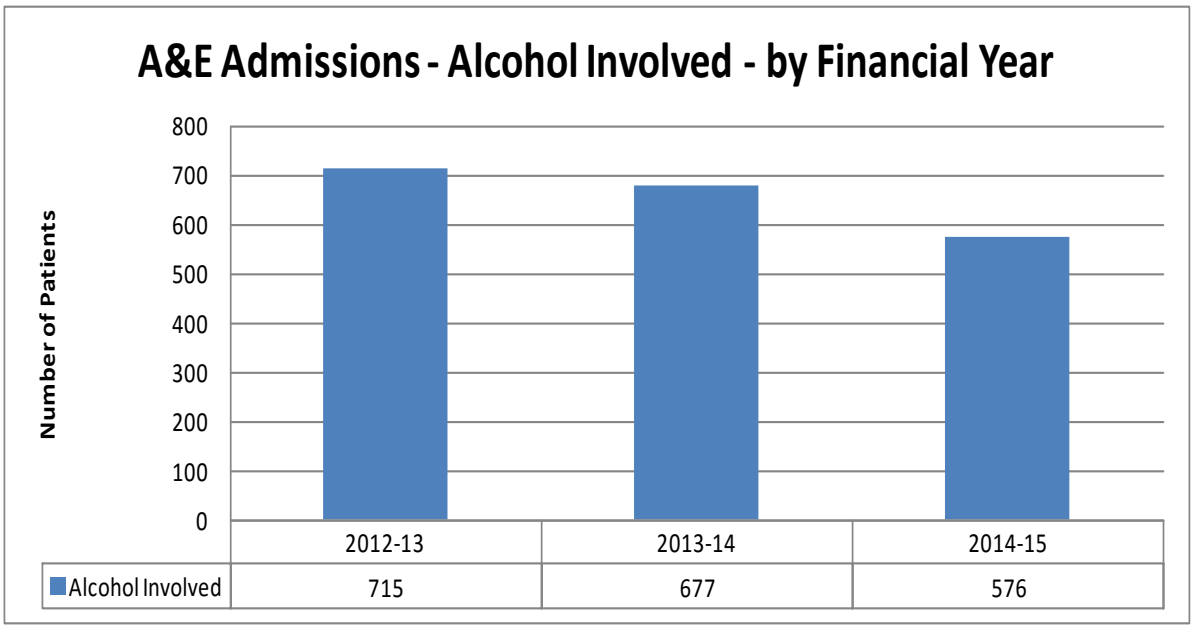
Alcohol related deaths and alcohol related hospital admissions

Alcohol related deaths and hospital admissions are a useful way of understanding the impact of alcohol on the population. The deaths figure will include deaths from diseases known to be related to alcohol consumption, such as cirrhosis of the liver. The hospital admissions figure includes admissions for conditions such as alcoholic liver disease, but also for some where alcohol was known to be a factor, for example injuries arising from alcohol related assault. Between 2004 and 2014 a total of 48 people died of alcohol related conditions during this time, averaging more than four per year.

Table 4: Alcohol Related Deaths in Shetland 2004-14 (NHS Shetland)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Deaths	6	6	6	6	4	3	9	4	0	1	3

Figure 1.4: The number of A&E Admissions to the Gilbert Bain Hospital where Alcohol was involved, over a three year period 2012-15 (NHS Shetland)



In summary, between 2012 and 2015, there were:

- Almost 2,000 admissions where alcohol was involved
- 4 fatalities
- 556 discharged to an NHS service or hospital ward
- 28 discharged to the Police Station

An audit of suicides and sudden deaths in Shetland over the last 12 years shows that alcohol is almost always a contributing, if not a causal, factor. This conclusion is based on a complex auditing process, developed from the UK National Confidential Inquiry into Suicide and Homicide; the data is then used by the National Suicide Register for Scotland. The audit uses information from GP, Psychiatric, and Social Work records, alongside toxicology and post mortem reports, and is conducted by a multi-agency group comprising the Medical Director of NHS Shetland, the Consultant Psychiatrist, and Social Work and Police representatives. We know that the chemical composition of alcohol means that it has a depressant effect on human beings and is also a disinhibitor, making risky behaviour more likely.

Police data

Table 5: Drunkenness and other disorderly conduct recorded by the police, Shetland Islands, 2010-11 to 2014-15 (Police Scotland)

Crime	2010-11	2011-12	2012-13	2013-14	2014-15
Drunk & incapable and habitual drunkenness	18	22	28	15	7
Drunk & attempting to enter licensed premises	0	1	0	0	1
Disorderly on licensed premises	2	0	1	2	3
Refusing to quit licensed premises	0	4	5	9	5
Consumption of alcohol in designated places, byelaws prohibited	7	12	0	7	5

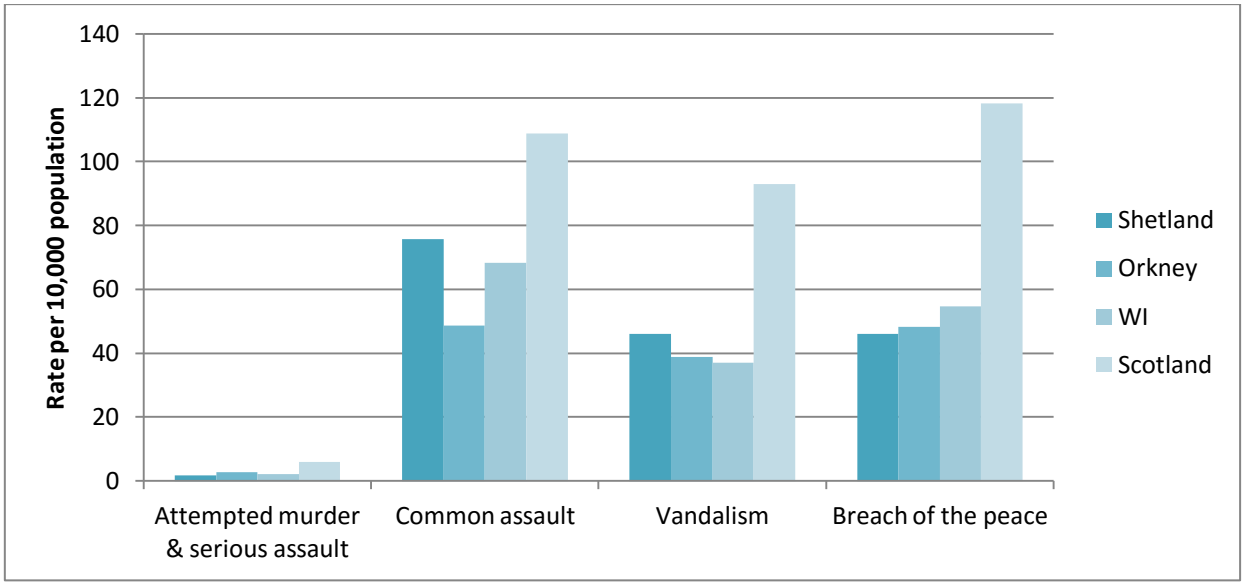
Over these five years, there were 154 offences. Of these:

- 90 were drunk and incapable and habitual drunkenness offences (58.4%)
- 31 were consumption of alcohol in designated places, byelaws prohibited offences (20.1%)

- 23 were refusing to quit licensed premises offence (14.9%)
- 8 were disorderly on licensed premises offence (5.2%)
- 2 were drunk and attempting to enter licensed premises (1.3%)

There were 203 alcohol and/or drug related driving offences within Shetland over the last 5 years, an average of 40 per year. We do not have comparative data for the islands or other areas of Scotland, but we do know that driving while under the influence of alcohol or drugs presents a danger to both self and others.

Figure 1.5: a comparison between Shetland, Orkney, the Western Isles and Scotland in terms of types of alcohol related offences. (ScotPHO)



Alcohol Focus Scotland reports that around three-quarters of all alcohol drunk in Scotland is now bought from off-licences – mainly supermarkets. Rather than alcohol being kept for special occasions, it's become normal to include it as part of the weekly shop and to keep the fridge stocked up. Alcohol has become so embedded in our society that there's a perception that regular drinking is normal, risk-free, and a good way to de-stress, without the recognition that regularly drinking too much increases the risk of cancer, heart disease and mental health problems. This shift to people drinking at home rather than in the pub has been driven by supermarkets selling alcohol at such low prices that pubs simply can't

compete.[22] The Faculty of Public Health suggests that off-licence sales can potentially increase health related harm due to the fact that home measures are often larger than pub measures and as prices in licensed premises increase, and off-licence prices decrease, more people are drinking at home and therefore potentially drinking a lot more than they think. [23]

Studies described and reported by Babor et al consistently show that restrictions on availability are associated with reductions in both alcohol use and alcohol-related problems. [24]

What are the views of dependent users of alcohol?

Research has been undertaken recently with people recovering from alcohol dependency in Aberdeen. These people recognised arguments about free choice and free-will, but also described the struggles faced daily in trying to overcome alcohol misuse and dependency. They suggested the following actions as being supportive to people in recovery (and potentially people worrying about their alcohol use):

- Restricting licensing hours would be a big help, if off sales were not permitted until late afternoon or evening rather than from 10 am
- Most buy alcohol from supermarkets, it is difficult to be in recovery and go about normal daily living tasks if they have to pass the alcohol display. Making it a condition of licences that alcohol is sold in a separate area where people can use the rest of the shop and not enter would be helpful (e.g. the use of aisles at the back of the store away from the tills rather than in the middle of the store)
- In smaller shops, stopping alcohol from being on display behind the counter

So Drink Better is designed to work at several levels. It involves 'educating' young people and 'educating' the public about the new guidance, for example. But at the same time it involves working with Licensing Boards to increase their understanding of the potential

[22] www.alcohol-focus-scotland.org.uk/news/every-child-has-the-right-to-grow-up-safe-from-alcohol-harm/

[23] Faculty of Public health. *Alcohol and Public Health Position Statement*. London: FPH; 2008. Available at: www.fph.org.uk/uploads/ps_alcohol.pdf

[24] Babor T, Caetano R, Casswell S, et al. *Alcohol: No Ordinary Commodity*. Oxford; Oxford University Press: 2010.

power of the Licensing Board in tackling availability of alcohol and therefore accessibility to alcohol.

Social marketing

Social marketing is a method of applying the science of marketing to social policy and behaviour change in the context of health improvement. In a book on social marketing, subtitled 'Why should the devil have all the best tunes?', Gerard Hastings, a lecturer in Social Marketing at the University of Stirling, argues that the techniques used by big companies to get us to eat big brand beef burgers and smoke particular types of cigarettes can also be used to encourage people to eat healthily, preserve their lungs and walk to work.[25]

A key element of the *Drink Better* campaign is the use of social marketing techniques. But to do this we need to be cleverer about understanding our target audiences. Social marketing uses techniques such as branding and 'segmentation'. Understanding the very different reasons that people have for drinking alcohol, and the very different ways that different groups of people use alcohol, will help us to design interventions which are far more likely to have an impact on them, because they are far more likely to be relevant.

Social marketing isn't just aimed at the public though. It also aims to influence people with decision making powers to think about how they can make alcohol use safer, or those who are involved in selling alcohol to think about other sources of income.

[25] Hastings, G *Social Marketing: Why should the devil have all the best tunes* London: Butterworth-Heinemann; 2013

CHAPTER 3 SMOKING

The three strands of tobacco control are prevention, protection and smoking cessation. Schools in Shetland are very good at building tobacco and smoking into their curricula, but we recognise more work is required to stop young people taking up smoking habits. Tobacco protection laws in Scotland are very strong, and there is proposed legislation to ban smoking in cars where there are children present. Shetland Islands Council Trading Standards department have a role in enforcing this legislation.

Smoking remains a public health issue; it has substantial negative health and economic effects on individuals and the economy, and the Scottish Government described it as the greatest single cause of preventable ill health, disability and premature death in Scotland, accounting for a quarter of all deaths per year.[26]

Figures from general practices indicate there are 2950 smokers (over the age of 15) in Shetland. This is around 15% of the population; below the national average of 22%.[27]

Two thirds (67%) of smokers say they would like to quit smoking, and research from Health Scotland (2010) tells us that use of NHS smoking cessation services combined with pharmacotherapy increases a person's chances of quitting smoking by up to four times compared to using willpower alone.[28]

Prevention

There is also a strong relationship between smoking and disadvantage, along with evidence that smoking, (including second hand smoking) has a negative impact on cognition and learning – which is why smoking in young people should be of interest to those interested in education attainment and closing the gap between young people who achieve, educationally, and those who don't.

As noted above, schools in particular undertake some excellent work around tobacco use and smoking: it is very hard to find a primary school aged child in Shetland who thinks

[26] Health Scotland. *Health Scotland's position on e-cigarette use in NHS Scotland November 2014*. Edinburgh: health Scotland; 2015. Available at; www.healthscotland.com/uploads/documents/24383-1.%20NHS%20Health%20Scotland%20Position%20Statement%20on%20e-cigarettes%202015.pdf

[27] Information Services Division (ISD) National Services Scotland

[28] http://www.healthscotland.com/documents/4661.aspx

there is anything good about smoking. But still people take up the habit. Have we run out of ideas for smoking prevention? Or are we placing too much emphasis on education when actually we should be focusing much more on tackling inequalities, disadvantage, vulnerability and poor self esteem that means that young people look for coping mechanisms in tobacco?

There is an additional driver for us, as our funding reduces; we would be able to put fewer resources into adult smoking cessation if people didn't start smoking in the first place, or didn't move from being occasional smokers to regular dependent smokers.

Prevalence of Smoking among young people

The proportion of 13 and 15 year olds who smoke regularly has fallen steadily to its lowest nationally recorded level. In 2013, 2 per cent of 13 year olds smoked regularly, down from a peak of 8 per cent in 1998, and 9 per cent of 15 year olds smoked regularly, down from a peak of 29 per cent in 1996. The proportion of occasional smokers has also fallen to 1 per cent (13 year olds) and 4 per cent (15 year olds)[29].

Family, Friends, Society and Health

Societal factors which appear to increase the risk of a young person smoking include:

- Having friends, parents or siblings who smoke
- Living in a non-traditional family, e.g. lone parents, or with step-parents
- Parents having less knowledge of how the young person spends their time
- Regular social activities such as hanging out on the street, going to concerts or gigs or being out most evenings, whereas pupils who play sport at least weekly are unlikely to be regular smokers
- Not enjoying school
- Difficulty engaging with school, e.g. truanting or a history of school exclusions
- Having physical or mental health wellbeing issues

[29] SALSUS 2013 available at: www.isdscotland.org/Health-Topics/Public-Health/SALSUS/Latest-Report/

- Having non-academic ambitions after leaving school, such as entering work or a further education college, as opposed to university

Attitudes to Smoking

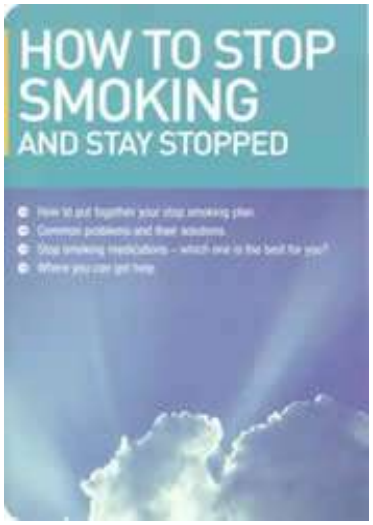
Families of regular smokers are likely to be aware that the young person smokes, but this is not the case with young people who smoke occasionally: most families of all young people would try to convince the young person to stop smoking.

There has been some good progress with respect to young people's attitudes towards smoking, for example:

- The proportion of pupils who think it is ok to try a cigarette to see what it is like has declined steadily over time
- More than 90 per cent of smokers and non-smokers agree that smoking can cause lung cancer and heart disease
- A low proportion of both smokers and non-smokers feel that it is easy to give up

However, there is still some progress to be made on how young people perceive smoking: regular and occasional smokers are more likely than non-smokers to agree with statements about "positive" aspects of smoking, e.g. around issues of relaxing, coping with life and confidence.

Stopping smoking



If two thirds of people who smoke want to stop, why don't they just do it? Some people need that 'last straw' incentive such as a heart attack or birth of a baby to motivate them to quit. (Can we raise awareness about the benefits of stopping smoking **before** getting pregnant, to avoid the damage caused by smoking during pregnancy?) Others people who smoke may have tried many times to stop, but always eventually returned to smoking. The average number of failed (perhaps 'practice' is a better description) attempts before a smoker finally gives up for good is seven to eight. Some people may have smoked for many years and may have no intention of ever giving up and there is really very little that we can do through public health and health promotion initiatives to change that. However, some apparently intractable smokers do unexpectedly find a reason to give up smoking and we must ensure that information, advice and support is available for these smokers when they want it.

A national review of smoking cessation services in 2014 recommended some actions to reduce the variation in quit rates across the country and to improve the consistency of services, under the following headings:[30]

Reducing variation in quit outcomes and consistency between NHS Boards

1. Improving access to varenicline and combination NRT.
2. Offering a variety of behavioural support options, tailored to client needs.
3. Validating quit rates and using feedback from smokers, which ought to be used to inform service development.
4. Improving referral systems and maximising links between a smoke-free NHS and smoking cessation services.

[30] Smoking Cessation Services Review Advisory Group. *Review of NHS smoking cessation services: advisory group report.* Edinburgh: NHS Health Scotland; 2014. Available at: www.healthscotland.com/documents/23527.aspx

Increasing reach and success, particularly with priority groups

1. Identifying clients and maintaining motivation
2. Community development and third sector approaches to client engagement
3. Increasing options for smokers
4. Young people
5. Specific settings
6. Pregnant women

Improving processes within smoking cessation services and training:

1. Follow-up
2. Carbon monoxide (CO) monitoring
3. Training

Around 420 people have stopped smoking (measured at three months post quit) through the NHS Shetland smoking cessation services since consistent recording began in 2003. The original targets from government were that clients should stop smoking for four weeks, and so this was where we concentrated our efforts. Along with the rest of Scotland, we attempted to follow people up at three months, in order to check on progress, but we had a very poor follow-up rate.

Two years ago, the target was changed, so that we are now required to measure at three months rather than four weeks. We feel that this gives us a better measure of success, even though it might be more challenging, as someone who has managed to stop smoking for three months is far more likely to maintain their quit. We also have significantly improved our recording and monitoring data, and our follow-ups are much more effective.

The success of our tobacco control work means the challenge now is that the relatively small number of people who continue to smoke tend to be in the hardest to reach and more vulnerable groups, and find it the hardest to quit.

Current targets

NHS Shetland had a Government target during 2015-1016 to achieve 33 'quits'. That is 33 smokers who live in the more socio-economically disadvantaged areas of Shetland to stop smoking for three months. In fact we helped 51 people out of the 144 who signed up from these areas to stop smoking for at least three months, so not only met the target but

exceeded it by 55%. Four people were helped by pharmacy services and the others were supported by health improvement team in various settings (mainly primary care). The total number of three month quits for the year was 73 (38 men and 35 women).

Our quit rate at three months was 35%, compared to a Scotland-wide quit rate of 20%, so clearly the ways that we deliver our services are accessible and successful. However they require intensive staff input, and the *cost* effectiveness has not yet been evaluated.

The new target we have for 2016/17 is 43 quits at three months within the most deprived areas. This is going to be challenging for the team as in some areas there are very few people signing up to the smoking cessation service despite efforts to engage them. Those that do attend often need more intense support and may have several serious attempts before they quit; they may also need support for much longer than the 12 week programme we offer. We will continue to work alongside colleagues in general practice, community pharmacies and secondary care to encourage referrals and build capacity for others to offer smoking cessation support.

What's next?

- Continue to work one to one with individuals and will run groups if appropriate e.g. in workplaces
- Work with surgeries on an individual basis to engage with smokers e.g. inviting in those recorded as smokers for a Keep Well health check
- Supporting individuals to reduce harm from tobacco and encourage attendance from e-cigarette users
- Work to increase referrals through secondary care routes
- Continue supporting prevention work in primary and secondary schools
- Support the campaign around the ban on smoking in cars while children are passengers

How do we deal with e-cigs?

E-cigarettes are consumer products that help some smokers to quit smoking tobacco. They are freely available over the counter from many shops, often ones that do not sell tobacco products. E-cigarettes have not been tested and licensed in the same way as NRT products. However, two brands have recently received marketing authorisation for medicinal licences from the MHRA (Medicines and Healthcare Products Regulatory Agency). This means that these can become available on prescription, although they are not available as yet.

The evidence base on e-cigarettes is still developing. There is general agreement that they are significantly less harmful than smoking tobacco, but are not risk free:

- Most e-cigarettes contain nicotine, which is addictive;
- The delivery device mechanisms vary widely and users need to know how to operate their device safely;
- The other constituents of e-cigarettes vary - currently little is known about the impact on an individual's health of inhaling heated chemicals using an e-cigarette.

Nationally and internationally, we will need to wait until we see the long term impact of e-cigarette use to understand fully the safety of these products. While smokers will benefit from switching to e-cigarettes, the safest option for non-smokers (either former smokers or never-smokers) is to use neither cigarettes nor e-cigarettes.

Analyses of e-cigarette vapour contents indicate that they contain considerably lower concentrations of many of the major toxins in cigarette smoke. The balance of evidence currently suggests that e-cigarettes present much lower risks than traditional cigarettes, but there are major knowledge gaps. The risks and inhalational toxicity of chemicals once heated are not well characterised, and further research is required in order to assess the risks more accurately.

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Are there any benefits to e-cigarettes?

E-cigarettes are increasingly available and popular. There are likely to be benefits to their use but there are also some uncertainties.

The main benefit is likely to be their use in harm reduction, either in established smokers or recent quitters. E-Cigarettes can be effective in supporting reduced tobacco use or as a replacement (replacing tobacco addiction with an alternative that is likely less harmful). The end goal should always be complete abstinence from both tobacco and nicotine.

What are the uncertainties?

There is incomplete evidence about quality, safety and effectiveness of use, particularly in the longer term. Although almost certainly less harmful than tobacco much is still not known and they cannot be recommended as 'safer' based on this. Because e-cigarettes have appeared and developed so quickly, public policy has had to develop fairly quickly as well. NHS Health Scotland issued two position statements, in 2014 and 2015:
The 2014 statement was fairly guarded about the use of e-cigarettes, based on the lack of evidence about their safety and their effectiveness in supporting people to stop smoking:

> 'the NHS only endorses use of licensed products which have proven evidence of effectiveness, safety and quality. These should be concentrated on helping people ultimately to quit tobacco use, and with a view to quitting tobacco and ENDS use entirely. Use of non-prescription items is a matter of personal choice. '[31]

[31] NHS Health Scotland. *NHS Health Scotland's position statement on Electronic Nicotine Delivery Systems – ENDS - e-cigarettes and other smoking simulator products statement.* Edinburgh: NHS Health Scotland; 2014. Available at: www.healthscotland.com/uploads/documents/24383-HS%20ENDS%20postn%20statmt%20311014.pdf

The 2015 statement was slightly more accommodating of the role that e-cigarettes might play, in that it encouraged smoking cessation staff to discuss the range of medicinal and non-medicinal options available to service users, including evidence of effectiveness of each. It stated that should service users want to stop smoking with the support of e-cigarettes, as long as they had considered all the options, they should be supported to do so.[32]

The guidance from Health Scotland is now that:

- Smoking cessation staff should discuss the range of medicinal and non-medicinal options available to service users[33], including evidence of effectiveness of each; [34] [35]
- Once service-users have considered all the options, and if they want to quit using e-cigarettes, they should be supported to do so;[36]
- Services should advise that dual use (e-cigarettes and tobacco) is recommended only as a route towards quitting smoking tobacco. To reduce harm, smokers should aim to give up tobacco completely.

NHS Shetland smoking cessation staff welcome individuals who are using e-Cigarettes (either in place of tobacco or dual use to reduce tobacco) to attend services for support to reduce use further and stop.

[32] Health Scotland. *Health Scotland's position on e-cigarette use in NHS Scotland November 2014*. Edinburgh: health Scotland; 2015. Available at; www.healthscotland.com/uploads/documents/24383-1.%20NHS%20Health%20Scotland%20Position%20Statement%20on%20e-cigarettes%202015.pdf

[33] *Guide to smoking cessation in Scotland 2010,* including its Harm Reduction addendum 2014, the Brief Intervention Practitioners Flowchart and its accompanying E-cigarettes/Harm Reduction for Brief Intervention notes 2015 . Available at: www.healthscotland.com/documents/4661.aspx.

[34] Smoking Cessation Services Review Advisory Group. *Review of NHS smoking cessation services: advisory group report.* Edinburgh: NHS Health Scotland; 2014. Available at: www.healthscotland.com/documents/23527.aspx

[35] Health Scotland Effectiveness Evidence briefings available at www.healthscotland.com/scotlands-health/evidence/effectivenessevidencebriefings.aspx.

[36] "'How to' guide on *cut down to quit* and *e-cigarettes*" is available via smoking cessation co-ordinators.

CHAPTER 4 DRUGS

The recovery model

In 2008, a new Drug Treatment Action Plan 'The Road to Recovery: A new approach to Tackling Scotland's Drug problems' was published by the then Scottish Government. It opened with the following words:

> 'For too long, debate in Scotland has centred on whether the primary aim of treatment for people who use drugs should be harm reduction, or abstinence. We fundamentally disagree with the terms of this debate. We do agree with the United Nations Office on Drugs and Crime, which said in a recent report that *"harm reduction is often made an unnecessarily controversial issue, as if there were a contradiction between treatment and prevention on the one hand, and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary"'.*[37]

In the Government's view, 'recovery' should be made the explicit aim of services for problem drug users in Scotland. Their view of recovery was **a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society**. Furthermore, it incorporates the principle that **recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment**. In short, an aspirational, person-centred process.

Recovery means different things at different times to each individual person with problem drug use. For an individual, 'the road to recovery' might mean developing the skills to prevent relapse into further illegal drug taking, rebuilding broken relationships or forging new ones, actively engaging in meaningful activities and taking steps to build a home and provide for themselves and their families. Milestones could be as simple as gaining weight, re-establishing relationships with friends, or building self-esteem, but need to be sustained.

[37] UN Office on Drugs And Crime.*Reducing the adverse health and social consequences of drug abuse: A comprehensive approach.* UNODC.; 2008.

Recovery as a principle has been used in the field of mental health for many years and is now being applied to alcohol too.The concept of recovery was key when we re-designed our alcohol and drugs services in Shetland recently. Along with substance misuse nursing staff and a Psychiatrist, the Shetland Substance Misuse Recovery Service employs community substance misuse workers who are able to offer one to one support, moving on skills, housing, debt and family support. The service works closely with a substance misuse social worker. Support for clients includes relapse prevention, trauma, anger management, peer support, and the setting up of a mutual aid partnership where people in recovery can support each other in achieving their aims and goals.

Flying the flag for substance misuse recovery services

Local users of NHS Shetland's Substance Misuse Recovery Services (SMRS) have created a colourful flag to represent Shetland at the Recovery Walk Scotland in September. The walk is taking place in Falkirk and is the fifth annual event aimed at bringing together recovery activists from across Scotland and beyond to celebrate recovery from addiction. The Shetland flag was created during newly established SMRS art classes that run weekly on Monday afternoons. Art therapy is recognised as a valuable tool in the treatment of addiction and substance misuse and it is hoped that the regular classes allow the attendees to access peer support and also offer an alternate, non-verbal means of communication. SMRS staff are available after each session should someone feel the need to speak further.

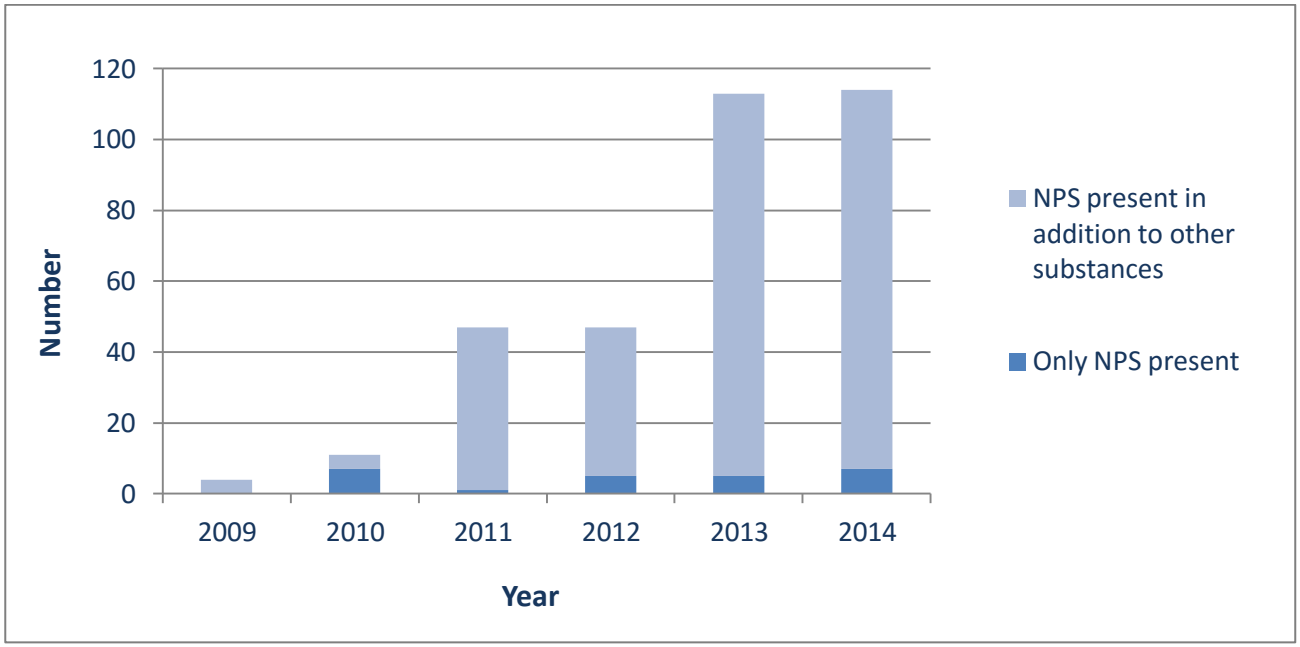
Karen Smith, Alcohol and Drugs Development Officer, and Annie McKee, SMRS worker, displaying the Shetland Recovery Flag.

Novel psychoactive substances

Current situation

In 2014 across Scotland there were 743 deaths, 114 where NPS was present in addition to other substances and seven where NPS was the sole substance present.

Figure 1.6. Number of drug deaths in Scotland where NPS present (data taken from National Records of Scotland Annual Report 2015)



In Europe there are currently more than 450 NPS being monitored by the European Monitoring Centre for Drugs and Drug Addiction. In 2014, 16 public health alerts concerning circulating NPS were issued.

Psychoactive Substances Bill

Legislating to restrict the availability of harmful NPS is difficult. For a substance to be classified under the Misuse of Drugs Act there has to be evidence of harm suffered by the person taking the substance. This can be time-consuming to collect and evoke the required legislative change. Furthermore, once a substance had been banned manufacturers can be adept at making a slight tweak to the content or molecular structure of the new psychoactive substance, to allow the new (albeit nearly identical) substance to avoid falling under the same classification as the original, newly banned substance.

In order to break this cycle and legislate more proactively to restrict the availability of NPS, the Psychoactive Substances Bill came into force on the 26th of May 2016. The bill essentially bans any substance that is mood altering and that is not exempted. Substances which are exempted in the Act are those that are already controlled through existing legislation (for example alcohol, tobacco or medicines) or where psychoactive effects are negligible (caffeine and certain foodstuffs).

Possession of NPS for own personal use is not an offence under the Psychoactive Substances Bill but it is an offence to produce, supply, offer to supply, possess with intent to supply or import or export a psychoactive substance. The purpose of the Bill is very much to disrupt supply and availability of NPS, rather than penalise the end-consumer. This is very important as often the person taking NPS needs support and we want them to feel able to engage with services without fear of repercussions.

Images of Novel Psychoactive Substances

Stigma

'Stigma' is when a person possesses an attribute or status which makes him/her different, less desirable or acceptable to others.[38] Stigmatisation as the overt (explicit) exclusion of individuals because they participate in a perceived undesirable phenomenon is a fundamental issue not only around injecting drugs, but also to having an infectious disease diagnosis.[39] [40] So people who have become infected with a Blood Borne Virus (BBV) such as HIV or Hepatitis C Virus (HCV) through their injecting behaviour can be 'doubly' stigmatised. Added to this can be a further stigma of a criminal record for those who have been caught using illegal drugs.

Often stigma, or other people's perceptions, is not about the users' drug-taking behaviour, as this may be 'hidden'. There are often subtle clues which people pick up on and lead to a drug user being stigmatised: e.g. physical appearance, clothing and employment/housing status. However, these same clues may lead to assumptions being made about an individual which are misguided. [41] And the stigma may be self-perceived with the individual feeling more stigmatised that they actually are by those around them.

Negative labels such as 'junkie' and 'druggie' and the embarrassment and reported shame of being associated with a lifestyle of this nature, appears to be relevant to the choices an individual makes, and the injecting practice they deem acceptable. [42] [43] The avoidance of stigma and negative connotations is cited as one the reasons many individuals make an informed decision to choose controlled use of heroin over addiction. The lifestyle of individuals who choose to inject drugs may appear no different from the general public

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[38] Goffman, E.*Stigma: Notes on the Management of Spoiled Identity*. New Jersey: Englewood Cliffs, Prentice-Hall; 1963.

[39] Gilbert, P. Shame, stigma and the family: "Skeletons in the cupboard" and the role of shame. In: Crisp, A.H. (ed.), *Every Family in the Land*; London: Royal Society of Medicine Press; 2004.

[40] Furst R.T, Johnson B D, Dunlap E. and Curtis R. The stigmatized image of the "crack head": A socio-cultural exploration of a barrier to cocaine smoking among a cohort of youth in New York City, *Deviant Behaviour* 1999: 20 (2), 153–81.

[41] Lloyd, C. *Sinning and sinned against: the stigmatisation of problem drug users.* London: UK Drug Policy Commission; 2010.

[42] Clark T. The science of stigma – to help addicts, look beyond the fiction of free will. *The Scientist:* 1998 **12** (16): 9.

[43] Warburton H, Turnbull PJ & Hough M. *Occasional and controlled heroin use: Not a problem?* London: King's College; 2008.

around them. One of the factors injecting drug users report as influencing their choice to inject in a controlled manner is to avoid the stigma of being perceived to be a 'junkie'. [44] [45]

Choosing to use heroin and inject in a controlled way, means a user probably remains hidden from society. Issues around prohibition, the covert (hidden) nature of the act of injecting, and society's fear of drug use and users are often subtle and unspoken. Heroin use and the myths surrounding it fuel the stigmatising attitudes of others. This can have a profound effect on users. Long-term, sustained and apparent controlled use of intravenous substances is still important in terms of risk but still may have the attachment of social phenomena such as stigmatisation. It is certainly the case that linked to stigma is the illegality of the act of injecting and use of an illicit drug.

In the study described below, which focuses on ethical issues, injecting drug use and HCV, stigma was identified as a key theme for drug users. Injecting is portrayed negatively, and it is injecting which leads to transmission of Hepatitis C Virus for so many. Bound up in the stigma of injecting is the morality of right versus wrong and the ethical stance of the negatively portrayed 'junkie'.

Apart from the obvious effect of stigma on psychological wellbeing, whether it is real or perceived, feeling stigmatised also often means that people are very reluctant to seek help and support. That might be support from family and friends, needing occupational input at work or seeking medical help.

Contrary to the portrayal of an 'evil' deviant individual; injecting drug users who participated in the local research displayed acts of integrity, wisdom, friendship, care, support and protectiveness of others. Acknowledgement of these morally good characteristics, and other ethical beliefs together with the strong Shetland community minded spirit described by participants, offer opportunities for services and the wider population to foster an environment where stigmatising behaviour can be challenged and individuals can be better supported and empowered in tackling addictive and risky behaviours.

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[44] Burris S. Stigma and the law, *The Lancet.* 2006: 367: 529–31.

[45] Biernat, M. and Dovidio, J. Stigma and Stereotypes, In: Heatherton, T., Kleck, R., Hebl, M., and Hull, J., (eds), *The Social Psychology of Stigma*, New York: Guilford Press; 2000

'AN EXPLORATION OF THE ETHICAL PARADIGM AND EFFECT OF KNOWLEDGE OF HEPATITIS C VIRUS STATUS ON RISK TAKING BEHAVIOUR IN INJECTING DRUG USERS IN SHETLAND, UK: A QUALITATIVE STUDY'

This is an abstract of a piece of local research undertaken as a PhD thesis. Some background will first be given to set the scene.

Background

Hepatitis C Virus (HCV) is a Blood Borne Virus (BBV) which is treatable and often curable. Transmission of the virus is via the blood, such as through contaminated blood products prior to screening being introduced, and injecting drug use. HCV is often a silent disease with little or no symptoms, meaning many infected individuals may have been unaware of risks taken decades before. At the outset of this piece of research in 2005, it was estimated that there were 50,000 individuals infected with the virus in Scotland, 38,500 un-knowingly[46]. The public health challenge prompted a change in national policy on how to tackle the issue, resulting in the national action plan: *Hepatitis C Action Plan* with government funding to allow localities to progress testing, prevention, treatment and care. Shetland's stoic population and culture where issues such as anonymity and confidentiality can challenge service delivery around sensitive issues was relevant. Shining a light on issues which may further challenge individuals in difficult situations sowed the seed of a research proposal.

Research Aims

The overall aim of the research was to explore the ethical dimension and effect of knowledge of HCV status on risk taking behaviour in Injecting (heroin) Drug Users (IDUs), in the Shetland Islands.[47]

Background to the thesis

Illegal drug use and in particular injecting heroin has a reputation as the most addictive, destructive illicit drug, with users portrayed as evil, untrustworthy and morally corrupt. This

[46] Scottish Executive. *Hepatitis C Action Plan for Scotland Phase 1: September 2006 - August 2008*. Scottish Executive. 2006.

[47] Research on injecting drug use in the past often focused on the medical model of physiological addiction. At the outset of the study, there was less evidence in the literature of exploration of the impact of ethical issues on individuals with HCV.

presents a significant global public health problem and creates ethical dilemmas. The Hepatitis C Virus (HCV) has relatively low prevalence in Shetland compared to Scotland and Europe, but this may not reflect a hidden, more controlled user group.

Methods:

An iterative qualitative methodology was used in a three step process: i) In-depth interviews were conducted with 19 Intravenous Drug Users, using an interview guide developed to address the study objectives. Interviews were recorded and transcribed and supplemented by observational field notes, ii) emerging themes were explored with service providers in two focus groups and service developments proposed, iii) IDUs reviewed and amended/endorsed the proposed developments in a focus group and telephone interviews. Analysis used a thematic-approach based on grounded theory.[48]

Findings:

Powerful cross-cutting themes emerged of: compounding ethical dilemmas, particularly evident around family and younger injectors; and the Shetland community spirit, which is protective but also stigmatising. Injecting criminal offenders face a double stigma, and this, along with the stigma faced by hidden, more controlled users, may discourage testing and treatment. A novel output was the bringing together of user and provider views in the service blueprint.

Results:

This study found that knowledge of Hepatitis C Virus status did affect the behaviour of IDUs in Shetland. IDUs did have ethical concerns around their own behaviour and its effect on others, in particular on their family and the ethics of initiating other users. Although professional stakeholders reported limited understanding of the injecting drug users ethical concerns, this iterative process developed their understanding further. The knowledge and insight gained enabled new public health approaches to be considered,

[48] Descriptor of research methodology terms (iterative, qualitative, thematic, and grounded theory): This piece of local research used a qualitative design - this type of data gathering approach uses the 'quality' of what people say, rather than statistical numbers gathered in quantitative research. The research used a 3-step phased approach which is described as iterative as one phase informs the next. Analysis of the data was themed according to the repeatedly emerging pieces of information, which participants spoke about. Grounded theory is an approach used to analyse data where the emergent findings are rooted firmly in what the participants have said.

that would fit with national policy and a blueprint for different approaches for service delivery was scoped. This was with the endorsement of both service providers and service users. Local issues were considered particularly around anonymity and confidentiality in a remote island community. Specific recommendations for service delivery were made including:

- raising awareness of availability of anonymous testing for BBVs.
- access to, availability and provision of injecting equipment as part of wider harm minimisation in injecting behaviour.
- focus on history, lifestyle and underlying causes of addiction in assessment process
- continuity of treatment and care for users if in prison and once released.

The emergent themes representing the journey into drug taking were summarised under the following headings:

- Challenging early life/fraught lifestyle: *Black sheep*
- *Fun to despair*: Injecting scene, incarceration and death
- *The 'Hep!'*: Hepatitis C Virus status
- Powerful Shetland community-minded spirit
- Stigma

> *"**Stigma** in Shetland to injecting more than Hepatitis C Virus, maybe partly due to ignorance, **if you're a junkie** **[people think]** **you're the lowest of the low**...."*
>
> *"**There's definitely stigma** [against the Hepatitis C Virus] – '**dirty junkie'. I was that dirty junkie**."*

Conclusions:

The research extends the knowledge base concerning injecting drug users and Hepatitis C Virus, and offers unique insights into previously unreported ethical concerns held by users. The ethical paradigm (issues), stigma and community-minded spirit are important dimensions which, if acknowledged by service providers could encourage greater

awareness of the nature of addiction, HCV testing and the treatment journey in positive injectors.

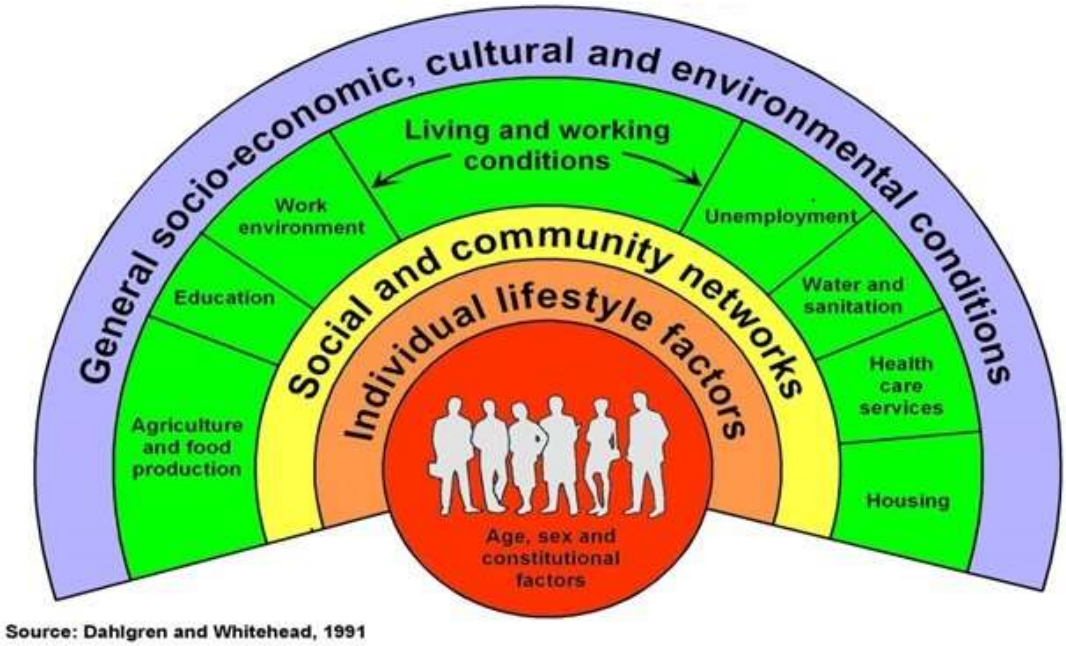
> *"I never injected until I was in my 30s, I was very dismissive of heroin, had no time for it, then it became more socially acceptable, and one thing let to another,* ***you don't think you'll get hooked, it's just a laugh...*** *before I knew it,* ***much to my shame, I was injecting everyday*** *for a couple of years...* ***It's done now and I can't change it****, I was the* ***baddy of the family.*****"**

PART II

PUBLIC HEALTH AND HEALTH IMPROVEMENT ACTIVITY REPORT

More than targets……but targeted more.

Dahlgren and Whitehead created the model below to describe the determinants of health.[49] This model highlights that health care services themselves are only a small part of health improvement. The model shows that the person and their genetic make-up is central to health improvement but then goes on to show how their lifestyle, their community and social networks, their living and working conditions and their general socio-economic, cultural and environmental conditions all impact on health. This is a well recognised model which is widely used nationally and internationally. By using it as a focus for this report we can start to evaluate where we are locally in relation to each of the health determinants and identify and address any gaps.



Source: Dahlgren and Whitehead, 1991

[49] Dahlgren G., Whitehead M., *Tackling Inequalities in Health: What Can We Learn from What Has Been Tried? Working Paper Prepared for the King's Fund International Seminar on Tackling Inequalities in Health.* London: The King's Fund, 1993.

We also need to consider the overarching theme of health inequalities. It has been well documented and is now widely known that there is a large gap in health between the most affluent and the least affluent in society, and in Shetland, these inequalities manifest themselves in ways that are different to mainland Scotland and the UK; we tend to have individuals and families who do not have the financial or personal resources to be able to enjoy a decent life, rather than geographical areas of deprivation.[50]

Barton and Grant and the UKPHA strategic interest group developed the health map (below) based on Dahlgren and Whitehead's earlier model.[51] This map continues to place people at the centre, but sets them within the global ecosystem which includes:

- natural environment
- built environment
- activities - such as working, shopping, playing and learning
- local economy - includes wealth creation and markets
- community - social capital and networks
- lifestyle

These are the social, economic and environmental determinants of health.

[50] Shetland's Commission on Tackling Inequalities. *On Da Level – Report and Recommendations from Shetland Commission on Tackling Inequalities*. Shetland Islands Council: Lerwick, 2016.
[51] Barton H, and Grant M. A health map for the local human habitat. *The Journal for the Royal Society for the Promotion of Health* 2006: **126** (6): 252-253.

In practice, this means that health improvement and public health must deliver a broad spread of activity, and use a wide range of approaches in order to be effective. These can be described under the following headings:

1. Formulating, implementing and monitoring healthy public policy;
2. Re-orienting public services to become health-promoting;
3. Implementing programmes to improve health for individuals and communities, and across a range of settings, such as workplaces;
4. Encouraging environmental measures to improve health;
5. Incorporating community development approaches, so that communities are empowered;
6. Developing people's personal skills by enabling them to identify their own needs and involving them in planning and evaluation processes;
7. Encouraging appropriate service utilisation, including screening and immunisation services; and
8. Delivering health information and education, including the use of social marketing techniques
9. Tackling inequalities

This report is presented under those headings. This helps to show the spread of activity and identifying the areas that we have targeted and those which require to be targeted more.

This report covers most of the public health and health improvement work we do in Shetland, including elements of health protection (immunisation and screening). It does not include other health protection areas such as communicable disease control and emergency planning, which are covered in the Control of Infection Committee Annual report and the Emergency Planning Annual Report respectively.

All the data in this part of the report have been collected locally unless otherwise stated.

1 Formulating, implementing and monitoring healthy public policy

As noted above, society, the environment, the economy and culture all have a major impact on health. Changing these for the better will improve the health of whole communities or populations – which, if successful, will have more impact than working with people individually.

Trying to influence public policy is an important part of the Health Improvement Team's job. By 'lobbying', educating and encouraging decision makers we can try to make sure that they consider health improvement when making any decisions.

Sometimes this can involve changes in the law, usually to try and protect groups of people, e.g. minimum age for buying alcohol and tobacco or drink driving laws. It also involves more local changes, for example, the introduction of parking restrictions to encourage walking.

Healthy public policy doesn't have to be about introducing new laws: it can be about making small changes and thinking about health when making decisions, like considering transport links and paths when building new housing schemes. Public Health and Health Improvement staff lead or are members of a number of multi-agency groups. This allows us to influence decisions across a number of sectors. However, there are number of sectors that we have limited involvement with and others that we are involved in but need to influence more as a matter of priority.

Alcohol Licensing

The Shetland Area Licensing Board's **Statement on Licensing Policy** is currently being reviewed. Licensing is seen as a useful tool for influencing accessibility and availability of alcohol. Work has been undertaken with the Licensing Forum to demonstrate the extent of alcohol misuse in Shetland and its impact on families, communities, and public services, and we will continue this engagement over the coming year.

Physical activity special interest group

We lead the **Physical Activity Special Interest Group** for Shetland. This multi-agency group was established in April 2014 to bring together partners who all had a particular

remit or interest in increasing physical activity for the least active members of our community.

A key part of the work the group has done has been identifying gaps in the provision of and access to physical activity opportunities in Shetland. Sub groups have then been formed to drive forward particular issues. Recently the decision has been made broaden the focus of Shetland Sport strategy group so that it encompasses the wider physical activity agenda. The Physical Activity Special interest group is supportive of this move as they see sport as one of a range of ways to be active and want to firm up the pathways between participation and sport as this will help to improve activity levels.

Some key achievements of the physical activity special interest group over the last year:

- There has been further expansion of localities based activities such as health walks, aiming in particular to support the least active and roll out of the **Laterlife chair-based exercise** programme.
- **Physical activity brief advice** and referral / participation pathways are in primary care and being introduced into secondary care. These are brief sessions which help patients to identify goals to increase their physical activity levels and work through some of the barriers to achieving these.
- Assisting 'NB Communications' in the development of an interactive online map which displays various physical activity opportunities throughout Shetland.
- Increasing hours of access to the Lerwick Flower Park Tennis court by key and equipment hire being administered by Islesburgh reception.
- One of main outcomes of the establishment and maintenance of this group has been the sharing of information across agencies. One example of this is that links were made between the local Active Schools team and the Disability Shetland group. As a result of this Active Schools are now funding transport in and around the area of Lerwick once a fortnight to take members of the Disability Shetland group to the Clickimin to take part in their recreational club.

Plans for 2016-17

- Work with the Shetland Islands Council, Shetland Integrated Joint Board and other key decision makers (through the Community Planning process) to understand their roles in improving public health. To then decide where more involvement/representation from the team is required in terms of influencing decision making and the order of priority.
- Development of a local Physical Activity, Sport and Health Strategy.

2 Re-orienting health services to become health-promoting

Primary Care Strategy

Individual and family lifestyle change programmes are primarily delivered through health improvement practitioners based in Health Centres. This move to localities took place over two years ago and has been hugely successful in increasing referrals to all programmes. The aim of the move to direct delivery of programmes in localities is to build up belief and confidence in the primary care work force so that through time they will deliver programmes themselves, with the health improvement team being there to provide training and updates in relation to the programmes and behaviour change. However, the current demand on primary care and the knock on effect prevent this from happening. A recent survey undertaken with the Primary Care staff by health improvement unequivocally reveals that the health improvement programmes would not take place if health improvement staff were not there to deliver them. A summary of the results of the survey are contained in Appendix C. This overwhelming response by primary care staff has forced the team to reconsider the plan for direct delivery of health improvement by primary care staff, at least in the short term.

Van Den Broucke argues that by working on an individual level on behaviour change acts as an assessment of community needs and assets allowing the wider determinants of health to be identified and tackled as well.[52] The health improvement practitioners often find that within a defined community, the same barriers to change are presented repeatedly by different people, which provides a good basis for developing community work. An example of this was in Yell where many **Counterweight** clients felt that there was a lack of fruit and vegetables locally. The health improvement practitioner contacted all the shops in Yell and has now produced an information sheet which is used in Counterweight appointments to show patients how the shops will support them to access fruit and vegetables more readily.

Nevertheless in primary care, we still need to develop the capacity to do prevention, early intervention, supported self-management and anticipatory care effectively and as a core part of the service we deliver. We know that this will pay dividends in terms of better health

[52] Van Den Broucke S. Needs, norms and nudges: the place of behaviour change in health promotion. *Health Promotion International* 2014; **29** (4): 597-600.

and quality of life, and reduce the demands on services in the longer term. To get ahead of the demands which will be placed on services through an aging population and increasing long term conditions, and in order to shift care closer to home and into local communities, the majority of people need to be more independent and resilient and self-manage, so that support can be focussed on those with the greatest needs.

One of the 15 key improvement projects that the Health Board is committed to is the implementation of an asset based approach to health care and prevention. This programme will include self care and self-management, realistic medicine and looking at different ways of supporting frequent attenders of services who might benefit from a level of social rather than medical support.

In her report *Realistic Medicine* the Chief Medical Officer for Scotland explains how the current primarily authoritative model used in healthcare needs to change to one where the practitioner and the patient can combine their expertise and are more comfortable in sharing the power and responsibility of decision-making.[53] This is an approach which is similar to how the health improvement practitioners work through their use of behavioural change approaches. The report describes how the model needs system and organisational change in order to be implemented as illustrated in the house of care model (below).

[53] Chief Medical Officer. Chief Medical Officer's Annual Report 2016; Realistic Medicine. Edinburgh: Scottish Government, 2016.Available at: www.gov.scot/Resource/0049/00492520.pdf

We have demonstrated through our achievements that working like this can improve patients' outcomes. As previously highlighted, though, primary care staff are currently limited in working in this way due to the demands on the service. A robust plan needs to be part of the self-care/self management project, in order to support this shift. Health Improvement staff are key to this piece of work as they can provide the expertise and insight to help staff change to this way of working.

In order to re-orientate health improvement delivery in primary care the implementation of the House of Care model will involve three phases:

1. Phase 1: Health Improvement deliver behaviour change and specific health improvement programmes directly with patients; at the same time plans are developed and delivered to change organisational processes required to support other practitioners to work in this way, including primary care staff best suited to delivery of programmes.
2. Health Improvement staff train and support staff to deliver behaviour change techniques applying this to wider areas of work such as self-management. Health Improvement would also support primary care staff to deliver specific health improvement programmes (e.g. counterweight) themselves which may involve health improvement staff delivering the initial three sessions then primary care staff delivering the remainder.
3. Primary care staff deliver behaviour change and specific health improvement programmes with patients directly. Health Improvement staff withdraw and deliver specialist only services for more complex cases and provide training updates on programmes to staff and evaluations services for assessing programme impacts with a focus on meeting inequalities.

In addition the health improvement team have been working alongside the **Shetland Mental Health Forum** to implement the **Triangle of Care** and are currently looking at how this can be integrated into their practice. This represents another key feature of the **House of Care** model.

Plans for 2016-17

The following actions are described in Shetland's **Primary Care Strategy**. Health improvement and Public Health will provide support for their implementation.

- Develop a comprehensive anticipatory care programme with better case management to reduce the burden of disease, reduce the out of hours workload, prevent hospital admissions and reduce hospital bed usage with shorter lengths of stay and quicker discharges.
- Increase understanding within communities, the workforce and in management of the importance of this approach and the payoff.
- Develop a Primary Care Workforce Plan that includes an understanding of core skills required to deliver prevention and anticipatory care effectively and the amount of time required to do this well - who needs to do it, how do they do it in the team and how do they all need to be supported?
- Provide skills development and training as well as a structure which provides guidance on roles and responsibilities, including specifically 'end of life' conversations and the use of advanced directives, primary/ secondary prevention, more holistic social care and reducing poly-pharmacy.
- Focus in the short term on the areas where there will be the biggest payoff e.g. using SPARRA[54] data to focus on poly-pharmacy and anticipatory care.
- Develop and implement a framework and programme for self management and self-care, which should include a comprehensive website with links to self-care advice for common conditions, and support for staff in helping patients develop their own capacity for self-care.

Secondary Care: Health Promoting Health Service

We take a lead on the **Health Promoting Health Service** (HPHS). The aim of HPHS is to support the development of a health promoting culture and embed effective health improvement practice as part of healthcare delivery. This is not without challenges – if easy, it would already be done, and there are lots of competing demands on staff time –

[54] SPARRA: Scottish Patients at Risk of Readmission and Admission

but time for all of us to recognise that we're part of solution and that staff in hospitals have a significant contribution to make to prevention / secondary prevention. The HPHS programme also includes a focus on staff health and wellbeing and on income and financial wellbeing in recognition of the impact these have on health.

Community based health services also have a significant contribution to make in prevention and some people believe that prevention should be done in the community setting. However there is great scope for supporting the good work carried out in the community when the public access hospital services. For many, it may be too late by the time people get to hospital, but making the most through opportunistic face-face contact with the large numbers of patients, carers, visitors and staff in hospitals are key reasons for taking this approach.

As a service provider and employer, the NHS affects the health of its patients, staff and the wider community. The NHS also has the potential to be an organisation that actively promotes health and tackles inequalities, and it has a unique contribution to make in the broader picture of changes required to improve health outcomes for all.

One particular highlight from the last year was the roll out of the physical activity pathway into secondary care.

Managed Clinical Networks (MCNs)

A managed clinical network (MCN) is a linked group of health professionals and organisations across different sections of the health service (including community, hospital and specialist) working together in partnership with social services, voluntary organisations and, most importantly, patients and carers. Members of the Health Improvement Team take an active role in a number of MCNs. As described above, there is still a role for prevention even once somebody is in hospital or in care services. For example, if someone has respiratory disease, it is just as important that they stop smoking as if they didn't have the disease.

- **Respiratory MCN** – The main focus for health improvement is smoking cessation provision in secondary care.

- **Cardiac MCN** – We contribute to the Heart Improvement Plan focusing on overweight and obesity management; physical activity brief advice and intervention; and healthy eating awareness.
- **Diabetes MCN** – here health improvement contributes to obesity and overweight management; physical activity brief advice and intervention, and the link between health improvement and dietetics.
- **Falls MCN** – Falls prevention is included within holistic health improvement and also promoted through specific physical activity interventions.

The Health Workforce

'Working for health equity: the role of health professionals' sets out the role that health professionals have to play in tackling the wider determinants of health.[55] The report illustrates that there are many things that the health system can do to influence the wider social and economic factors beyond access to health care services rather than tackling the symptoms and behaviours that people present with. Much of this action is taking place on a national level through incorporating this into the training of the workforce. Locally, however, the health improvement team need to further understand the gaps in knowledge of staff in order to help them influence the wider determinants more effectively.

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[55] Allen M, Allen J, Hogarth S, Marmot M. *Working for Health Equity: the role of health professionals* London: UCL Institute of Health Equity, 2013.

3 Implementing programmes to improve health for individuals and communities, and across a range of settings

Workplaces

We have a high level of employment in Shetland, but in-work poverty appears to be increasing and one in five households in Shetland have an income of £13,500 or less; this is less than half the median household income of £28,068.[56] The number of people in work, however, means that workplaces are a very useful setting for health improvement work. More and more employers understand the need to promote the health and wellbeing of their staff, in terms of efficiency and productivity. This links to issues identified in Shetland, such as the number of men lost to suicide over the last few years.

We have developed a unique approach to **Keep Well Health Checks**. We deliver these by targeting small businesses, or lone workers identified through health centres; as far as we know, we are the only area of Scotland that uses this approach. A total of 252 checks took place during 2015/2016, with 136 to date in the current financial year. The aim is to target people who would not otherwise be accessing health services. Although primarily we wish to detect risk factors for heart disease and cancer early and support lifestyle change, we also look out for wider wellbeing issues which impact on health, such as poor mental health, low income, housing and relationship issues. (We now talk about 'wellbeing checks' rather than 'health checks'.)

As checks have been delivered over the past three years we are now being contacted by businesses who have already had the health checks but have now taken on new employees, an indication that the checks are valued. All data from the checks is fed into EMIS so it is possible to track action that individuals have taken as a result of the checks.

Plans for 2016-17

We plan to undertake a piece of work to look specifically at the impact of having health checks on workplaces and organisations. This will be based on a sample survey of participants and managers.

[56] Shetland's Commission on Tackling Inequalities. *On Da Level – Report and Recommendations from Shetland Commission on Tackling Inequalities.* Lerwick: Shetland Islands Council,2016.

Healthy Start

The **Healthy Start** scheme gives eligible families free vouchers to spend on milk, fresh or frozen fruit and vegetables and infant formula milk. The vouchers are for anyone who gets income support, income-based job seekers allowance, child tax credit, is on a low income, or is a teenager.

The Child Health Team had identified that one of the barriers to discussing entitlement to Healthy Start was staff confidence in talking about money matters. Joint training was organised between the local **Citizen's Advice Bureau** (CAB) and Health Improvement to deliver training on debt advice and awareness of benefits along with Healthy Start. The training was attended by midwifery, health visiting, and occupational therapy and trainee nurses. The Health Improvement team also spoke to local shops to promote the scheme and encourage them to sign up to the Healthy Start Scheme.

Counterweight

Adult Weight Management services continue to be delivered using the **Counterweight Programme**. The demand on the service has continued to increase with 290 patients recorded as beginning the programme in 2015/16. We know this number to be higher as not all individuals give permission for their data to be included. The programme is delivered in both group and one-one settings, allowing the most cost and time effective means to be sought. We keep patients preferences at the forefront to ensure they receive the best service for them in a location that is convenient. This has included workplace and community groups being run alongside one to one GP practice based interventions.

The following data is based on all patients who commenced the programme between March 2015 and September 2016. The team have seen 430 patients in this 18 month period; 108 patients so far have reached their 5% weight loss target; and a further 33 reached their 10% target. Research on the Counterweight programme overall shows that 31% of the participants had lost over 5% of their weight at 12 month: and our figures match with this. Further data analysis is required in order to look weight loss maintenance beyond 18 months. During this 18 month period, there were 2542 appointments which an average of six appointments per patient.

The table below shows the number of patients attending each session of the programme.

	Screening	Session number					Follow up at 3, 6, 9 & 12 months			
	(From March 2016)	1	2	3	4	5	3 months	6 months	9 months	12 months
No of patients	88	401	363	303	246	214	205	107	72	46

We are currently working with the dietitian to further develop the referral pathway for adult weight management in Shetland. As well as dietetic led weight management support on an individual level, the dietitian is looking to set up a **Dietetic-led Counterweight** group. Dietetics will also be offering **Counterweight Plus**, a low calorie liquid diet programme from early 2017.

Child Healthy Weight

The results of the 2014 Health Behaviour in School Aged Children in Scotland (HBSC) survey were published in October 2015. NHS Shetland had paid for a larger than normal sample to be surveyed, in order to give us a useful level of data. In relation to child healthy weight there were a number of areas highlighted including low levels of daily fruit and vegetable intake, relatively low levels of individuals eating crisps and chips daily, but 25% of young people eating sweets on a daily basis.

There were low levels of individuals meeting daily physical activity guidance and high levels of sedentary behaviour both during the week and at weekends. It is worth noting that 80% of pupils reported that they travelled to school by bus or car. Even allowing for distance this suggests that, where appropriate, we need to support and encourage a change in attitude towards active travel.

Primary 1 data from 2015-16 showed that 27.1% of the children were described as being ‘at risk of overweight or obesity’, because they had a high BMI. This is higher than the average for Scotland, and is the highest percentage in Shetland for the past few years: since 2009 the figure has fluctuated between 19% and 24%. No children were assessed as being at risk of underweight in this year group.

We know that ‘statistically speaking’ the increase in the number of children with a high BMI in one year may not be very significant because of our small population. However, the

figures still show that over a quarter of the children in P1 last year had a problem with their weight at the point at which they were measured.

There is still a need for all teams working with families and children to become more confident and adapt their way of thinking when raising the issue of weight. This can be a difficult conversation; however it does not *need* to be difficult. We know that it is much easier to change habits and routines when they are not so engrained. Early intervention is key to tackling any behaviour change, particularly eating and activity. Further work and development is needed with all key agencies and sectors to ensure that children and parents are getting the help and support needed to provide healthy, sustainable life habits for themselves and their families. It would be incredibly helpful to have political backing for reducing the availability and attractiveness of sugar laden soft drinks and promotions of high calorie/low nutrition foodstuffs.

We have continued to deliver **SCOTT (children's weight management programme) and Counterweight Families.** Both programmes aim to help the whole family make healthy lifestyle changes and for BMI maintenance of the children concerned (**not** weight loss). Since March 2015 eighteen children have been engaged in the child healthy weight programmes, nine of whom have adopted a healthier lifestyle or stabilised their BMI or both. Working through child healthy weight programmes with families and seeing the complexity of many inter-relating issues has reinforced to health improvement staff the need for a programme which incorporates the adoption of a healthy lifestyle as part of wider more holistic programme such as the Life programme - a holistic, family centred approach which supports the needs of a whole family and aims to break the 'intergenerational' poor health and poor outcomes faced by the most vulnerable in Shetland (see page 101 for more on this approach).

Continued work alongside key departments such as child health and schools service is ongoing to ensure that families are given the opportunity for support either through the programme or through less structured support. We continue to see children who are severely obese, whereas, ideally we would like to see all children and families before they reach that point before habits are far entrenched.

Reducing mental health problems and suicides

Our rate of suicides or deaths of undetermined intent (measured over five years because of the small numbers involved) continues to fall, although the rate of male suicide is still above the national average. We use rates because this allows us to compare ourselves more easily to other areas, but this was actually 23 people who have completed suicide over the last five years – enough people for two football teams. We continue to work with partners such as **Mind Your Head** and **Samaritans** to increase community awareness and confidence in talking about mental health, and deliver training in workplaces to increase knowledge of mental health issues and help people develop skills in supporting people with mental health issues. We have also continued to audit every sudden death that may be due to suicide or drugs, identify common themes and trends and take appropriate action if possible.

The Health Improvement Team and the Mental Health Team worked together to implement the **Computerised Cognitive Behavioural Therapy (CCBT)** programme **'Beating the Blues'** as part of a European Funded Project pilot. It consists of eight, one hour sessions done at weekly intervals and is designed for mild to moderate depression or anxiety. Health Improvement's role was to support people to start the programme and keep going with it. NHS Shetland was the only board that delivered support alongside the programme in this way. A pathway and information sheet was developed to outline how the support should be delivered. The end of year evaluation has shown than Shetland performed well within Scotland in terms of completion rates: this has led to funding being extended by a further 12 months and includes an upgrade and update of the CCBT programme. A summary of the evaluation for the 1st year of the pilot can be found in Appendix A.

Access to services to support people with low level mental health issues has been recognised as an area of need both through Shetland's Primary Care Strategy and recent research undertaken by Mind Your Head. The workload associated with dealing with mental health problems remains a significant issue for primary care staff and members of the community. GP colleagues recognised that with additional training, the Health Improvement Practitioners already based within Primary Care could deliver **Behavioural Activation interventions** - a low level high intensity programme which is evidence-based and is recommended as a first tier intervention for mild to moderate depression. It can

also be helpful for 'sub-syndromal' low mood. It is an approach that is potentially extremely helpful for people who do not want to engage with more cognitive 'psychological' approaches, and will help to manage the volume of mental health issues that exist in the community and present to primary care.

This view was shared by the health improvement team as often behaviour change programmes such as **Counterweight** or stop smoking support can involve tackling underlying low level mental health issues. It was felt that specific training in this could enhance their work in other behaviour change programmes as well as being a stand-alone programme for tackling the low level mental health issues. We know that people in Shetland can access computerised CBT (the **Beating the Blues** programme) and telephone guided self help or CBT via the **NHS 24 Living Life** service. However many people dislike the idea of an approach that involves no face to face contact, and behavioural activation will provide a welcome alternative.

Working alongside members of the Mental Health team including the GP with a special interest in mental health, a successful bid was made to the **Primary Care Mental Health Transformation Fund**. This has allowed us to employ a practitioner on a temporary contract to organise the implementation and evaluation of **Behavioural Activation** in Primary Care in Shetland. The training is scheduled to take place in early October 2016.

Smoking cessation

Smoking cessation services again exceeded their targets (51 people quit at three months against a target of 33) which we see as a significant achievement for all the staff involved locally in helping people to stop smoking. Our smoking rates remain low compared to the rest of Scotland (less than 16% from GP systems data, 17% from Scottish Household Survey data) and the people we are helping now are generally those who find it the hardest to quit. This includes mothers smoking in pregnancy: midwives are now fully trained in delivering smoking cessation support and a range of programmes aimed at reducing the numbers smoking at booking are in place.

Physical Activity

Adults need 150 minutes of moderate activity or 75 minutes of vigorous activity for health (or a combination of both) as a minimum, each week. The main measure used for

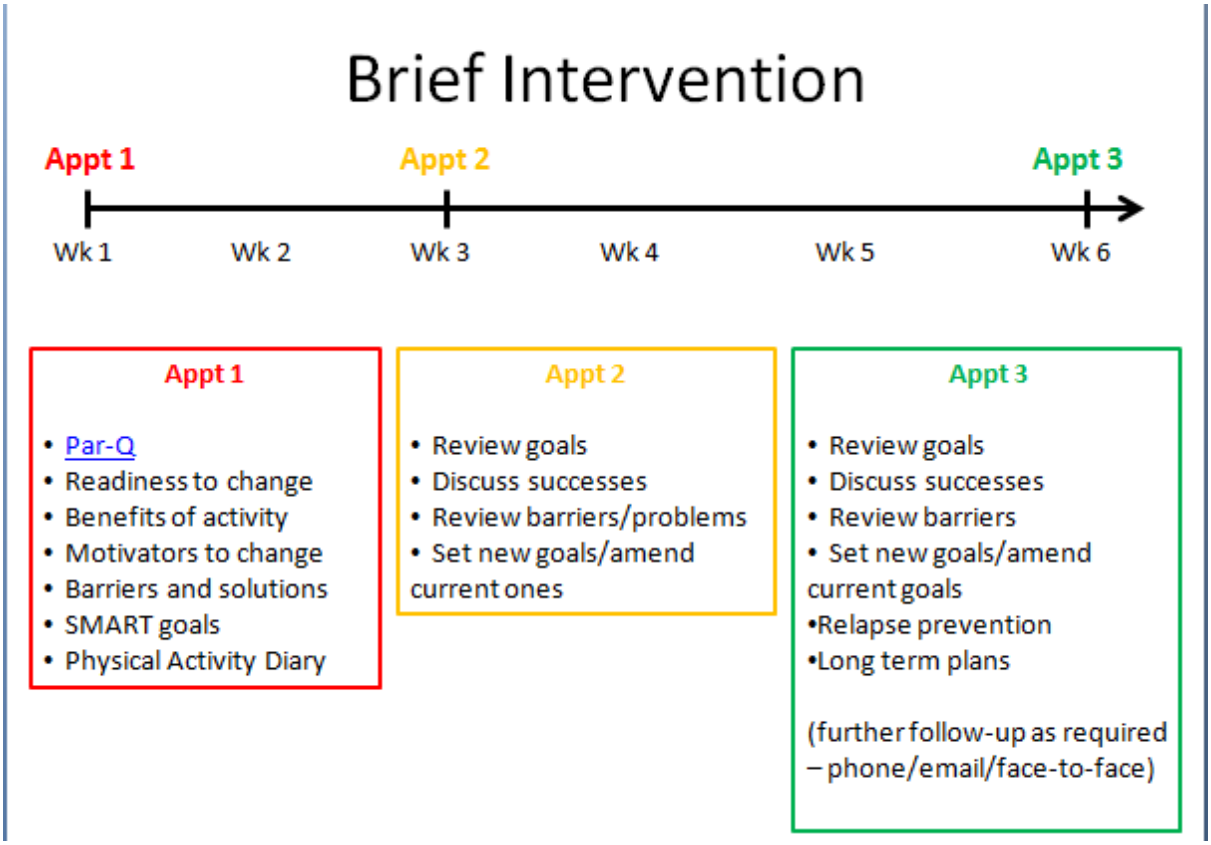
recording adult physical activity levels in Shetland is through the Scottish Health Survey. The latest data was published in March 2016 and is for the period 2012 – 2014, which shows that 64% of adults in Shetland are meeting physical activity guidelines. The data also shows that 36% of adults are not meeting these recommendations, 18% of whom are undertaking very low activity (less than 30 minutes weekly of moderate activity or 15 minutes of vigorous or combination of both). If this is the case there is still a great deal of work required to help these people become more active, as it is widely known that getting the least active more active has the greatest health gains overall. The validity of Scottish Health Survey data could be questioned as it is based on a sample of 300 people over a 3 year period, but can serve as an indication of activity levels.

In recognition of the need for better data on physical activity levels we have been working over the past three years to increase data collection on physical activity levels in primary care by implementing the physical activity brief advice pathway. As far as we are aware, this is the only current method to record individual adult physical activity levels in Shetland. In addition this allows the least active to be targeted and given the appropriate advice in the appropriate way to maximise chances of becoming more active.

Over the past year Health Improvement team have reviewed how we train staff to deliver physical activity brief advice and intervention for physical activity in primary care. The review was instigated through staff working in primary care and gaining hands on experience of how this could work. Four main areas were focussed on.

1. The training for staff had to be shorter – Action taken: training reduced from 3 hours to 15 minutes.
2. The recording had to change from paper based to electronic – Action Taken: EMIS Template developed.
3. There needed to be a defined programme for patients to follow - Action taken: a brief intervention pathway was established to consist of three, one-one appointments with more follow ups where necessary. Simple resources were created to sit alongside the pathway consisting of; an information booklet for practitioners on the main areas to cover and a workbook for patients. (See example pathway below)

4. Sometimes primary care staff did not have time to deliver the interventions – Action taken: primary care staff given the option of delivering themselves or referral to Health Improvement Practitioner in their practice.



The pathway has also been integrated into Shetland's weight management pathway (currently in draft). It is anticipated that this will further increase 'buy-in' from primary care staff.

The EMIS template, with support from the information team, has recently been updated to reflect the national changes to classifications of activity levels.

The training delivered in primary care has been adapted for secondary care. As part of the training, feedback is being sought from individual departments as to the best ways of recording physical activity levels in secondary care. Ideally physical activity levels would be screened in secondary care and then information sent back to primary care to be recorded on the EMIS template. We are currently exploring ways that this could happen.

This work has been recognised at a national level and members of the team delivered a presentation to the **National Physical Activity Special Interest Group** earlier this year,

which enabled us to express an interest, now accepted, in being part of a national pilot for trialling a new clinical champion model for physical activity brief advice. The findings will be shared and learnt from nationally.

Otago Programme – Unst Pilot

The **Otago exercise programme** is a strength and balance programme which is designed to help people reduce their risk of falling by improving strength, balance and confidence.

It is particularly suited to people who:

- Have experienced a fear of falling
- Sometimes feel unstable on their feet
- Can lack confidence when walking
- Have experienced a fall(s)

The NHS Shetland physiotherapy team led the roll out of this programme in Unst with co-ordination support provided by members of the health improvement team. The programme ties in well with health improvement as it is a multifaceted programme which touches on all areas of health from nutrition to foot care. It provides a way of ensuring that holistic health improvement in vulnerable older people takes place, whilst also increasing mobility.

This project involved input from occupational therapists, podiatry, physiotherapy, opticians, health improvement practitioners, the practice nurse, community nurses, pharmacy and social care staff from Bruce Hall Terrace and Nordalea Care Centre. This multi-disciplinary, multi-agency way of working fits exactly with the sort of approaches described in the **Older People's Health and Wellbeing Strategy** for Shetland; and we should be using this approach more often. It involved partners being flexible, using a team approach, being inclusive and breaking down barriers, and clearly demonstrated the value of joint working and sharing of skills. The programme is made up of eight, weekly sessions consisting of one hour of specialised strength and balance exercises followed by a talk. Each talk is based on a topic that ties in with falls prevention, for example, eating a healthy diet, being active and looking after your mental wellbeing. Participants practice the exercises twice weekly between sessions. The programme was designed by

physiotherapy in order to meet all national falls prevention guidance. The evaluation of this programme is included at Appendix B.

Alcohol Brief interventions (ABIs)

Alcohol Brief Interventions continue to be delivered within the key settings of primary care, Accident & Emergency, Sexual Health Clinic and Maternity, again exceeding the nationally set target for 2015-16. However, during the first half of 16-17, the numbers of ABIs in primary care have fallen showing that this is not yet embedded in primary care practice. In addition there has been difficulty in collecting data from maternity and A&E which are moving / have moved to new electronic patient record systems.

Keep Well checks are used to identify people who may be more disadvantaged or vulnerable, and need an ABI.

Employability / Unemployment

It is well documented that being in employment is good for an individual's mental health. More recently Van Der Noort et al undertook a systematic review of prospective studies on the health effects of employment.[57] They concluded that employment is beneficial for health, in particular for depression and general mental health.

In Shetland an Employability pathway has been established to support people into employment. It has 5 stages and is in line with the national model (see below). Both national and local employability agencies operate within the pathway, as well as other support services. Each agency has a clear understanding of their role within the pathway and uses a case management approach where support is delivered in line with an individual's goals.

[57] Van Der Noordt, M et al. Health effects of employment: a systematic review of prospective studies. *Occupational and Environmental Medicine* 2013. Available on line at: http://oem.bmj.com/content/early/2014/02/20/oemed-2013-101891

Employability Pathway Working Group

The **Employability Pathway Working Group** is the local strategic group tasked with overseeing the operation of the pathway and keeping abreast of national and local developments. We are core members of this group and recently Elsbeth Clark was nominated as the Vice-Chair. Although the pathway has been used successfully and is robust in nature, there is still room for a pre-pathway step, involving keeping people in employment so that they never need stage one of the pathway.

Fit for Work

As part of the Employability Pathway we have promoted the Fit for Work service. This service aims to:

- support people to reduce the length of sickness absence
- reduce the chances of people falling out-of-work and on to benefits
- increase awareness of the benefits of working to a person's health
- increase the positive actions taken by employers, employees and GPs in contributing to a change in attitudes towards health and work.

We do need to promote this service further, as uptake hasn't been high, and there would be definite benefits from employers, GPs, and staff members working together to help people to stay in work where possible.

As the website states: 'There's a very strong evidence base for sickness absence that shows that the sooner the causes of absence are identified, and acted upon, the better. Intervention at four weeks, compared to six months, has a greater impact as an employee is more likely to still have an attachment to work. The longer an employee is off work, the lower their chances of ever returning to work.'

Condition Management Programme (CMP)

Early in 2015 we were successful at bidding for funding from the European Structural Fund to set up and deliver a **Condition Management Programme**, in partnership with **Job Centre Plus** and as part of **Shetland's Employability Pathway**.

The purpose of the CMP is to provide intensive support to clients to overcome barriers to work. An Occupational Therapist was employed, to support 15 unemployed people into work experience, paid employment, volunteering and other non paid opportunities.

Robust referral and monitoring and reporting systems were developed in order to be able to measure effective outcomes. 16 individuals were supported through the programme.

In addition to the one to one work the CMP practitioner also delivered a **reading for well being group**. The group was held over 10 weeks from November 2015 as a pilot. It took place at the Old Library and was facilitated by Eleanor Bartlett and Jim Taylor. Referrals for this closed group were received from the Community Mental Health Team (CMHT), Substance Misuse Recovery Service (SMRS) and the employability pathway.

The group was based on the work of the Reader Organisation, with a focus on the shared process of reading. The concept is not a 'book club' or a literacy class. Reading has a surprising number of health benefits and can support in the recovery of mental and physical illness. It is an excellent form of relaxation and research has demonstrated that just six minutes may be enough to reduce stress levels by more than two thirds.

Shared reading and reading aloud may be helpful for people who are socially isolated, lack confidence, have poor communication/interaction skills, limited concentration and poor motivation. Attending a group can add structure and purpose to daily routine (which those experiencing mental problems often lack), and the group itself provides a safe environment to reflect on difficult feelings in a productive manner (using the text theme or character to gain insight into oneself).

The group attendance ranged from three to five consistent attendees, all male. A variety of material was read, mainly short stories, but also a few poems too. The group put forward suggestions of authors, genres and themes, and the facilitators located texts to meet these requests. Members were encouraged to read aloud a segment of the story/poem, although

there was no pressure to do so. An informal discussion was held at the end of each reading to reflect on the text.

Feedbacks forms were completed with positive responses. Participants generally felt that the group improved their mood and that they found the experience relaxing. If another group was to run, all stated that they would be interested in attending again. People felt that the sessions gave them something to 'get up and out of the house for' therefore adding a motivating factor, which is important for those struggling with low mood.

Plans for 2016-17

- Development of a **Weight Management Programme** and pathways for those with BMI of 35 or greater, or BMI of 30 plus other health conditions.
- Staff training in **Behavioural Activation** and **Motivational Interviewing**
- Further develop **Alcohol Brief Intervention** programme as part of Tier 1 and 2 Alcohol support programme, with clear referral routes into the Substance Misuse Recovery Service.
- Development of **Condition Management Programme** to support people currently in employment but vulnerable to job loss due to health or social issues.
- Promote and develop referral pathways into **Fit for Work** service.

4 Encouraging environmental measures to improve health

Healthy Working Lives

The Scottish Centre for Healthy Working Lives is a national organisation that provides information and support to promote health in the workplace. They have a web-site and telephone helpline and offer a range of training. They run the Healthy Working Lives Award programme consisting of a bronze, silver and gold award levels aimed at promoting health in the workplace. Health Improvement has supported organisations to achieve these awards over the last 10 years. The majority of workplaces which hold the award are those with a large number of employees and we are working to create a simpler programme which incorporates Keep Well (or Wellbeing checks), and is more appropriate for smaller organisations, but with the same aims as the national programme. A design is in place and is currently being piloted.

Training with workplaces

Mental health for managers is a one-day training course developed by the Scottish Centre for Health Working Lives (SCHWL) in partnership with the Scottish Development Centre for Mental Health (SDCM). We focus particularly on mental health for managers because the need for good mental health and wellbeing is so universal and linked to so many other aspects of work. The training is designed to encourage good practice in promoting positive mental health and well-being, thereby contributing to a more open culture that puts mental health on the agenda alongside physical health, social inclusion and productivity.

Over the past year 21 supervisors/managers from the Shetland Islands Council have been trained. Participants reported that they felt the course had equipped them with tools to help talk to staff who they were concerned about as well as giving them a better understanding of mental health in general.

The need for Mental Health for Managers training amongst NHS staff has been raised through the **NHS Shetland Health and Safety Committee** and a commitment to this is now in place board-wide. The first session is due to take place at the end of October 2016.

Housing

The Public Health team have been involved in the Housing Joint Strategic Needs Assessment for Older People in Shetland, thinking about how we can join up assessment processes e.g. medical housing points, or use health improvement skills to avoid expensive adaptations to properties: for example in delivery of weight management services before housing adaptations are required.

Active Travel

There is plenty of research to say that Active Travel is one of the most successful ways of improving health, through building physical activity into people's day to day lives. Increasing the number of people who choose to walk or cycle instead of taking the car, where practical, is a key strand of the **Shetland Active Lives Strategy**. Staff highlighted a funding opportunity for a feasibility study for active travel hubs; this resulted in the establishment of a **Shetland Active Travel Group** and an application being submitted, led by Zetrans, which has been successful. As members of this group we are helping to progress the project. This is a useful example of the role that Health Improvement plays in initiating actions which can then be taken on by other relevant bodies.

We have taken a lead in working towards **Cycle Friendly Employer Status** for NHS Shetland Gilbert Bain site, which allows access to a small pot of funding. An assessment was undertaken in May of this year and there is one outstanding action to be achieved before status can be achieved. In addition we actively promote the cycle friendly employer award to businesses we work with.

Plans for 2016-17

- Evaluation of the **Mental Health for Managers** training programme is done through electronic survey and is undertaken by the national Healthy Working Lives team. This is carried out immediately after the training and 6 months post training. The programme evaluates well, but we haven't yet looked at the longer term impact of it. Does it really lead to change in attitudes in the workforce and to sustained changes in how mental health issues are managed? Over the next two years we plan to apply a Return on Investment assessment to the training in order to identify the long-term benefits of the training and decide whether to continue to deliver the training or to look at alternatives.

- Contribute to Active Travel Feasibility study (Low Carbon Travel and Transport Fund, Transport Scotland)
- Continue lobbying to increase opportunities for active travel and reductions in the availability and accessibility of sugar-laden foodstuffs, particularly in public service organisations.

5 Incorporating community development approaches, so that communities are empowered

We are in the early days of developing asset based approaches within communities in Shetland. Often the tradition is to identify needs and then try to find ways to fill these needs in order to tackle health inequalities. Applying an asset based approach, on the other hand, involves identifying what assets there are in a community and building on these. Current cuts in public services make it even more imperative to look at the asset based approach in order to make full use of all resources at our disposal. Asset based approaches are not a replacement for investment in services or for addressing the structural causes of health inequalities, but they can reduce demand on services in the long term and bring about more effective services.

Although every person has health assets to offer they are often not taken advantage of. Asset based approaches uncover the knowledge, skills, connections and potential in a community. This in turn increases capacity, connectedness and social capital.[58] Marmot[59] takes this a stage further by suggesting the use of an asset based approach in order to implement effective strategies for reducing health inequalities focusing on:

- Inequalities in being well and well being rather than mortality as a measure of health inequality
- Disability free life expectancy instead of mortality – i.e. those who suffer health inequalities are more likely to have shorter-lives compounded further by disability.
- Tackling the causes of the causes
- Implementation of proportionate universalism – delivery on health should be universal but to scale in terms of disadvantage levels
- The importance of mental health and stress and personal and community resilience on physical and health and life chances, individual control and social support
- Strengthening the role and impact of ill health prevention

[58] McLean J. *Asset Based Approaches for Health Improvement: Redressing the Balance* Glasgow: Centre for Population Health Glasgow, 2011.

[59] Marmot M., *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*. London: The Marmot Review, 2010.

- Create and develop sustainable communities that foster health and well-being, ensure social justice and mitigate climate change.

Community Health Walks

Two years ago health improvement organised for walk leaders training funded through **Paths for All** to come up to Shetland. As a result of this walks have been held in a six geographical areas across Shetland and in one workplace. Two of these groups meet regularly and are run by a workplace and a community. The remaining four groups were led by us but have been difficult to maintain long term due to capacity.

In recognition of the latter we have recently successfully applied for **Paths for All** funding to increase our capacity to make the health walks more sustainable. The aim is to have trainers within Shetland who can secure the continued roll-out of health walks and related programmes. The project involves the co-ordination and further development of walking projects already in existence in Shetland, with a firm focus on integration across NHS, Local Authority and Third Sector Partners. Core to this will be to recruit more volunteer walk leaders and establish health walks in communities and led by communities where they are not taking place in Shetland on a regular basis. This includes targeting inequalities groups and linking in with **Community Sports Hubs**, whilst also tying in with the physical activity brief advice pathway. Clear outcome measures have been set for the project which will be rolled out over the next two years.

The attempt by a local group of parents to take ownership of the empty Quarff school building and turn it into an active play area is a great example of community empowerment, even though in this case it was ultimately unsuccessful. Public health and health improvement are often not directly involved in this work, but very much support the approach and would be happy to offer support.

Plans for 2016-17

In line with the Board Strategic Plan, to implement an asset based approach to health care and prevention. This will be a multi-dimensional cross cutting project to include: self care and self-management, realistic medicine and frequent attenders.

6 Developing people's personal skills by enabling them to identify their own needs and involving them in planning and evaluation processes

One of the roles of health improvement is to identify those whose voices aren't being heard and help them to be heard, through advocacy, inclusiveness and a bottom up approach, in line with Derek Wanless' 'Fully Engaged Scenario' where 'levels of public engagement in relation to their health are high' and 'the health service is responsive'.[60] The Shetland Mental Health Forum is a great example of this type of approach being taken forward.

Mental Health Forum

We lead the **Mental Health Forum** for Shetland. The Forum has membership from carers, service- users and from a range of mental health related services and agencies. The forum has a varied role ranging from promotion of mental wellbeing and reducing stigma to putting forward ideas for change in current services and in some cases actioning these.

In the past year this group has:

- Developed an engagement and communication framework to help people understand the ways that they can be involved in influencing mental health services.
- Updated the group role, remit and membership in order to strengthen its networking capacity.
- Increased membership to approximately 20 active members
- Successfully applied for funding for **Triangle of Care** training, organised and held the training and are now working through an action to implement this. (Triangle of Care is a set of 6 key standards developed by the Carers Trust for building a therapeutic alliance between carers, service users and professionals, to enhance partnership working within mental health services).

[60] Wanless D. *Securing our future health: Taking a long-term view* London: Public Enquiry Unit, 2002.

- Developed a multi-agency **Mental Health Awareness Month** campaign due to be held in October 2016.

Carers of people with mental health problems have particularly welcomed the opportunities to be involved in shaping and developing mental health services. The challenge, of course, is to ensure that the service improvements required are seen through. There are huge opportunities to build on this successful model, though some clinicians can find it a challenging approach. Although this particular piece of work isn't solely the responsibility of Health improvement, the value of involving patients and carers in developing care pathways, and patient information, for example, is immense, and also contributes to increases in effective self management and potentially fewer crises.

Plans for 2016/17

- Complete a scoping exercise on all mental health services available to Shetland residents and their carers in order to better inform the public (due to be finished by the end of March 2017).
- Work alongside **Drink Better** to tackle the stigma surrounding mental health and alcohol plans are currently in the early stages.

7 Encouraging appropriate service utilisation, including screening and immunisation services

Detect Cancer Early (DCE)

The aim of the national Detect Cancer Early programme is to diagnose cancers at an earlier stage (Stage 1) so that treatment outcomes are better, compared to when the diagnosis is made at a later stage. The percentage of breast, bowel and lung cancers that were diagnosed as Stage 1 in the two year period January 2014- December 2015 was low at 16.9% (15 patients); compared to 25.1% for the whole of Scotland. This figure has not varied much over the four years of the DCE campaign, ranging from 15.6% to 19.3%. Our target has been 29% (a 25% increase in the baseline, which equates to six more people being diagnosed at Stage 1 rather than a later stage).

The factors that influence this figure include completeness and accuracy of the data; screening rates; presentation at the GP; GP referral rates and waiting times for secondary care appointments and diagnostics. We are reliant on NHS Grampian for much of our data capture, and are working with the teams there to ensure the accuracy and completeness.

There is no screening programme for lung cancer and the current advice for people to visit their GP after three weeks of a cough is difficult to manage given the prevalence of non-specific viral infections, especially in the winter.

The national DCE campaigns do not seem to have made much difference to the figures in Shetland by encouraging people to present earlier with symptoms, although with the very small numbers involved it can be difficult to interpret. However we will continue to promote national awareness raising campaigns for breast, bowel and lung cancer. Publicity materials are widely distributed across Shetland with the aim of reaching all communities, especially the most remote and rural, and ensuring that the materials are available in a variety of settings including local rural shops and post offices, leisure centres and public halls. Other national campaigns to promote early detection of cancer are promoted locally; for example oral cancer week is promoted annually, including free checks at dental surgeries.

There has also been work with community pharmacists and other community based practitioners to identify people with potential cancer trigger symptoms who are using these

services e.g. following medications reviews. Once patients present to their GP, our GP referral rates are amongst the highest in Scotland, so low GP referrals does not seem to be a specific issue.

There are no significant delays for cancer diagnostics and even if there were, one or two weeks is unlikely to make any difference to the stage of the cancer, particularly if the patient has waited two years before going to their GP. At the beginning of the programme we reviewed our capacity for any increase in clinical workload, and used some of the non-recurrent allocations for diagnostic equipment.

Looking at the breakdown of cancers detected at Stage 1 in the two year period 2014-2015:

- 26.9% of breast cancers were stage 1. This is much lower than other areas (40.5% across Scotland) but can be explained by no breast screening during this period.
- 11.8% of bowel cancers (4 people) were Stage 1. This is lower than Scotland (15.4%) but slightly higher than our neighbouring Boards, Grampian and Orkney.
- 13.8 % of lung cancers (4 people) were Stage 1. This is lower than Scotland (17.9%), but again slightly higher than Grampian (12.1%).[61]

The number of cancers where the staging is not known can make a significant difference to the figures, especially where the numbers are so small. For Shetland, the staging was recorded for all lung cancers, and for all but one bowel cancer (compared to 4.8% and 9.8% for Scotland). However for breast cancer, with Shetland residents the staging was not known for 15.4% of cancers (four patients) compared with 3.0% for Scotland.

In order to identify if there is any more than can be done to encourage patients in Shetland to present earlier with symptoms potentially consistent with cancer, we are conducting a retrospective audit of late presenting cancers.

Screening

The national population based screening programmes for adults are for breast cancer; bowel cancer; cervical cancer and abdominal aortic aneurysm. There also a range of

[61] Source: Information Services Division (ISD) National Services Scotland

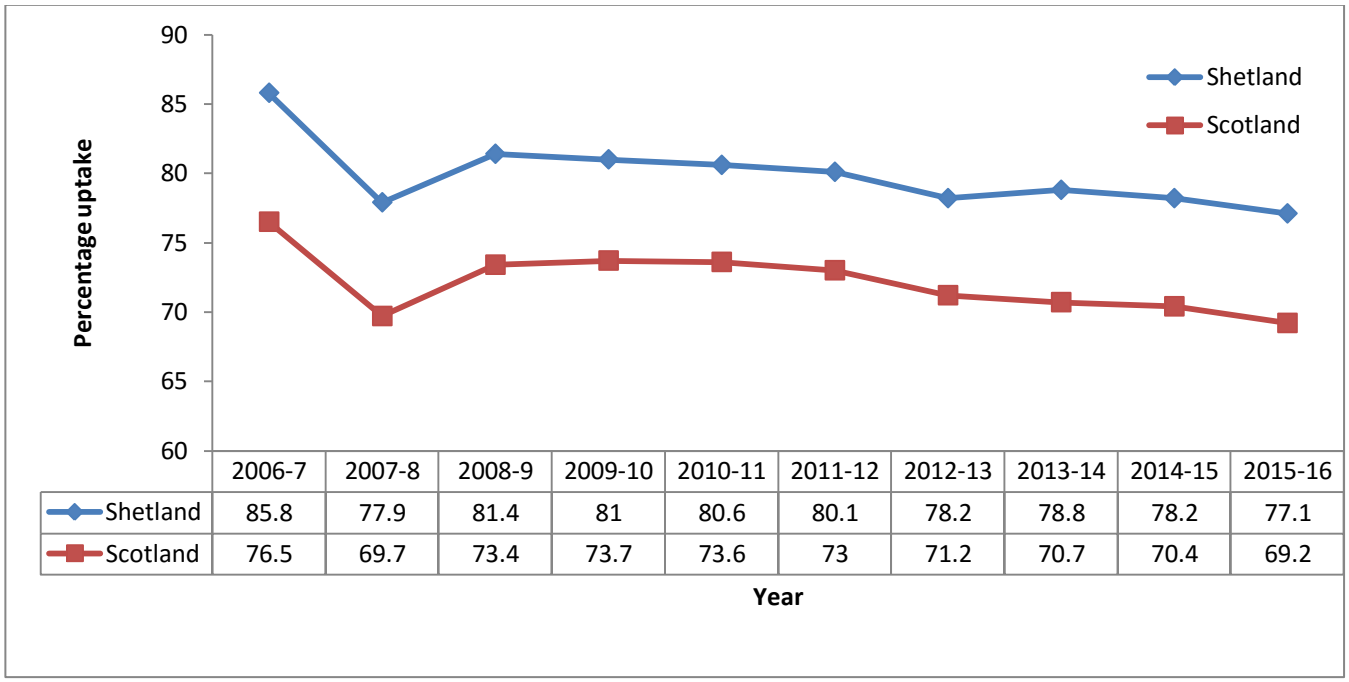
antenatal and neonatal screening programmes which are offered to pregnant women and their babies; and childhood screening programmes including vision testing.

The **cervical screening programme** has been in place nationally since 1988. Cervical screening is designed to detect pre-cancerous changes in the cells sampled from the cervix (the neck of the womb). This is known as 'cervical intraepithelial neoplasia' (CIN) and can be effectively treated to prevent cervical cancer developing. The 'smear test' is the process of sampling the cells and is usually carried out at the woman's own GP practice, by the practice nurse or GP.

Up until June 2016, cervical screening was offered to all women aged between 20 and 60 years in Shetland every three years, as in the rest of Scotland, with over 1,800 women in Shetland screened every year. The only women who are not offered screening are those who have had a total hysterectomy. This applies to about 6% of Shetland women. Following a review of the evidence of effectiveness of the programme, the age range has now changed to 25 to 64 years of age. Women aged 25 to 49 continuing to be screened every three years, and those aged 50 to 64 being screened every five years.

Figure 2.1 Uptake of Cervical Screening

(Percentage of women aged 20-60 who have had a screening test in previous 3.5 years)



	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Shetland	85.8	77.9	81.4	81	80.6	80.1	78.2	78.8	78.2	77.1
Scotland	76.5	69.7	73.4	73.7	73.6	73	71.2	70.7	70.4	69.2

Year

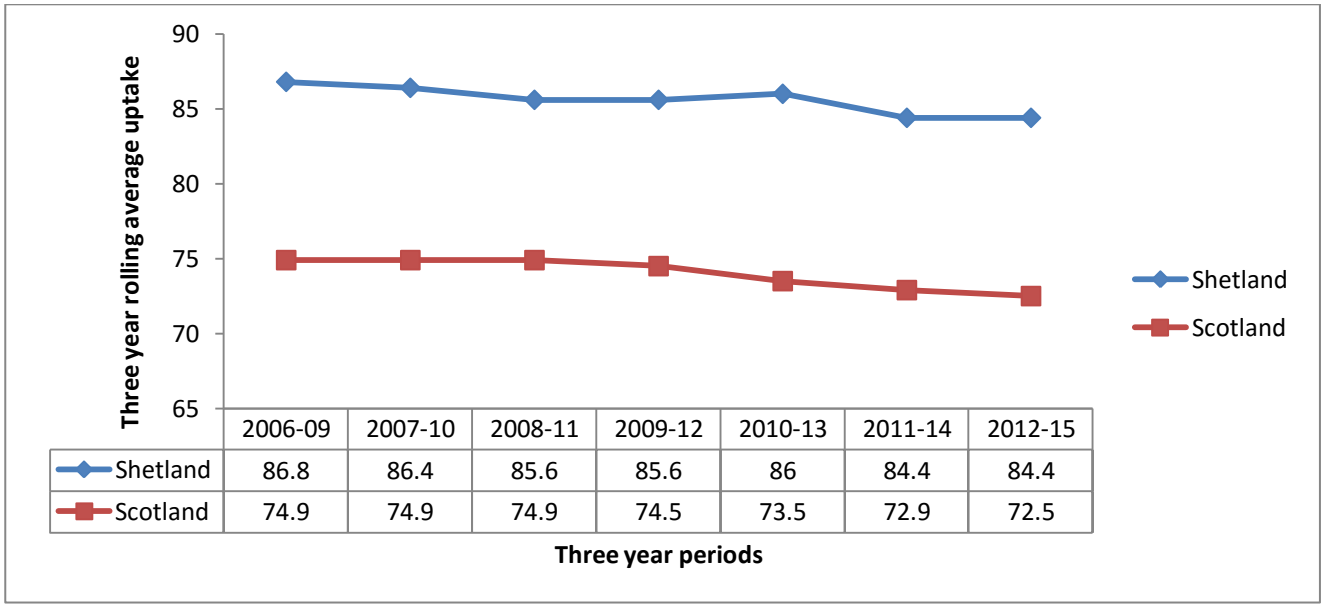
Source: Information Services Division (ISD) National Services Scotland

The chart above shows that Shetland has a consistently higher uptake compared to the rest of Scotland, currently the highest in Scotland. However, the uptake rate has been dropping in Shetland, as in the rest of Scotland over the past 10 years. We are now below the target of 80% uptake. This is despite ongoing campaigns to encourage women to take up their screening invitation. We know that the drop is mostly in the younger age group. This may, at least in part, be due to the introduction of the HPV immunisation campaign which protects women against a virus that causes cervical cancer; young women may think they do not need smears if they have had the vaccine. However it does not protect against all the strains of HPV that cause cancer so women still need to go for smear tests.

The Scottish **Breast Screening programme** invites all women between 50 and 70 years old for breast screening every three years. All women should receive their first invitation by the age of 53. Women aged over 70 are not sent an invitation but are still welcome to make an appointment to attend for screening. The programme in Shetland is delivered in conjunction with NHS Grampian and a mobile breast screening unit comes up to Shetland every three years. The screening consists of having a mammography (like an x-ray) of the breasts. If there is any abnormality seen on the mammogram, the woman is referred for further investigation.

Figure 2.2 Uptake of Breast Screening

(Percentage of women aged 50-70 who have been screened in each three year period)



	2006-09	2007-10	2008-11	2009-12	2010-13	2011-14	2012-15
Shetland	86.8	86.4	85.6	85.6	86	84.4	84.4
Scotland	74.9	74.9	74.9	74.5	73.5	72.9	72.5

Three year periods

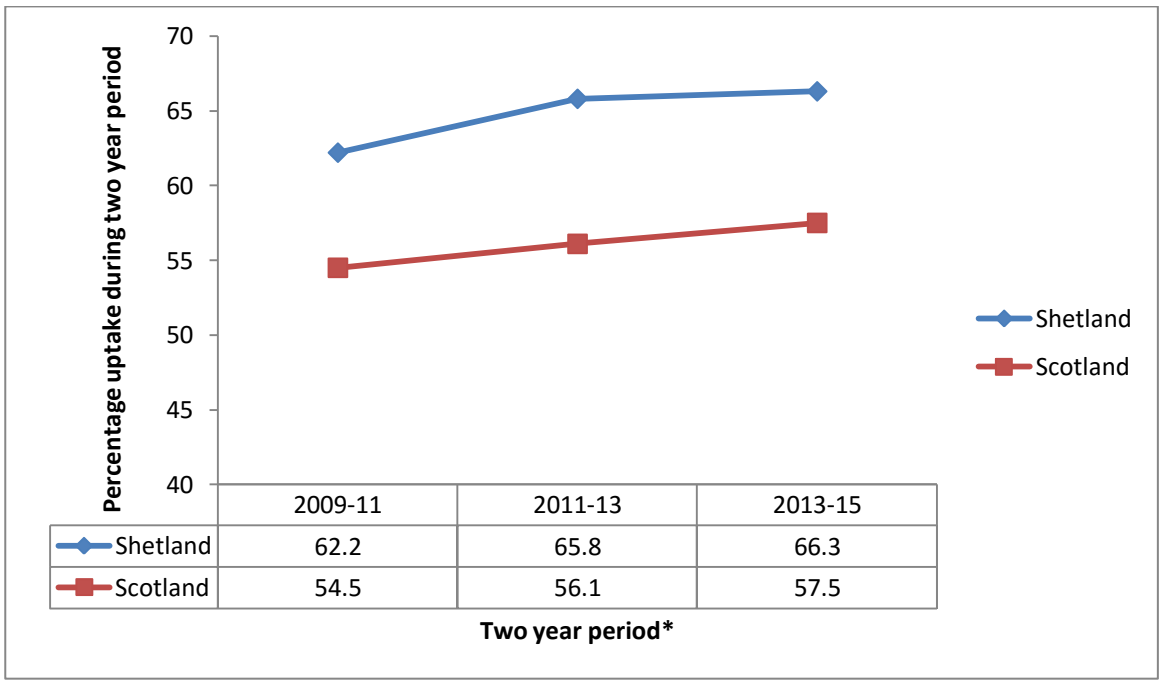
Source: Information Services Division (ISD) National Services Scotland

The chart above shows that, like the other screening programmes, we have a high uptake of breast screening in Scotland, consistently higher than the rest of Scotland, and usually the highest in Scotland. Howe, like cervical screening, there has been a gradual slight reduction in uptake since 2008, more marked in Scotland as a whole than in Shetland. However, uptake rates are still above the target of 70%.

The **National Colorectal (Bowel) Cancer Screening Programme** was introduced in Scotland in 2007 and rolled out by NHS Board, with NHS Shetland starting in October 2009. Men and women aged 50-74 are invited every two years to take part in the screening using a test kit that is posted out, completed at home and returned to the National Screening Centre in Dundee. The test (called the 'FOB' test) looks for evidence of blood in the faeces, which can be a sign of bowel cancer. If blood is found then the patient is invited to attend for a further investigation, a colonoscopy, at the Gilbert Bain Hospital.

Figure 2.3 Uptake of Bowel Screening

(Percentage of adults aged 50-70 invited during each two year period, who have been screened.)



	2009-11	2011-13	2013-15
Shetland	62.2	65.8	66.3
Scotland	54.5	56.1	57.5

Source: Information Services Division (ISD) National Services Scotland

*each two year period runs from November to October.

The chart shows that the uptake of bowel screening in Shetland is higher than the rest of Scotland and is gradually increasing. It has consistently been the highest in Scotland since the programme started, and exceeds the target of 60%. The figures below show the difference in uptake between men and women in Shetland, with women having a higher uptake; a similar pattern to Scotland as a whole.

Table 2.1 Uptake of Bowel Cancer screening in Shetland and Scotland 2009-15 by gender

	2009-11	**2011-13**	**2013-15**
Men	57.3%	62.2%	62.8%
Women	67.4%	69.6%	70.0%
Total	62.2%	65.8%	66.3%

Source: Information Services Division (ISD) National Services Scotland

A screening programme for **Abdominal Aortic Aneurysms (AAA**) for men aged 65 was implemented in Scotland through a phased rollout from June 2012. NHS Shetland started screening in October 2012 and by November 2013 all NHS Boards were participating. An AAA is a swelling of the aorta, the main artery in the body, as it passes through the abdomen. As some people get older, the wall of the aorta in the abdomen can become weak and balloon out to form an aneurysm. The condition is most common in men aged 65 and over and usually there are no symptoms. Large aneurysms are uncommon but can be very serious. As the wall of the aorta stretches, it becomes weaker, and it can rupture (burst). If the aneurysm ruptures, this leads to life-threatening internal bleeding and, in 8 out of 10 cases, death. The Scottish AAA screening programme aims to reduce deaths associated with the risk of aneurysm rupture in men aged 65 and over by identifying aneurysms early so that they can be monitored or treated. The screening test is a simple ultrasound scan of the abdomen. Men aged 65 are invited to attend AAA screening and men aged over 65 can self-refer into the screening programme. Most men have a normal result and are discharged from the screening programme. Men with detected small or medium aneurysms are invited for regular surveillance screening to check the size of the aneurysm. Men with large aneurysms are referred to vascular specialist services.

Because the programme was only fully implemented in 2013, there has only been one set of uptake figures published to date. These show that in Shetland between October 2012 and March 2014, 414 men were eligible to be screened; 414 were invited and 376 were screened, giving an uptake of 90.8%. This was the highest in Scotland, with the Scottish average being 85.8%.[62]

Out of the 376 men screened, six aneurysms were detected; four small and two medium sized, these men are not on annual or quarterly recall for repeat surveillance scans.

Immunisation

Immunisation is one of the key public health measures to prevent infection and illness and death due to infectious disease. In Scotland, as in the rest of the UK, there are a number of national immunisation programmes including the childhood immunisation programme and the annual influenza vaccination programme for over 65s and pneumococcal and shingles vaccinations for older people. There are also a number of selective programmes which are targeted at groups or individuals at increased risk of certain infections such as TB and hepatitis B.

The Board's Vaccination and Immunisation Group meets regularly and reports to the Control of Infection Committee on uptake rates, and on local actions to improve uptake and comply with national policy. 2015-16 was again a busy year with further changes to the childhood programme, including the introduction of a meningitis B vaccine for babies for the first time and a rapidly implemented programme to immunise teenagers against Meningitis W in response to a UK wide increase in the number of cases. In addition, the implementation of the shingles programme for 70 year olds continued, with the second year of a catch up programme. And this was the second year of the implementation of the extension to the seasonal flu programme to include preschool and primary school aged children, using the new live nasal flu vaccine.

Also of note last year was the ongoing low uptake of MMR, although there is a gradual trend to children receiving their first MMR earlier and the uptake rates are slowly improving. There is still also a relatively low rate of uptake of the pre-school booster by

[62] Source: Information Services Division (ISD) National Services Scotland

age of school entry which is being addressed through the Vacc & Imm Group and individual practices.

There is an active training programme for staff involved in delivering the immunisation programmes. 13 staff are currently registered and actively working on the online training course 'Promoting Effective Immunisation Practice.' Two practice nurses completed the whole course in 2015-16; and two completed the theory elements. 12 staff attended one of the local annual immunisation update training sessions held in June 2015.

Uptake Rates

Uptake of vaccine is measured at certain ages: the uptake is the percentage of children who reach a specified age during a specified time period (a 'cohort') who have had their vaccines. The target we are always trying to reach for any cohort and any individual vaccine is 95%; this is the level at which the virus or bacteria cannot easily spread in the community and we have a 'herd immunity' effect even though not every person is immunised.

Childhood programme

The table below shows that over 95% of babies had their primary immunisations by age one year. Slightly less had rotavirus vaccine, however if this is not given by age 6 months the it is not given at all because of potential complications in older infants. Similarly, over 95% of children reaching age of two had had their primary immunisations, but less had received their 12/13 month jabs: just over 90% for the Hib / Men C and PCV boosters and less than 90% for the first dose of MMR.

Within the group of children who reached the age of five in 2015-16; although over 95% had received their primary immunisations as a baby, only 81.2% had received their pre-school booster which should have been given at the age of three years four months (40 months). Similarly, 95.2% had received their 1st dose of MMR, but only 81.5% had received the second dose which should have been given at 40 months.

There is an increase in these figures between five and six year olds. This is likely to be because in the first year of primary school, children have a P1 health check when immunisation status is checked and they are reminded to get any outstanding

immunisations. However it means that around 20% of children are starting school not fully immunised and therefore there is no herd immunity in this group

Uptake rates for April 2015 – March 2016

Age group	Number of children	Rota-virus	DTaP/ IPV/Hib	DTaP /IPV booster	MenC	Hib / MenC booster	PCV	PCV booster	MMR 1st dose	MMR 2nd dose
Children reaching age 12 months	251	92.4%	95.6%	-	98.0%	-	95.2%	-	-	-
Children reaching age 24 months	251	-	96.0%	-	-	91.6%	-	91.6%	88.8%	-
Children reaching age of 5 years	271	-	95.6%	81.2%	-	92.3%	-	-	95.2%	81.5%
Children reaching age of 6 years	287	-	-	91.6%	-	-	-	-	93.7%	91.6%

Source: Information Services Division (ISD) National Services Scotland

Rotavirus. Given at 2 and 4 months: not given after age 6 months

DTaP/IPV (diptheria, tetanus, pertussis (whooping cough), polio) Given at 2,3,4 months and booster at 40 months

Hib (haemophilus influenza b) Given at 2,3,4 months and booster at 12/13 months

Men C (meningitis C) Given at 3 months and booster at 12/13 months

PCV (pneumococcal). Given at 2 and 4 months and booster at 12/13 month: not given after age 2

MMR (measles, mumps and rubella) Given at 12/13 months and second dose at 40 months

MenB *(meningitis B) Given at 2 and 4 months and a booster at 12/13 months. Started in September 2015 therefore not yet included in uptake figures*

The school based **Human Papilloma Virus (HPV) Immunisation programme** aims to immunisation teenage girls to protect them against HPV which causes cervical cancer. The vaccine is given in school during the spring term: Secondary 1 girls get their first dose

and Secondary 2 girls get their second dose. In 2015, 82.8% of girls in S1 received their first dose of the vaccine and 83.9% of girls in S2 received their second dose.

The **shingles vaccine programme** is to immunise people aged 70 against the herpes zoster virus that causes shingles. The programme started in 2013 and the vaccine is offered each year to anyone that is aged 70 in the September of that year. For the first few years of the programme, there has also been a catch up to immunise others aged 71 to 79. The uptake is measured from September to August each year. In 2014-15, 218 people aged 70 received the vaccine (54.1%) with an additional 161 as part of the catch up programme. For the period September 2015 to July 2016, 235 70 year olds have received the vaccine (66.4%) plus an additional 465 people as part of the catch up.[63]

The **flu immunisation programme** runs each year in the autumn, and individuals at risk of flu are offered a vaccine each year because the flu viruses that are circulating change and so the flu vaccine has to be changed in response. People in Shetland aged 65 and over, pregnant women and other younger people considered to be at high risk if they catch 'flu, are offered the vaccine. For the last two years, all pre-school children aged 2 to 5 years and all primary school aged children are also being offered the vaccination. Most of them will be able to have the nasal spray (Fluenz Tetra) instead of a jab, as will most secondary school aged children in the high risk groups. The nasal spray is more effective than the injection at preventing 'flu in children.

In 2015-16, 72.6% of over 65s in Shetland had flu vaccine (the target is 75%); 49.2% of under 65s in risk groups; 60% of pregnant women; 63% of pre-school children (target is 60%) and 75.9% of primary school children (target is 75%).

Healthcare workers, social care staff and unpaid carers are also urged to have the vaccine. Last year 45.2% of frontline healthcare staff in Shetland had the vaccine; and 59.1% of unpaid carers.

This information has been extracted from GP records; local school health and occupational health data.

[63] Source: Information Services Division (ISD) National Services Scotland

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Health Needs Assessments

Conducting health needs assessment is a core part of health improvement business in order to identify and address health need. A **Black and Minority Ethnic Group Health Needs Assessment** is currently being undertaken. This was last done between 2003 and 2005. To take one example, we don't see many people from ethnic minority backgrounds accessing our stop smoking service. Research tells us that there are particular ethnic groups where smoking tends to be more common[64]; so are folk in Shetland different? Do they not smoke, or do they smoke and not want to stop, or do they smoke and want to stop smoking but find accessing support difficult?

The aim of the health needs assessment is to better understand the needs of this community in Shetland and to ensure that our services are accessible and appropriate for them.

Plans for 2016-17

- Audit of people who present with advanced cancers (Detect Cancer Early)
- Local implementation of national DCE awareness raising programmes
- The breast screening unit is in Shetland from April until September 2016: there will be local publicity to encourage women to attend.
- The age range for cervical screening changes in June 2016: there will be local publicity about the change along with continued awareness raising around cervical cancer screening.
- There will be continued implementation of the AA screening programme, including visiting screeners from NHS Grampian to cover maternity leave.
- We will work with the Maternity Department and Child Health to collate data on the antenatal, neonatal and childhood screening programmes to present next year.
- Further local campaign on MMR at age 12/13 months and pre-school – with a focus on nursery and other pre-school settings.

[64] ASH Scotland. *Tobacco Use and Minority Ethnic Groups.* Edinburgh; ASH, 2008.

- Implementation of annual flu vaccination campaign, aiming to increase uptake rates particularly amongst at risk adults and healthcare staff
- Rollout of SIRS (Scottish Immunisation Recall System) for inviting children for their vaccinations into every practice (currently used by two).
- Development of a specific project to identify and work with frequent primary care attenders, promoting self management
- Development of specific self management programmes
- Black and minority ethnic group Health Needs Assessment

8 Delivering health information and education, including the use of social marketing techniques

Within the schools we deliver health education sessions from early years and childcare (nursery) up to secondary. These come in a variety of forms; however each will cover diet, physical activity and mental health. In the nursery sessions this is delivered in the form of play and relaxation, looking at portion size and storytelling; up through the school years the sessions are adapted to suit the age and range of children. One to one sessions have also been arranged in the Secondary age where a concern may be raised as part of GIRFEC (Getting It Right for Every Child) and support can be arranged for the individual and families as part of meeting the child's outcomes.

We have continued to link into the local nurseries and schools to deliver sessions on eating well, active play and offered support to families who are struggling with weight issues. Further training has been delivered to the Midwifery team responsible for weight management at both fertility and during pregnancy. This has resulted in better links made with mothers and families once they are discharged back into the community, and support being offered beyond the period of pregnancy.

Health Information campaigns and promotions

We gained external funding two years ago to develop a web-site which is updated with information on a regular basis. Four main campaigns are chosen through the year and focused on. The team have also worked up a quarterly newsletter and tweet daily.

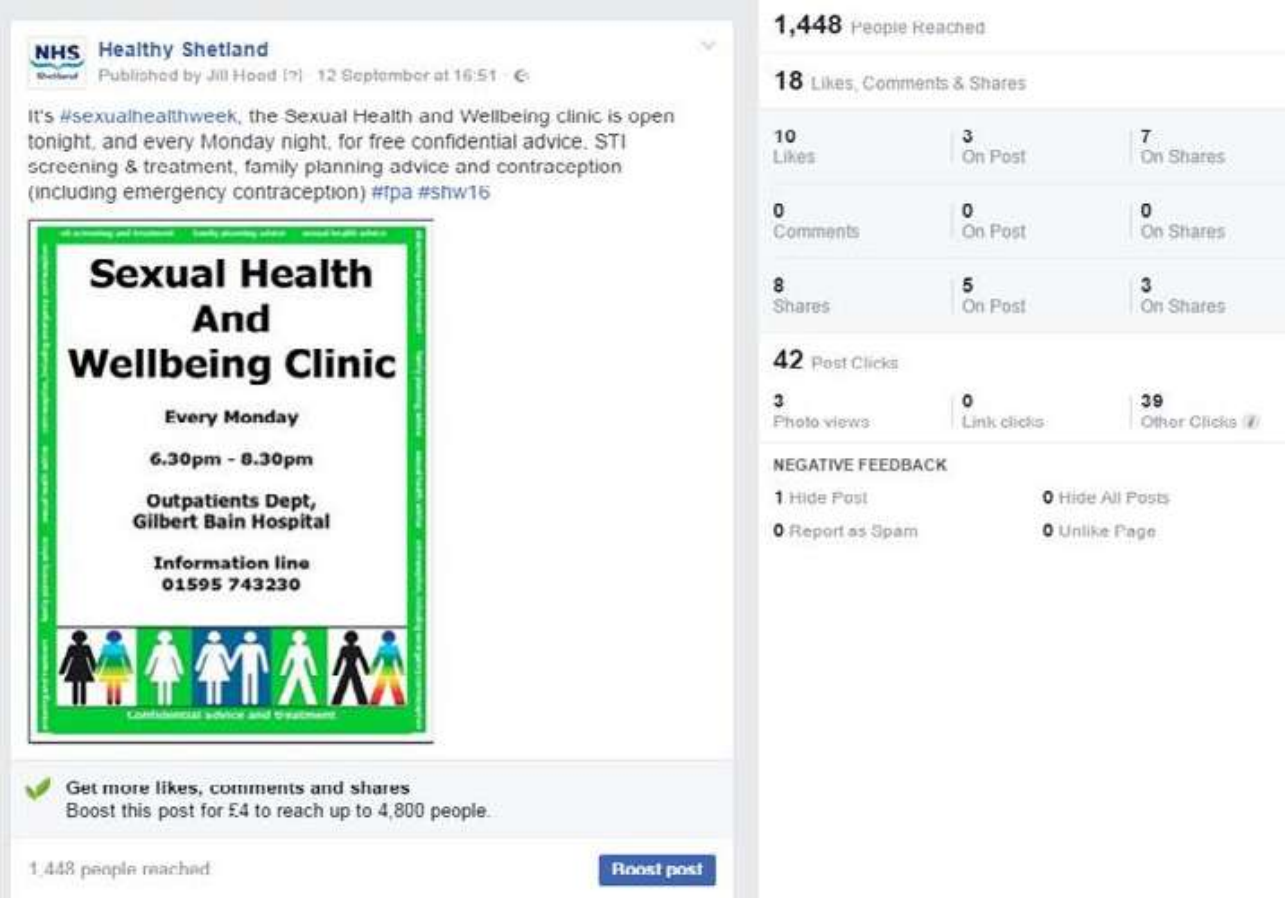
Twitter: We have 171 followers (this is a combination of other organisations and individual people).

Facebook: We have 688 likes on our page.

Our post reach (how many folk actually see it) varies quite a lot but overall posts with images perform much better. Our most successful recently was the revised sexual health clinic poster which was seen by 1,488 people and had been 'liked' 10 times and 'shared' 8 times.

Most of our facebook followers are women aged 25-34. We can use this to target our posts. We also know that more of the people who like our page are online in the evenings

so it's a good idea for us to use the 'schedule' button so that our posts can appear at the times when more of these people are using facebook.



Drink Better

Drink Better is a social marketing approach to tackling the culture of alcohol misuse in Shetland. It is based on a model developed in Quebec, and we have adapted the approach to fit the Shetland context. It is described in more detail in Part I of the Public Health Annual Report.

Schools: a presence in all high schools

The **School Nursing Plan for Scotland** requires a 'drop-in' facility to be available in secondary schools; this doesn't necessarily have to be provided by the school nurse, and at present the health improvement team are providing this role, with plans for school nursing to take it back on in the future. The **Curriculum for Excellence Health and**

Wellbeing outcomes raised the profile of health within education, but schools still feel there is merit in external agencies supporting the delivery of elements of the curriculum.

Current situation:

- Unst: initial meeting held to commence fortnightly drop-in from Oct 2016
- Yell: Established fortnightly drop-in, education as requested in response to local identified need.
- Aith: Established fortnightly drop-in, education as requested in line with local identified need.
- Whalsay: Education as requested in response to local identified need
- Brae: Working alongside youth workers that are based there.
- Anderson High School: Working alongside youth workers that are based there.
- Sandwick: Established fortnightly drop-in, education as requested in response to local identified need.

To some extent it feels as if the concept of Health Promoting Schools has been lost since Curriculum for Excellence was developed; this sets out clear requirements for curricular context, as would be expected. However there are issues that we feel are missed, including healthy tuckshops (which Oral Health Promotion are leading a piece of work on) and mental health and wellbeing for children and young people.

Education and training

Health Improvement and Public Health have a wide-ranging role in supporting professionals, volunteers and members of the community in developing their own health improvement roles. The range of training that we deliver - often flexibly and on demand, is available here: www.healthyshetland.com/resources/training

Plans for 16/17

- Agree drop in arrangement in Whalsay School
- Undertake mental health and wellbeing needs assessment for children and young people: work with Integrated Children's Services to formulate plans for filling gaps.

- Work with education service to agree programme for supporting teaching staff in becoming more confident in delivering health related topics.
- Review and relaunch Drink Better Campaign with targeted marketing.

9 Tackling inequalities

We continue to play an active part through partnership work on achieving the healthier and fairer priorities in the Local Outcome Improvement Plan and we were actively involved in providing evidence to Shetland's Commission on Tackling Inequalities.

In Shetland we do not have some of the harder to reach groups such as prisoners and travellers. We do have relatively small numbers of people who are homeless, and these are generally accommodated in temporary accommodation rather than being on the street or in hostels. We have small immigrant populations and few non-English speakers. However, rurality and access is a major issue for us. In terms of socio-economic and remote and rural disadvantage, our **Keep Well** (previously Well North) programme targets and engages with those living in the most disadvantaged areas of Shetland and has been rolled out across all practices including those in the most remote and rural areas. The programme includes a health check (including uptake of screening), healthy lifestyle advice and referral for alcohol problems, smoking cessation and weight management. Our year-end target for Keep Well health checks was exceeded, and our local programme continues despite even larger than anticipated reductions in national funding. Evaluation shows that we are reaching people who often struggle to be engaged with services. Our success in helping people to stop smoking and lose weight is very much tied into this outreach approach.

We continue to implement our **Outcomes Focused Action Plan** to mitigate the unhelpful effects of Welfare Reform. This has included awareness raising for staff on welfare reform to enable staff to identify issues and signpost / refer patients (and themselves / colleagues) to services such as the Citizen's Advice Bureau (CAB) where appropriate. CAB has continued to provide an outreach service to GP practices, including those in remote and rural areas. In health settings, we are also promoting grant schemes to reduce fuel poverty.

The work of the Inequalities Commission and the subsequent *On Da Level* report and delivery plan has firmly focused attention on inequalities in Shetland. All areas for action are relevant to tackling the health inequalities agenda. The team have been involved in progressing actions from the plan in line with current work areas. In terms of health

inequalities the priority for health improvement and public health is to continue to support delivery on the implementation plan.

Vulnerable children and families

Work with vulnerable children and families aims not just to tackle current problems but to prevent patterns repeating in the future. The Life Model is a whole-family approach to supporting the most vulnerable and chaotic families within a community. It was created by services and families in Swindon in 2011.

The drivers for the change in developing a new approach were:

- Previous interventions, over the last 20 years, had not led to positive or long-term change for the families;
- The high cost of delivering services to these families (without substantial results); and
- The desire to move from a service intervention approach for individual family members to an outcome focused approach for the whole family (and extended family) and each person within that family.

The model was developed by living and working alongside families in Swindon. At an early stage it was determined that families need to develop their own solutions, and that, in order to do this, they need to develop high trust relationships with those working with them and repair relationships within their own family. A group of services within Shetland have been looking at developing this approach in Shetland, by using existing resources and re-shaping the way that we work to support the most vulnerable. However this is proving very difficult and other ways of using the key elements, without replicating the whole model are being explored.

Community Justice Partnership

The Government's vision for community justice is that Scotland is a safer, fairer and more inclusive nation where we:-

- prevent and reduce further offending by addressing its underlying causes
- safely and effectively manage and support those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all citizens.

The work to achieve this is to be carried out locally through the Community Justice Partnership which reports to the Community Planning Board. Inequality, exclusion and stigma are key issues for people currently and previously within the criminal justice system. By tackling these and other underlying causes of crime, the aim is to prevent repeat offending in the future. The Public Health team is part of the Partnership and involved in developing and implementing the local strategy.

Gender Based Violence

Nationally **Gender Based Violence** (GBV) is considered an issue of gender inequality with the new Violence Against Women Strategy reflecting that. Locally, although we recognise that GBV affects women disproportionately, we consider anyone who is affected by GBV as vulnerable, potentially isolated and disadvantaged. Domestic Abuse and other gender based violence services in Shetland are delivered by a number of organisations and departments within the Voluntary Sector, Shetland Islands Council, Police Scotland and NHS Shetland, which are overseen through the Shetland Domestic Abuse Partnership. Public health is currently leading on a health needs assessment and development of a '**Domestic Abuse and Sexual Violence Strategy**'.

Plans for 2016/17

- Continue to demonstrate the need for genuine multi-disciplinary and holistic support for vulnerable children and families which focuses on life circumstances and breaking the cycle.
- Re-prioritisation of health improvement activity in the context of continued reduced funding to ensure that health inequalities and prevention, in particular through delivery on the actions as set out in the *On Da Level* Implementation Plan.
- Completion of Domestic Abuse and Sexual Violence Strategy.

10 Targetted more: future work

Looking at the Health Map, there are obvious areas that we have not yet focused on and need to target more. We know that in terms of inequalities our work is firmly focused on delivery of the *On da level* implementation plan. In addition in line with Marmot Report on tackling health inequalities we need to further develop a community asset based approach. The move to working from localities has meant that we have been accessing people who are in greater need which again supports the health inequalities work. As a short-term measure this is proving effective in targeting people who are subject to health inequalities. By targeting our Keep Well checks we are again reaching this group. We achieve good outcomes in all the programmes that we deliver whilst meeting set targets. It is therefore important the direct delivery of programmes in localities and targeted Keep Well checks does not stop until an alternative mode of delivery, proven to be more or equally as effective is in place. However, in the longer-term services must be refocused and owned by communities and at public policy level as we know that this is where the greatest impact can be had in terms of public health.

All health staff have a role to play in tackling the wider determinants of health. In primary care, we still need to develop the capacity to do prevention, early intervention, supported self-management and anticipatory care effectively and as a core part of the service we deliver. As stated previously we know that this will pay dividends in terms of better health and quality of life, and reduce the demands on services in the longer term.

In secondary care we need to continue our work through MCNs and the wider workforce by helping staff see their role in health improvement, reinforcing the messages of the Health Promoting Health Service and 'Making Every Health Care Contact Count'. Everyone has a role to play, at times needing to step back to think about the causes of the causes, not merely treating the symptoms. Training staff in all areas of health and social care to deliver health improvement programmes, and brief advice is also required in order to increase capacity across all sectors as part of the longer-term plan, as well as recognition of and action on the wider determinants of health.

The integration agenda presents an opportunity for real joint working across sectors. The Unst **Otago Pilot Programme** which was supported by health improvement is an example

of a project which has relied on integrated working and we will use this as learning for future projects.

Over the next two years we need to work to ensure that we are influencing policy and strategy where we are not currently. We want to work with the following organisations to influence their agendas, to make them as positive and health promoting as possible. Health is everyone's business, and we need to work out what the specific arguments for specific settings would be in order to engage them fully. Critical partners include:

- Integrated Joint Board
- All Shetland Islands Council Executive Managers and Elected Members
- Third Sector
- Zetrans
- Economic Development
- Shetland Recreational Trust
- Shetland Charitable Trust
- Agriculture sector
- Shetland Arts
- Shetland Area Licensing Board

We know that delivering health improvement and public health goes far beyond the role of our teams. We know that health improvement is more than government targets. We have come a great way in targeting our services more but with the current economic position and the need to focus on prevention and early intervention becoming higher on the agenda it is even more imperative that the focus is maintained.

APPENDIX A

CCBT FIRST YEAR EVALUATION

The Computerised Cognitive Behavioural Therapy (CCBT) programme 'Beating the Blues' as part of a European Funded Project pilot. It consists of eight weekly one hour sessions done at weekly intervals and is designed for mild to moderate depression or anxiety. Health Improvement's role was to support people to start the programme and continue with it. NHS Shetland was the only board that delivered support alongside the programme in this way. A pathway and information sheet was developed to outline how the support should be delivered. The end of year evaluation has shown than Shetland performed well within Scotland in terms of completion rates: which has led to funding being extended by a further 12 months and includes an upgrade and update of the CCBT programme.

Shetland Data

The information below has been extracted from the Beating the Blues program.

Usage Data

Stage of Treatment	Patient Numbers
Started Treatment	208
Still Active in Treatment (active in last 4 weeks)*	87
Completed all 8 Sessions	43
Completed 5 Sessions (clinical dose)	60

Completion Rates

Completion rates are calculated only on those patients who are not currently active in the treatment. This equates to 121 patients.

Completion Point	Rate %
All 8 Sessions	36%
At least 5 Sessions (clinical dose)	50%

These numbers are comparable with face-to-face treatment and do not reflect those patients that have dropped out prior to the fifth session as they feel the treatment has been successful. This rate does not include those that do not start treatment.

Clinical Outcomes

Clinical outcome data comes from the CORE OM, which is comprised of 34 questions presented to the patient at the start of the first and fifth sessions and the end of the eighth session. Due to the smaller number of patients analysed the improvement is slightly below the national average where the reduction is to 1.1 for all 8 sessions, the starting point is roughly the same.

APPENDIX B

EVALUATION OF THE FIRST EIGHT SESSIONS OF UNST OTAGO PILOT

The Otago exercise programme is a strength and balance programme which is designed to help people reduce their risk of falling by improving strength, balance and confidence.

It is particularly suited to people who:

- Have experienced a fear of falling
- Sometimes feel unstable on their feet
- Can lack confidence when walking
- Have experienced a fall(s)

The NHS Shetland physiotherapy team led the roll out of this programme in Unst with co-ordination support provided by members of the health improvement team. The programme ties in well with health improvement as it is a multifaceted programme which touches on all areas of health from nutrition to foot care. It provides a way of ensuring that holistic health improvement in vulnerable older people takes place, whilst also increasing mobility.

This project involved input from occupational therapists, podiatry, physiotherapy, opticians, health improvement practitioners, the practice nurse, community nurses, pharmacy and social care staff from Bruce Hall Terrace and Nordalea Care Centre.

Physiotherapy results:

Attendance and progress records were kept at each session. Number of participants attending was as follows:

All 8 sessions	7 out of 8 sessions	6 out of 8 sessions	5 out of 8 sessions	Total number of regular attendees
9	5	1	4	**20**

The physiotherapy measures that were taken at the start of the programme were repeated at the end of the programme and the results were as follows:

- 100% of participants had improved muscle strength
- 100% of participants had improved balance

- 100% of participants had improved confidence
- 100% of participants had increased exercise tolerance

Maintenance of the initial post programme benefits is reliant on regular practice of the exercises by the participants. This is further enhanced by having ongoing follow up classes with participants with full benefits of the programme only being evident 12 months post programme. Unfortunately due to staff shortages it has not been possible to do the follow-up classes as planned. Furthermore plans for the follow up sessions to be run by the Shetland Recreational Trust (SRT) did not go ahead. Therefore, it is predicted that outcome measures in the longer term will be lower than anticipated.

Medication Reviews

All participants underwent medication reviews (which includes consideration of the impact of medication on falls).

Occupational Therapy

As part of the multi-factorial falls risk assessment the occupational therapists (OTs) were able to identify if any individual required a home assessment which was then followed up by the OT team. In addition all participants were given a home safety checklist to complete and bring back, these were all returned and any subsequent actions were undertaken by the OT team.

Participant Surveys:

Participants were issued an anonymised post-programme survey to complete. There was a 95% response rate to the survey from those that regularly attended the programme.

The results of the survey were:

- 95% of respondents said they would recommend the programme to a friend or family member.
- 95% of respondents rated the different aspects of the programme as good or very good (this included: assessment pre-programme, exercise sessions, talks, cup of tea and chat, venue).

- 100% of respondents said that:
    - They felt included in the group,
    - Doing exercises as part of group made them feel confident,
    - They felt the exercise sessions were at the right pace,
    - They felt that the leaders of the exercises sessions and talks were professional, confident, reliable and approachable.
    - They found the talks helpful

- 53 % of respondents managed to practice the exercises twice a week at home between sessions, with 42% managing this sometimes.
- 95% of respondents said they had experienced benefits from being on the programme. This was based on a multiple choice question where they could select more than one answer:

Answer Options	Response Percent	Response Count
Improved mobility	52.6%	10
Improved confidence	84.2%	16
I felt more independent	36.8%	7
Reduced pain	10.5%	2
Social benefits	63.2%	12
Improved knowledge	68.4%	13
Other	5.3%	1
Please expand on your answers		8
answered question		**19**
skipped question		**1**

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When asked to expand on their answer comments were as follows:

- Apart from all round improvement it was contact with the physios and a trust that they knew what they were talking about. The time passed quickly as everyone enjoyed it.
- So good to engage in physical activity with such good leadership and in company. Very difficult to regulate alone. Made me realised there was help with pain in shoulder (after fall) and knees (painful climbing up and down stairs) with physio input plus the benefits of the programme.
- The course has made me more mobile i.e. joints seem more mobile, The talks and the social interaction after the Otego session were also very good.
- I am able to move around more easily. I know better how to do things to help keep myself mobile and really enjoyed the company.
- My legs got stronger. I felt more independent because I could use my walker. I have more understanding of the correct exercises to do.
- Had I been able to continue to the end and not hurt myself I am sure I would have benefited from it.
- More improved confidence, slightly improved independence.
- Although my mobility did not improve, it kept me moving and more supple. This is due to my condition. Overall the programme was excellent and had many benefits

- 63% of participants said that the programme had enabled them to do things they could/did not do before. Comments on this were as follows:

  - Mum more confident, can stand on her own without grabbing for Zimmer etc. can get into the shower with less help, recovered quicker after sliding off the bed onto the floor
  - Only because I am fairly fit and mobile so far
  - Carry trays on the buffet on Northlink ferry. Carry a cup in each hand. Hang out clothes on a windy day. It gave me a lot more confidence
  - My problem is not so much physical as fogginess in my head
  - Still of an age that I am still quite sure on my feet. Went on programme thinking of the future and looking at ways to try and ensure that I do everything I can to prevent me from falling
  - I am more confident getting in and out of chairs and going up and downstairs. I also find it easier dressing and undressing
  - some of the exercises I had not done before
  - balancing on one leg much improved

- I feel more confident using my walker
- Because I hurt myself and I have been less able. I still do the neck exercises
- To walk more confidently
- Not suitable for me
- Got up the stairs

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APPENDIX C
PRIMARY CARE SURVEY

Health Improvement staff have now been based in health centres across Shetland for 18 months. Earlier this year we asked primary care staff to tell us how they found the service and how they thought it should be developed. The results presented below are a summary of the anonymised responses from the 35 primary care staff who replied.

100% of respondents answered 'yes' to the question 'Have you found it useful to have a health improvement practitioner working in your practice?'

There was general agreement that Health Improvement Practitioners (HIPs) bring a level of flexibility, skill and experience that isn't otherwise available. Holistic support as well as specific behavioural support (weight management, smoking cessation) has been provided to patients, but staff have also used the HIP 'as a useful resource to augment our own knowledge', and to discuss patients with.

'Many patients come with problems...that require a more holistic approach, and HIP proves an excellent resource for those needs that cannot be met by a prescription.'

'I feel that the patient is getting a much better service from having a dedicated health improvement officer, as personally, I can't give the same expert advice that a HIO (Health Improvement Officer) can give'

'We have managed to get patients to engage who have never engaged before'

'I think the HIOs make a valuable contribution to the patient experience as we are able to offer a more holistic approach right on the patients' doorstep. From a multi-disciplinary team perspective, it's a great all round service – someone to discuss patients, seek advice from, etc. In my opinion, an extremely valued and integral member of the team.'

'I use the HIP a lot following up families with obese children. The whole families need help, and often part of the problem is motivation for exercise and lack of access to services...'

'Healthier patients are less likely to need GP appointment slots, which can be allocated more readily to more urgent problems'

'I am amazed at how much you do offer'.

'What they offer is invaluable and professionally delivered; they are very forward thinking'.

'Changed my life'

'I am really impressed with the services we have been given access to. This has freed up clinical time and provided a more seamless service.'

'Me (and a lot of my patients) would be heading towards insulin'.

'Invaluable, please don't change it.'

Clearly the extra capacity created is welcomed; this creates an ability to 'strike while the iron's hot', and the HIPs have been able to offer regular follow-up and ongoing support to patients and clients. Staff report that patients are very satisfied with the service and that the clinical time of GPs and practice nurses has been freed up, which has been welcomed.

However there is more work to be developed. Some Primary Care staff were unaware of the range of services that can be offered and didn't feel they knew enough about the skill set of a HIP to know what they could or couldn't ask them to do. So one action this coming year will be to publicise these and to make it clear that Health Improvement Practitioners are an incredibly holistic, flexible and adaptable resource which should be used in areas of greatest need – in group work as well as work with individuals; that they have skills in organisational change and development as well as individual behaviour change; that they can work in whatever setting is more appropriate – whether this be a patient's home, the surgery, a youth club or the local garage; and that they are trained to seek solutions to problems and to overcome barriers. They have skills in needs assessment, data gathering and analysis, so can help organisations to understand and analyse patterns of health and ill health within their organisations, and help to prioritise actions to address these.

The full survey report is available from the Health Improvement Team.

Appendix D

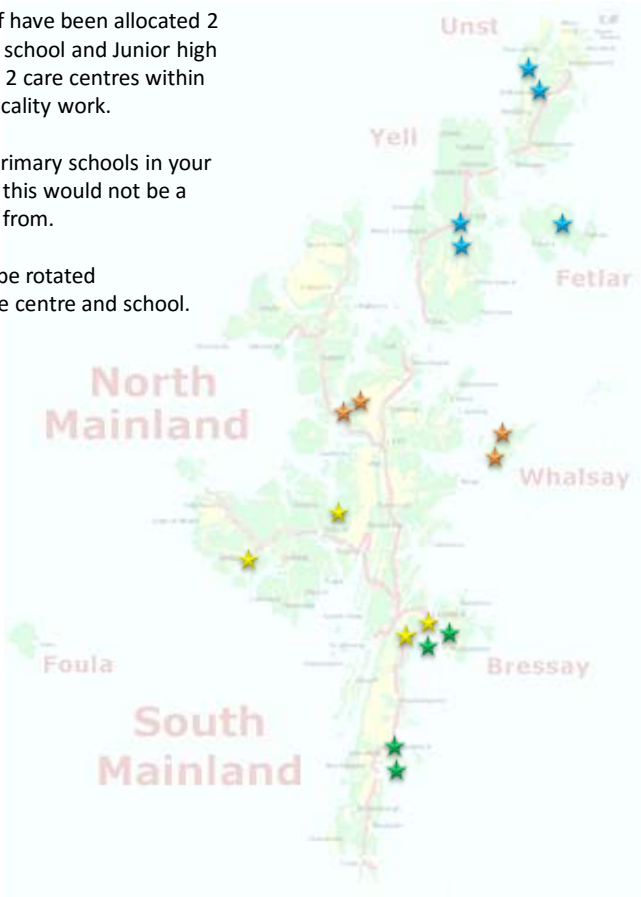
Health Improvement Staff and localities

Schools and Care Centres

Full time staff have been allocated 2 schools (high school and Junior high Schools) and 2 care centres within the area of locality work.

Link in with primary schools in your area also but this would not be a base to work from.

Time should be rotated between care centre and school.



Lauren
• Unst – Unst H.C (Tuesday fortnightly) and Nordalea Care Centre, Baltasound school JHS and Fetlar school.

• Yell H.C (Monday) – Isleshaven Care Center, Mid Yell JHS.

Nicola
•Hillswick H.C (Tuesday) Brae H.C (Monday) and Northhaven Care Centre and Brae High School.
•– Whalsay H.C (Thursday fortnightly) and Fernlea Care Centre and Whalsay JHS.

Jill
•Lerwick H.C (Thursday) and Anderson High School and one of ET or Taing
•Walls H.C (Tuesday fortnightly) and Wastview Care centre, Aith JHS.

Lucy
• Lerwick H.C (Thursday fortnightly)– Anderson High School and one of ET or Taing
•Sandwick JHS and Overtonlea Care Centre

Mel
• Levenwick H.C (Thursday)

Appendix E

Glossary

ABI	Alcohol brief Intervention
Active Travel	Incorporating physical activity into travel, rather than relying on cars
BBV	Blood Borne Virus
BMI	Body Mass Index (BMI) is calculated by dividing an individual's weight in kilograms by their height in metres squared.
CAB	Citizens Advice Bureau
CMO	Chief Medical Officer: Chief advisor to the Scottish Government on protecting and improving the population's health
CMP	Condition Management Programme
CCBT	Computerised Cognitive Behavioural Therapy
DCE	Detect Cancer Early
EMIS	Egton Medical Information Systems – Electronic Patient Record System
GBV	Gender Based Violence
GIRFEC	Getting It Right for Every Child
HBSC	Health Behaviour in School Children (Survey)
HCV	Hepatitis C Virus
HIP / O	Health Improvement Practitioner / Officer
HIV	Human Immunodeficiency Virus
HPHS	Health Promoting Health Service
HWL	Healthy Working Lives
Incidence	The number of new cases of a particular condition disease during a specific period of time, e.g. 20 cases of flu in Shetland during a year
Keep Well	A programme which includes Health checks to identify risk factors for heart disease and stroke
MCN	Managed clinical network
NPS	Novel Psychoactive Substance
Otago	A programme which aims to prevent falls, by developing balance and gentle physical activity
Prevalence	The number of cases of a particular condition or disease at a specific point in time
SCHWL	Scottish Centre for Healthy Working Lives
SDCMH	Scottish Development Centre for Mental Health
SCOTT	A child healthy weight programme
SALSUS	Scottish Adolescence Substance Use Survey
SIMD	Scottish Index of Multiple Deprivation
Unit of alcohol	One **unit of alcohol** (UK) is defined as 10 millilitres 8 grams of pure alcohol – this is designed as a way of being able to compare the alcohol content of one drink with another.

Shetland Islands Health and Social Care Partnership

Agenda Item

2

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	23 November 2016
Report Title:	Scotland's Charter for a Tobacco Free Generation	
Reference Number:	CC-80-16 F	
Author / Job Title:	Elizabeth Robinson / Public Health Principal	

Decisions / Action required:

The IJB is asked to show support for Shetland and Scotland becoming tobacco-free by signing up to Scotland's Charter for a Tobacco-free Generation and helping work towards a Shetland and Scotland where our children can live smoke-free lives.

High Level Summary:

Scotland has a vision of creating a tobacco-free generation with fewer than 5% of the population still smoking by 2034.

Scotland's Charter for a Tobacco-free Generation is aimed at organisations whose work directly or indirectly impacts on children, young people and families.

The aim of Scotland's **Charter for a Tobacco-free Generation** is to:

- inspire organisations to take action to reduce the harm caused by tobacco;
- raise awareness of the goal of creating a tobacco-free generation of Scots by 2034 and the Scottish Government's tobacco control strategy and;
- support organisations whose work impacts on children, young people and families.

The Charter has six key principles that encourage discussion and enable organisations to examine how their own policy and practice can best contribute to the tobacco-free goal:

1. every baby should be born free from the harmful effects of tobacco;
2. children have a particular need for a smoke-free environment;
3. all children should play, learn and socialise in places that are free from tobacco;
4. every child has the right to effective education that equips them to make informed positive choices on tobacco and health;
5. all young people should be protected from commercial interests which profit from recruiting new smokers;
6. any young person who smokes should be offered accessible support to help them to become tobacco-free.

Corporate Priorities and Joint Working:

The main priority of the Public Health Directorate is to improve and protect the health of the people of Shetland; and it works towards meeting all the National Health and

Wellbeing Outcomes.

Joint working is essential for nearly all areas of public health and health improvement work. It is key in tackling alcohol, drugs and tobacco; primarily through the Drug and Alcohol Partnership.

Key Issues:

The Charter for a Tobacco Free generation contributes to the following National Health and Wellbeing Outcomes:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People who use health and social care services are safe from harm.
- Health and social care services contribute to reducing health inequalities.

Smoking harms nearly every organ of the body and affects a person's overall health, well-being and mortality whilst exposing others to the hazards of second-hand smoke.

Children growing up with parents or siblings who smoke are around 90% more likely to become smokers themselves. Similarly, though probably less strong, influences on smoking behaviour are likely to result from exposure to smoking outside the home.

Most smokers in the UK start smoking before they reach the legal age of sale for tobacco of 18 with early uptake being associated with future heavier smoking and poorer health outcomes.

We know that cigarettes kill half of lifelong regular smokers, and for each of these an average of 22 years life expectancy will be lost.

Smoking is a leading cause of Chronic Obstructive Pulmonary Disease (COPD), and COPD is a leading cause of repeated admissions to hospital. Smoking cessation is the single most effective and cost-effective way to reduce the risk of developing COPD and stop its progression. (http://www.who.int/respiratory/copd/management/en/) There were 276 people recorded as having COPD in Shetland in 2014-15 (QOF).

The table below, from ScotPHO[1], shows 2013 and 2014 numbers of deaths and diseases associated with smoking in Shetland.

Smoking Attributable Deaths and Disease	Year	3 year average
Smoking attributable deaths	2014	32
Lung cancer deaths	2013	13
COPD deaths	2013	6
Smoking attributable admissions	2013	434
Lung cancer registrations	2013	15
COPD incidence[2]	2013	41

Signing up to the Charter would contribute to our Public Health Ten Year Strategy, which aims to reduce smoking to 5% of the adult population by 2022, and has three strands:

- ***Prevention*** - creating an environment where young people choose not to smoke

[1] ScotPHO (The Public Health Observatory for Scotland) Tobacco Control Profile for Shetland 2016 (accessed 13.10.16)

[2] Number of new cases diagnosed (average of last 3 years)

- ***Protection*** - protecting people from second-hand smoke
- ***Cessation*** - helping people to quit smoking

Exempt and/or confidential information:
None

Implications :	
Service Users, Patients and Communities:	Smoking is strongly associated with poor health related quality of life. It is also associated with higher illness and death mortality, while stopping smoking at any age reduces these risks. The children of today will be the patients of the future, and it is in our interests to support them in being as healthy as possible for as long as possible.
Human Resources and Organisational Development:	Opportunities will continue to be provided for staff to access stop smoking support if they require it, and staff will continue to be asked to act as non-smoking role models. Training will be offered to all front line staff in delivery of brief smoking cessation interventions.
Equality, Diversity and Human Rights:	We know that people who experience inequalities, poverty, discrimination and adversity are more likely to smoke, and more likely to need support in stopping smoking. Signing up to this Charter will demonstrate commitment to creating a smoke free environment for all.
Legal:	Legislation is essential to reduce the harm caused by alcohol, tobacco and drugs at a national level. All public health and health improvement work is conducted within existing legislation.
Finance:	All work of the Public Health Directorate is largely within existing resources although external funding is sought and has been secured for specific projects. Preventing children from starting smoking or being exposed to second hand smoke is an investment in the future health of the Shetland population.
Assets and Property:	There are no implications for major assets and property.
ICT and new technologies:	There are no ICT issues arising from this report.
Environmental:	There are no environmental issues.
Risk Management:	If the work outlined in the first part of this report is not continued and developed, particularly relating to prevention and early intervention, there is a considerable risk of an increase in harm caused, the cost to society and number of people affected by alcohol, drugs and tobacco. Similarly, not continuing and not

	further developing all the work outlined in part two would result in a considerable risk of an increase in harm caused, the cost to society and number of people affected by a variety of health issues including obesity, inactivity, cancer, mental health problems, sexual health problems, gender based violence and communicable diseases.	
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 has authority to resource and direct the work of a number of services, such as Primary Care and Substance Misuse Recovery Team that work in partnership with the Public Health Directorate.	
Previously considered by:	NHS Shetland Board Meeting	4 October 2016

Contact Details:
Elizabeth Robinson Public Health Principal
Elizabethrobinson2@nhs.net

Appendices:
None

Background Documents:
The Charter Brochure:
http://www.ashscotland.org.uk/media/6377/Charter%20Brochure.pdf

The Charter Factfile:
http://www.ashscotland.org.uk/media/6379/TF%20Charter%20fact%20file.pdf

Shetland Islands Health and Social Care Partnership

Agenda Item

3

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	23 November 2016
Report Title:	Adult Protection Committee – Constitution	
Reference Number:	CC-84-16 F	
Author / Job Title:	Kate Gabb / Lead Officer Adult and Child Protection	

Decisions / Action required:

This report presents an updated Constitution for the Shetland Adult Protection Committee to the Integrated Joint Board for their consideration and agreement.

High Level Summary:

The purpose of this report is to provide information to the IJB about the Shetland Adult Protection Committee and its updated constitution

The Adult Support and Protection (Scotland) Act 2007 gives a statutory duty to Local Authorities and partner agencies to have an Adult Protection Committee Chaired by an independent Convener. The purpose of the committee is to ensure the provision of adult protection procedures, support interagency working to protect adults, to provide information and advice about adult protection, support training and the improvement of the skills and knowledge of staff

Section 44 of the Act allows Adult Protection Committees to regulate their own procedures and to ensure they have an up to date constitution in place. The constitution presented to the IJB has been updated to include new members- Scottish Fire and Rescue and Scottish Ambulance Service. It has also been updated to reflect the creation of the IJB and the building of appropriate links between the IJB and eth Adult Protection Committee

As all matters relating to adult social care and social work and Primary Health care are part of the remit of the IJB it is appropriate for the IJB to consider the constitution.

Corporate Priorities and Joint Working:

Under Section 42 of the Adult Support and Protection (Scotland) Act 2007 each local authority area has a legal responsibility to have an adult protection committee. This promotes partnership working in order to protect vulnerable adults in Shetland.

Key Issues:

To note that the Shetland Adult Protection Committee's updated Constitution (June 2016) has been amended to include the Scottish Fire and Rescue Service and Scottish Ambulance Service as members and updated to reflect the creation of the IJB.

Exempt and/or confidential information:		
None.		
Implications :		
Service Users, Patients and Communities:	Protecting vulnerable adults and supporting the work of the Shetland Adult Protection Committee	
Human Resources and Organisational Development:	The development and implementation of a multi-agency training strategy to all committee members ensures that staff are confident in delivery this strategy.	
Equality, Diversity and Human Rights:	Promoting equality and protection of vulnerable groups.	
Legal:	The Adult Support and Protection (Scotland) Act 2007 (http://www.legislation.gov.uk/asp/2007/10/contents) and Code of Practice April 2014 (www.gov.scot/Resource/0045/00455465.pdf)	
Finance:	Within existing resources.	
Assets and Property:	There are no implications for major assets and property.	
ICT and new technologies:	There are no ICT issues arising from this report.	
Environmental:	There are no environmental issues.	
Risk Management:	Identifying and responding to adults who may be at risk of harm and ensuring that individual risk assessments are in place for those adults is key part of the work of staff	
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. Part of the IJB's remit is to have an oversight of adult protection issues.	
Previously considered by:	The Adult Protection Committee. The Chief Officers' Group for Adult & Child Protection, MAPPA and MARAC.	17 June 2016 24 June 2016

Contact Details:
For further information please contact:
E-mail:
Telephone:
8 November 2016

Appendices:
Appendix 1 – APC Constitution

Shetland Adult Protection Committee

CONSTITUTION – June 2016

We agree this constitution:

Signed:

_____
Chair, Shetland Adult Protection Committee

_____
Chief Executive, Shetland Islands Council

_____
Chief Executive, NHS Shetland

_____
Chief Inspector, Shetland Area Command,
representing the Chief Constable, Police Scotland

_____
Chief Officer, Shetland Integrated Joint Health and Social Care

1. Shetland Adult Protection Committee

The name of the Committee is Shetland Adult Protection Committee (referred to as APC).

APC is a multi-agency body established under the terms of the Adult Support and Protection (Scotland) Act 2007 to ensure a co-ordinated approach to the protection of Vulnerable Adults (referred to as Adults in Need of Support and Protection) within Shetland.

APC covers the geographical area coterminous with that of Shetland Islands Council.

2. Aims and Responsibilities

APC is the primary strategic and planning forum for interagency adult protection work in Shetland.

The main aim of the APC is to provide the highest standards of inter-agency practice in preventing and responding to the abuse of adults in need of support and protection.

The APC is responsible for monitoring the implications of Shetland's Procedures – Adults in Need of Support and Protection.

3. Definitions

3.1 An adult in need of Support and Protection is defined as a person aged 16 or over who:

- Is unable to safeguard his/her own well-being, property, rights or other interests,
- Is at risk of harm, and
- Because he/she is affected by disability, mental disorder, illness or physical or mental infirmity, is more vulnerable to being harmed than adults who are not so affected

3.2 An Adult is at risk of harm if:

- Another person's conduct is causing (or likely to cause) the adult to be harmed, or
- The adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm

3.3 Abuse is a violation of an individual's human and civil rights by any other person or persons. It is the wrongful application of power by someone in a dominant position. Whatever setting abuse may occur within, it involves elements of a power imbalance, exploitation and the absence of full consent. It can involve acts of commission or omission.

4. Functions

4.1 The functions of the APC are determined by statute and are:

a) To keep under review the procedures and practices of member agencies that relate to the safeguarding of adults at risk in Shetland.

b) To provide information and advice, or make proposals to any member agency or relevant body on the exercise of functions that relate to the safeguarding of adults at risk.

c) To promote the improvement of skills and knowledge of staff providing services to adults at risk

d) To respond to the requirements of Scottish Ministers as appropriate

4.2 The APC will discharge its functions by:

a) Collaborative interagency working to ensure that agreed joint policies and procedures are in place to respond effectively to protect Adults in need of Support and Protection.

b) Ensuring the development and implementation of a multi-agency Adult Protection Strategy across Shetland.

c) Monitoring and Evaluating the effectiveness of both multi agency Adult Protection and single agency practice and complaints with agreed procedures and reporting to member agencies the outcome of evaluation and quality measures.

d) Ensuring that member agencies are informed of new legislation, guidance and examples of best practice.

e) Producing and disseminating public information on adult protection to raise awareness and influence attitudes to abuse.

f) Establishing an agreed mechanism for the multi-agency review of critical incidents or conducting Significant Case Reviews to promote continuous improvement in service quality.

g) Conducting an annual audit of interagency protection practice within Shetland, including carrying out case reviews..

h) Consider and make recommendations to resolve interagency operation problems or difficulties known to the committee.

i) Ensuring that multi agency and individual training and support needs are identified and met through the development and implementation of a multi agency training strategy.

j) Establishing and maintaining good communication and collaboration practices between local agencies with a responsibility for adult protection.

k) Publishing an annual report covering the activity of all committed agencies. In addition the Independent Convener will produce a Biennial Report for Scottish Government Ministers.

l) Agree the requirements of collecting and analysing management and performance information

m) Promoting direct links between child protection, adult protection and offender management services.

4.3 The APC may establish sub groups to assist in the discharge of its functions/responsibilities.

a) Membership of such sub-committees or working groups will be by agreement of APC and may include people who are not APC members where appropriate.

b) When establishing a sub-committee or working group APC will establish a remit and timescale.

c) APC currently has Standing Sub-Committees on Training, Quality Assurance, Protection in the Community and Health. APC may at any time, by majority agreement, decide to create new Standing Sub-Committees or dissolve existing Standing Sub-Committees.

d) All sub-committees and working groups are accountable to APC through the APC Convener. Unless specified by APC, subcommittees and working groups will appoint their own Chair.

e) A minute of all meetings of sub-committees and working groups will be taken and will be available to APC members and member agencies.

f) The constituent agencies of the sub-committee or working group are responsible for making arrangements available for the proper taking and distribution of agendas and minutes.

4.4 APC works to a business plan as completed by APC.

5. Membership of Committee

5.1 In line with current legislative requirements, Shetland Islands Council may appoint to the Committee, individuals who appear to it to have skills and knowledge relevant to the functions of the APC. Shetland Islands Council will also appoint members to the APC from all agencies with a statutory responsibility for protecting Adults in Shetland.

The following will be represented:

a) Shetland Integrated Joint Health and Social Care
Criminal Justice (attending as and when required/requested)

b) Shetland Islands Council:
Legal Services
Workforce Development Team
Housing Services
Chief Social Work Officer (Executive Manager, Children & Families)

c) NHS Shetland
   Primary Care including Community Nursing
   Secondary Care
   Accident & Emergency
   Advanced Nurse Practitioner (Protection)
   General Practitioner

d) Police Scotland

e) Third Sector

f) Crown Office and Procurator Fiscal Service

g) Scottish Fire and Rescue Service

h) Scottish Ambulance Service

i) Care Inspectorate (As and when required, or when requested by Care Inspectorate)

5.2 Member agencies will ensure that their representative hold a position of sufficient seniority to commit to decisions regarding policy, practice and resources on behalf of their agency.

Representatives will have the necessary skills and knowledge relevant to the functions of the committee.

5.3 If a nominated representative is unable to attend a meeting they may arrange for a substitute to attend on their behalf. Such representatives will have the authority normally vested in the nominated representatives.

5.4 As necessary for the effective functioning of the Committee and in accordance with statutory provision, relevant external organisations or individuals may attend. Organisations include:

- The Mental Welfare Commission
- The Public Guardian
- The Care Inspectorate where there is no constituent representative
- Any other public body or office-holder as Scottish Ministers may specify
- Representatives from the voluntary and private sectors

6. Roles & Responsibilities of APC Members

6.1 To regularly attend APC Meetings.

6.2 To arrange for an appropriate substitute to attend meetings of the APC as required.

6.3 To represent their agency and contribute to decision making with the delegated authority of their agency.

6.4 To reflect agency accountability in inter-agency decision making.

6.5 To collate the views of agency officers on particular issues as necessary, and to ensure that these are made available to the APC.

6.6 To ensure that decisions and/or recommendations of the APC are implemented in their own agency.

6.7 To ensure, in partnership with others, that inter-agency strategy in relation to adult protection is implemented on a Shetland wide basis, in accordance with the decisions and recommendations of the Committee.

6.8 To provide the APC with any information, which the Committee may reasonably require for the purposes of performing its functions.

6.9 To ensure the distribution of minutes of APC meetings to appropriate officers in their own agency.

6.10 To operate in accordance with the agreed strategy for adult protection.

6.11 The Independent Convener will report to the Chief Officer's Group.

7. Meetings

7.1 Ordinary business meetings of the APC will normally be held quarterly or at least on 4 occasions each year. Additional extraordinary meetings may be called for specific principles as required.

7.2 Meetings of the APC will be considered quorate for the purposes of decision making if one representative from each of NHS Shetland, Police Scotland and Shetland Integrated Joint Health and Social Care is represented. The APC will not be considered quorate in the absence of a representative from Social Care.

In the absence of a quorum, the APC may only meet to make recommendations for consideration by future meetings.

7.3 APC meetings will be convened by the Convener with administrative support. The agenda will be agreed by the Convener in discussion with the Lead Officer Child and Adult Protection and sent out in advance of the meeting, together with any relevant papers. Members of the APC may contribute to the agenda setting via the Convener.

7.4 Shetland Islands Council will service the meetings, all of which will be minuted.

7.5 Draft minutes of each meeting will be prepared and when approved by the Convener, circulated as soon as possible after each meeting.

7.6 From time to time the APC will discuss operational matters relating to individual cases or service providers (e.g. when reviewing significant cases). The identity of individuals under discussion will be protected as far as possible. Such discussions are confidential to the Committee and the Committee will determine how and with whom this information is shared. Quarterly statistics/Management information will be treated as confidential.

8. Convener and Vice-Convener

8.1 The Convener shall be appointed from amongst the membership of the APC by Shetland Islands Council for a period of 3 years, based on a recommendation to them from the APC. The Vice Convener shall be elected by APC members from amongst their members for a period of 3 years. In accordance with the provisions of the Adult Support and Protection (Scotland) Act 2007, the Convener will not be a local authority elected member or officer.

8.2 The Convener will be appointed on the basis of his/her relevant experience, expertise, seniority and capacity to ensure effective decision making and to represent the interests of all member agencies.

8.3 The Convener is responsible for convening and conduct of APC meetings in accordance with its constitution. In particular s/he is responsible for:

a) Chairing the meetings of the APC and the Quality Assurance Sub-group of the APC, and ensuring that they are conducted in a manner which reflects the contribution that all agencies have to make to adult protection.

b) Ensuring that the APC effectively fulfils its functions

c) Ensuring the development of the annual business plan

d) Working collaboratively with the Lead Officer Child and Adult Protection.

8.4 The Convener will represent APC as required at external meetings and functions, and to the wider public, including any communication with the media.

8.5 In the absence of the Convener, the Vice Convener will assume the responsibilities and functions of the Convener.

8.6 In the absence of the Convener and Vice Convener, members of the APC in attendance may, by agreement, identify a substitute for the purpose of Chairing that day's meeting.

8.7 The Convener will ensure the preparation of a Biennial Report setting out the functions and activity of the APC. The report will be submitted for approval to the Shetland Islands Council, NHS Shetland and Police Scotland. Copies of the approved report will be provided to member agencies and to:

- Voluntary Action Shetland
- Scottish Ministers

- The Mental Welfare Commission for Scotland
- The Public Guardian
- The Care Inspectorate if not a constituent member of the Committee
- Any other public body or office-holder as specified by Scottish Ministers
- The Convener will present the report to the Chief Officer Group.
- The Chief Social Work Officer will present the report to Shetland Integration Joint Board.

8.8 Shetland Islands Council shall be responsible for meeting the reasonable expenses incurred by the Convener in carrying out his or her duties in terms of the Act and this Constitution. The Convener's expenses shall be calculated, vouched and paid on the same basis as if they were a member of Shetland Islands Council. At the time of appointing the Convener the Shetland Islands Council shall decide on the amount of the remuneration, if any, of the Convener. The Convener's duties and responsibilities shall be set out in his or her letter of appointment which will also detail the Shetland Islands Council's decision regarding remuneration.

9. Confidentiality and Information Sharing

9.1 It is critical that, within APC, members are able to have available and discuss detailed information on a range of issues, which will often be sensitive and confidential. The working assumption for the APC is that members will treat APC papers and information as in confidence unless specifically agreed otherwise.

9.2 In general, papers and minutes will avoid the possibility of any particular individual or his/her family being identified. At times, individuals may be identifiable even where not named. APC papers and information will be made available under the Freedom of Information Act unless business is specifically declared as confidential and not for disclosure.

9.3 Members will ensure secure storage of all confidential APC materials.

10. Arrangements for amending this Constitution

10.1 Any amendments to this constitution will be agreed by APC by simple majority, the Convener having the casting vote. The amended Constitution will be referred to the Chief Officer Group and, if the amendments concern a change in membership, also to Shetland Integration Joint Board.

END

Shetland Islands Health and Social Care Partnership

Agenda Item

4

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	23 November 2016
Report Title:	Performance Overview	
Reference Number:	CC-81-16 F	
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care	

Decisions / Action required:

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

High Level Summary:

This report summarises the activity and performance within the functions delegated to the IJB. Key Performance Indicators for the set aside services will continue to be included through this year's reporting cycle. The IJB must consider performance against the Strategic Plan. Performance monitoring allows the IJB to understand progress against priorities and to direct through the Chief Officer, particular actions.

Corporate Priorities and Joint Working:

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

Key Issues:

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

Key areas for the IJB to note are:

— Appendix A
Projects and Actions for the Community Health & Social Care Directorate with current progress statements

— Appendix B
The Sickness Absences indicator continues to decrease due to the ongoing work of Team Leaders and Managers working with their respective staff groups with the support of both HR departments

FoISA responded to within 20 days has reached 100% (excellent) for Quarter 2.

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

— Appendix D
CCR001 - Delayed discharges have consistently remained between 0-2 in number.

PPS003 – An increase this quarter in the number of polypharmacy reviews has been due to the application of the Prescribing Action Plan.

ASW001 – Percentage of assessments completed on time has dropped to 92% as a small number of assessments took longer to complete due to staff availability.

— Appendix E
Complaints recorded to date. When there is a complaint which relates to a situation where the actions of both the NHS and the Council are involved, there is an agreed joint process for the investigation stage. Thereafter the Council is obliged to deal with complaints about its services in terms of the statutory social work complaints procedure. The appendix shows the number of complaints received from the health part of the directorate. For social care more robust recording of complaints is being addressed and Q3 report will show a more balanced view.

Exempt and/or confidential information:	
None	
Implications :	
Service Users, Patients and Communities:	The Scheme of Integration states that the Parties will listen and respond to community needs and aspirations. Performance will form part of the discussions that the IJB has with communities.
Human Resources and Organisational Development:	There is a continued focus on recruitment and retention including supervision, learning and development and some recent successful recruitment to key posts. The service continues to work in partnership with HR services across both Parties.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
Legal:	The IJB must monitor performance with regard to the functions delegated to the IJB by SIC and NHSS (the Parties) under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014. The IJB and the Parties must share information in this regard. Performance monitoring allows the IJB to measure performance and monitor progress towards achieving agreed national and local outcomes.
Finance:	Performance monitoring allows the IJB to make decisions on priorities and to direct expenditure to particular areas through the strategic planning process.
Assets and Property:	There are no implications for major assets and property.

ICT and new technologies:	There are no implications for ICT and new technologies.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Effective performance management is an important component of that which requires the production and consideration of these reports. Failure to deliver and embed this increases the risk of the IJB not working efficiently, failing to focus on customer needs and being subject to external scrutiny. Key risks are reviewed regularly using the IJB Risk Register and the Directorate Risk Register,
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.

Contact Details:
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1 November 206

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

Background Documents:
Community Health & Social Care Directorate Plan

Appendix A - Projects and Actions - Integrated Joint Board

Report Type: Actions Report

Generated on: 16 November 2016

Report Layout: IJB Simple Actions

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP017b Implement findings outlined within Mental Health review	Implement findings outlined within Mental Health review (2014)	People are able to access a mental health service which is able to respond appropriately to need.	Planned Start	06-Jan-2015		A number of actions in progress but needing completion. Refreshed action plan drafted. Additional expertise brought in to accelerate completion of strands of work.	Community Health & Social Care Directorate
			Actual Start	06-Jan-2014	71%		
			Original Due Date	31-Mar-2015	Expected Success		
			Due Date	30-Jan-2017			
			Completed Date		Experiencing issues, risk of failure to meet target		

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

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

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP026 Develop a joint Organisational Development and Workforce Strategy	Develop a joint Organisational Development and Workforce Development Strategy	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Planned Start	01-Apr-2015		Joint Strategy currently in draft form will be presented to the next Joint Staff Forum on 27 September 2016 with a view to presenting to the IJB in January 2017.	Community Health & Social Care Directorate
			Actual Start	11-Nov-2015	70%		
			Original Due Date	31-Mar-2016	Expected Success		
			Due Date	30-Dec-2016			
			Completed Date		Experiencing issues, risk of failure to meet target		

Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP027 Development of Oral Health Strategy	Deveopment of Oral Health Strategy	People are able to look after and improve their own health and wellbeing and live in good health for longer	Planned Start	01-Apr-2015		Oral Health Strategy approved by IJB on 28 June and NHS Board on 23 August 2016. Detailed action plan in development.	Community Health & Social Care Directorate; Oral Health
			Actual Start	01-Jul-2015	100%		
			Original Due Date	31-Mar-2016	Expected Success		
			Due Date	30-Sep-2016			
			Completed Date	26-Oct-2016	Likely to meet or exceed target		

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

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

Shetland Islands Council

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Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2013/14	2014/15	2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	
	Value	Value	Value	Value	Value	Value	Value	
OPI-4A Staff Numbers (FTE) - Whole Council	2248	2191	2169	2165	2169	2186	2190	Managers continue to carefully manage staff numbers and associated costs and reflects recruitment pressures in some areas.
OPI-4A-E Staff Numbers (FTE) - Community Health & Social Care Directorate	530	517	493	494	493	494	498	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4A-E+NHS Staff Numbers (FTE) - Community Health & Social Care Directorate inc. NHS			676	682	676	681	685	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4C Sick %age - Whole Council	3.6%	4.2%	3.7%	3.5%	4.0%	2.6%	2.4%	A reduction from previous year reflects a greater focus in maximising attendance.
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.0%	6.0%	5.7%	5.4%	5.7%	4.1%	3.9%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.
OPI-4E Overtime Hours - Whole Council	56,552	64,738	79,071	21,383	17,404	16,403	16,208	Overtime and Overtime budgets are devolved to departmental level. Overtime is often the most cost effective way to utilise existing teams and ensure prompt service to our customers.
OPI-4E-E Overtime Hours - Community Health & Social Care Directorate	1,856	5,675	7,546	2,644	1,218	246	550	Q2 increase due to annual leave cover
E01 FOISA responded to within 20 day limit - Health & Social Care Services	79%	91%	93.5%	85%	96%	92%	100%	Target met.

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

Shetland Islands Council

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

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	Previous Years				Last year	This year	
Code & Short Name	2012/13	2013/14	2014/15	2015/16	Q2 2015/16	Q2 2016/17	(past) Performance & (future) Improvement Statements
	Value	Value	Value	Value	Value	Value	
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	5.7%	5.4%	3.9%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.

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

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

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	Previous Years				Last year	This year
Short Name	2012/13	2013/14	2014/15	2015/16	Q2 2015/16	Q2 2016/17
	Value	Value	Value	Value	Value	Value
Sick %age - Whole Council	4.1%	3.6%	4.2%	3.7%	3.2%	2.4%
Sick %age - Chief Executive's "Directorate"	3.6%	1.4%	2.4%	3.6%	0.3%	1.5%
Sick %age - Children's Services Directorate	2.8%	2.8%	3.7%	2.9%	2.1%	1.6%
Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	5.7%	5.4%	3.9%
Sick %age - Corporate Services Directorate	3.0%	1.6%	2.4%	1.8%	1.0%	1.9%
Sick %age - Development Directorate	3.7%	2.7%	4.2%	3.5%	3.2%	3.0%
Sick %age - Infrastructure Directorate	4.0%	3.4%	4.0%	3.8%	3.8%	2.1%

Appendix C - Directorate Performance Report – Local Delivery Plan

Shetland Islands Council

Generated on: 16 November 2016

Local Delivery Plan

Code & Short Name	Years				Quarters				(past) Performance & (future) Improvement Statements
	2014/15		2015/16		Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Target	Value	Value	Value	Target	
LDP001 People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support	75%	50%	45.3%	50%	45.3%	45.3%	43.7%	50%	Note: this is an interim measure showing the percentage of people with newly diagnosed dementia who take up the offer of post diagnostic support (ie have an active link worker) as national data is not yet available. National data due Dec 2016.
LDP002 18 weeks referral to treatment for Psychological Therapies	62.5%	90%	94.4%	90%	94.4%	75.7%	76.6%	90%	The cCBT service introduced in September 2014 continues to have a positive impact on COMPLETED wait reporting. NB this positive results masks the long ONGOING waits for those needing face-to-face therapy.
LDP003a Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery			90%	90%	90%	75%	100%	90%	Target met
LDP003d Clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery	100%	90%	100%	90%	100%	100%	77.8%	90%	7 of 9 clients seen within 3 weeks this quarter.
LDP004 Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	438	240	360	261	360	41	77	129	We remain behind trajectory on this target. Health Improvement delivered the vast majority of ABIs on behalf of primary care, and staff reductions means smaller capacity. The actual number of ABIs recorded as being delivered in Primary Care remains low. Maternity are moving over to electronic system which will make data extraction much easier, and links are being developed with Community Pharmacy to capture the contribution that they make.
LDP005 48 hour access or advance booking to an appropriate member of the GP team	73.2%	90%	76.4%	90%	Not measured for Quarters	Not measured for Quarters		Not measured for Quarters	Practices run a mix of advanced booking, triage and on the day appointments through walk in clinics. Advance booking relates to the opportunity to have an appointment with a member of the clinical team, not a named GP. The largest practice currently has GP vacancies which is impacting on access, with several other practices also having vacancies. In the future National data will only produced every 2 years – next publication due in May 2018.
LDP006 4 hours from arrival to admission, discharge or transfer for A&E treatment	97.6%	98%	95.5%	98%	95.5%	94.7%	95.3%	98%	582 presentations out of 627 left A&E Department within four hours

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

Shetland Islands Council

Generated on: 16 November 2016

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

	Years		Quarters					
Code & Short Name	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Value	Value	Value	Target	
ASW003 Percentage of outcomes for individuals are met	Not measured for Years							The new system for gathering this has been delayed until the start of April 2017 in order for training of all staff to be completed.
PC002 Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre			100%	100%	100%	100%	100%	Monthly data return from practices shows 100% compliance for those patients who need to speak to a healthcare professional on the day
PC004 Percentage access to a Primary Care health professional for an appointment within 48 hours at any Shetland Health Centre			100%	100%	100%	100%	100%	Monthly data return from practices shows 100% compliance for those patients who request an appointment within 48 hours

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

	Years		Quarters					
Code & Short Name	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Value	Value	Value	Target	
CCR003 Percentage of people 65 and over receiving intensive care package (over 10 hours per week) in their own home rather than a care setting.	41%		41%	46%	47%	50%	40%	We are continuing to promote reablement programmes and personalised support to enable people to remain at home.
CCR007 Number of 65 and over receiving Personal Care at Home.	214	200	190	199	195	208	200	Personal care is offered to individuals with assessed need when they have no alternative suport systems in place. We are working closely with the Intermediate Care Team to reduce the need for personal care.
CN002 Number of early supported discharges with no readmission in 30 days by Intermediate Care Team		100%	100%	94%	100%	91%	100%	12 Intermediate care patients - 9 Early Supported Discharge, 1 Admission avoidance, 1 discharge from care centre, 1 declined by patient 1 Readmission for clinical reason
MH002 Admission rates to Psychiatric Hospitals			5	3	6	3	6	This will help us consider the effectiveness of our local service provision.

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
MH003 People with a diagnosis of dementia on the QOF dementia register			179	170	169	173	184	More people on the dementia register are dying or moving away than are being diagnosed. Plan in development to provide diagnostic training/awareness for relevant staff (e.g. GPs). Work continues to encourage people to seek earlier assessment and diagnosis. We are also intending to audit all people discharged from hospital with dementia indicated in the discharge summary to ensure that they are on the register so that no potential new diagnoses are missed.
AHP006 Increased number of people receiving home monitoring for health and social care (technology enabled care)			658	657	670	672	599	Latest national performance figures (2012/13) show Shetland ranked in top quartile of local authorities in Scotland for its telecare usage by care at home clients (Source- Draft Joint Inspection of Adult Services 2014/15).

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
CJ002 Percentage of offenders (supervision) seen within 5 working days of the order being made			100%	100%	100%	100%	100%	Target being met.
ASW001 Percentage of assessments completed on time			100%	100%	100%	92%	100%	Each instance of missed target analysed by line manager
ASW002 Percentage of reviews completed on time			89%	95.6%	91%	90%	100%	The data provided is a measure of 6 monthly reviews. Those that didn't meet this target were due to either a service user, family member or professional not being available on the date set. The reviews were held as soon after the original date as possible. In no case did we exceed the statutory minimum of holding a review within 12 months.

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
DS004 Number of people who are waiting to register with Public Dental Service (PDS) for ongoing Care			930	640	753	704	500	Source: Local data. Despite waiting, all these people are able to access NHS dental care elsewhere.

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
CN001 Number of Anticipatory Care Plans in Place			837	831	917	940	700	Data shows 27 new entries in February but overall reduction in total eKIS numbers reflects more deaths than new summaries put in place

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

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

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
CCR001 Delayed discharge from Hospital - no delays exceeding 14 days			2	2	0	2	2	Intense work with acute services to work out delays in systems and processes
CJ001 Percentage of court reports submitted on time			100%	100%	100%	100%	100%	Service consistently meets target
CJ004 Risk and need assessment completed and case management plans in place within 20 days			100%	100%	100%	100%	100%	Service consistently meets target
PPS002 Percentage rate of antibiotic prescribing in relation to Scottish average			99.05%	114%	98.8%	96.1%	99%	In general we are expecting less antibiotics to be prescribed in Shetland than in the Scottish population.
PPS003 Number of polypharmacy reviews completed			19	22	58	121	30	Polypharmacy reviews bring about better outcomes for patients and often significantly reduce costs. Increase this quarter is due to the application of the Prescribing Action Plan although this level of activity may be difficult to maintain with current staffing resource.
PPS004 Number of discharge prescriptions dispensed out of hours by nursing staff	114	98	166	112	47	34	48	Good discharge planning should reduce the need for nurses to dispense medicines out of hours. Dispensing by pharmacy always more appropriate.

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
CN003 Percentage of Catheter Associated Infections in individuals with an indwelling urinary catheter			0%	0%	0%	0%	0%	No catheter associated infections in the last audit. As this is the 3rd audit in a row to show no infections, we have now moved to 6 monthly audit with the next scheduled audit due in November 2016.

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

Code & Short Name	Years		Quarters					(past) Performance & (future) Improvement Statements
	2014/15		Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
	Value	Target	Value	Value	Value	Value	Target	
DS002 The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland	3,013		2,032	1,703	2,167	2,167	1,670	Sources: Local wte data and ONS population data. The greater the wte of dentists, the greater the available capacity for the resident population to receive NHS dental care. (Scotland ratio 1:1670)
AHP001 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count)			20	7	6	12	10	To achieve the nationally agreed referral to assessment timescales we have initiated a number of initiatives including streamlining our referrals and screening processes, reviewing all processes, and reconfiguring the team into a north and a south team to gain staff efficiency
AHP002 Percentage Waiting Time from Referral to Treatment for Orthotics Services (18 weeks)			98.1%	100%	100%	100%	90%	Each instance of missed target is analysed by line manager.
AHP003 Percentage Waiting Time from Referral to Treatment for Physiotherapy Services (18 weeks)		90%	97%	99.1%	99.2%	99.3%	90%	Service consistently meets target. Significant pressures due to long term sickness absence, and increased number of referrals.
AHP004 Percentage Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)			99.5%	100%	99.2%	100%	90%	Each instance of missed target is analysed by line manager.
CCR005 Occupancy of care homes	88.7%	90%	91.7%	91%	88%	90.3%	90%	Target now being met. The increased use of respite care will result in lost days during change over periods.
CJ003 Unpaid Work commenced within 7 working days	84.2%	100%	85%	92.3%	63.6%	66.7%	100%	Target not reached due to some individuals not attending placements due to employment and other reasons.
PPS001 Percentage spend for Shetland on GP Prescribing compared to the national average			96%	98%	98.1%	96.6%	99%	Shetland has traditionally spent less on medicines per patient. The costs per patient are increasing and there will be a need to undertake additional prescribing efficiency work to maintain the current position..

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

Shetland Islands Council

Generated on: 16 November 2016

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

Code & Short Name	Previous Years						This Year	(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2016/17	
	Value	Target	Value	Target	Value	Target	Target	
E15 Proportion of last 6 months of life spent at home or in community setting	92.1%	90.8%	92.3%	90.8%				Best performing partnership in Scotland. Managed Clinical Network for Palliative Care established in 2015. Note: 2015/16 data due in August 2017.
DS001 Decay experience of children in P1: Percentage of children with no obvious caries in deciduous teeth (children aged 5-6 years in P1 attending SIC primary schools)	80.9%	75%			79.4%	75%		Source: NDIP data. Gives prevalence of dental decay in one age group (P1 or P7) of the total child population.

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

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

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

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

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

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

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

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

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

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

Code & Short Name	Previous Years						This Year	(past) Performance & (future) Improvement Statements
	2013/14		2014/15		2015/16		2016/17	
	Value	Target	Value	Target	Value	Target	Target	
AS005 Number of Social Care staff trained to implement Positive Behaviour Support.			4			6	6	The target of 6 staff trained in 2015/16 is on amber due to long term absence of the trainer. Training is now underway and will be completed in 2016. The 2016/17 intake will be slightly delayed however is anticipated to be completed within the 2016/17 monitoring period. UPDATE 25.10.16. Trainer remains on long term sick leave. Target for 16/17 is on AMBER

APPENDIX E - Summary of complaints for community services in 2016/17

A summary of formal complaint activity for NHS Shetland from 1 April 2016 to 3 November 2016 is set out below. Further detail, including the actions taken as a result of each formal complaint relating to community health in 2016/17 is provided.

From 1 April 2016 to 3 November 2016 the Board received a total of 40 formal complaints. Complaints and feedback staff have also handled 62 patient feedback contacts. Of the 40 formal complaints received in year to date, 23 relate to the community health and social care directorate and three span both community and acute directorates.

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

2016/17	**Quarter 1**	**Quarter 2**	**Quarter 3 (to date)**	**Quarter 4**	**Total**
	1.4.16 – 30.06.16	**01.07.16 – 30.09.16**	**01.10.16 – 03.11.16**	**01.01.17 – 31.03.17**	
Directorate of Acute and Specialist Services	6	4	3		13
Directorate of Community Health and Social Care	10	11	2		23
Acute & Community	1	1	1		3
Board HQ Services	1	0	0		1
Other	0	0	0		0
Withdrawn	0	0	0		0
Total	**18**	**16**	**6**		**40**
Outcome	Upheld: 5 Partly upheld: 8 Not upheld: 5	Upheld: 10 Partly upheld: 5 Not upheld: 1	Open: 6		

Community Health and Social Care Directorate Complaints received 1 April 2016 to 3 November 2016

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

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

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

19	Discharge without pain relief, lack of dignity in death	Acute and community	N		Upheld	• Apology given for poor communication in specific aspects • Recommendation that discharge arrangements to be reviewed • SEA requested to identify specific learning points for future palliative care cases • Training provided to GPs regarding sensitive situations such as examination following death
20	Poor dental service for Northern Isles	Dental	Y		Upheld	• Cuts in dental funding provision explained and apology given • Appointments offered at either Brae or Lerwick to complete required work
21	Allergic reaction to prescribed drug, staff attitude	LHC	Y		Upheld	• SEA carried out by staff member, case to be discussed at practice meeting • Apology provided
22	Inclusion of inappropriate comment in partner's assessment	CMHS	N	Availability of key staff member	Partly upheld	• Explanation about terminology provided and apology for ambiguity
Quarter 3						
23	Poor communication and inability to pre-book GP appt	LHC			Open	
24	Lack of physical examination and missed symptoms	GP and secondary care			Open	
25	Access to treatment	Orthodontics			Open	

Shetland Islands Health and Social Care Partnership

Agenda Item

4a

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board Audit Committee	23 November 2016
Report Title:	Risk Register – IJB	
Reference Number:	CC-82-16 F	
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care	

Decisions / Action required:

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

High Level Summary:

This report summarises the high level risks that affect the IJB. Recognising and highlighting risks facing the IJB will help ensure that appropriate controls are considered and put in place

Corporate Priorities and Joint Working:

Members of the IJB have identified a core set of risks that relate to the Strategic Board with responsibility for directing the integrated functions.

Key Issues:

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

Risk IJB019 remains on a high rating as the current expenditure is exceeding the budget allocation from the NHS, and although a recovery plan is in place the year end position is not likely to balance.

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

Exempt and/or confidential information:

None.

Implications :

Service Users, Patients and Communities:	A robust approach to risk management by the IJB is essential in order to prevent or reduce potentially negative impacts on the integrated functions of Community Health and Social care, and potentially on the Community.

Human Resources and Organisational Development:	Risk management promotes best practice and seeks to ensure the effective delivery of the responsibilities of the Integration Joint Board.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
Legal:	There are no legal implications arising directly from this report. Legal issues are considered as an integral part of the risk management process.
Finance:	There are no financial consequences arising directly from this report.
Assets and Property:	There are no implications for major assets and property.
ICT and new technologies:	There are no ICT issues arising from this report.
Environmental:	There are no environmental issues.
Risk Management:	Risk management is a continuous process which requires that risk information be presented periodically for consideration. The IJB Risk Register ensures that we are actively managing risks, mitigating negative impacts and promoting positive risk taking.
Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. The IJB Audit Committee has responsibility to review risk management and insurance arrangements and receive regular risk management updates and reports (Scheme of Administration and Delegations – Audit Committee Terms of Reference, Section 5.2).
Previously considered by:	This report has not been presented to any other formal meeting.

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3 November 2016

Appendices:
Appendix 1 – Integration Joint Board Risk Register

Background Documents:
Community Health & Social Care Directorate Plan

Risk Assessment - Integration Joint Board

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

Category **Corporate**

Corporate Plan *F5. Our "20 by '20" - Standards of Governance*

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

IJB0022 - Policies - effect of - The IJB fails to adequately identify community needs through the planning processes and is unable to differentiate the particular differences between localities and so cannot begin to address issues arising within a defined community.	Possible	Major	High	• Locality planning in the development of the Strategic Plan. The planning process for the Strategic Plan 2016-19 included conversations at a locality level. Locality leads need to be identified.	Unlikely	Significant	Medium
IJB0023 - Modernisation - too slow - Inability to deliver safe and effective Mental Health services. Unable to deliver the strategic aims and objectives for mental health as set out in the 2016/17-19 Strategic Commissioning Plan.	Almost Certain	Major	High	• NHS Shetland recognise the risk of not being able to deliver the mental health service and have updated their CorporateRisk Register. A range of measures are in place to support the existing team so that they can deliver the clinical service. Additional management capacity procured as an interim measure. External sources providing support and assurance on quality.	Possible	Major	High

Shetland Islands Health and Social Care Partnership

Agenda Item

4b

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board Audit Committee	23 November 2016
Report Title:	Risk Register – Community Health & Social Care Directorate	
Reference Number:	CC-83-16 F	
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care	

Decisions / Action required:

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

High Level Summary:

This report summarises the high level risks that could impact upon the Services of the delegated functions under Community Health and Social Care. Recognising and highlighting risks facing those Services and regularly reporting those risks to the IJB will ensure that the Board has oversight of the risks, the controls that are being implemented and the changing profile of the risks to the various Services.

Corporate Priorities and Joint Working:

The Parties (NHS Shetland (NHSS) and Shetland Islands Council (SIC)) have identified a core set of risks that relate to health and social care services for delegated integration functions.

Key Issues:

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

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

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

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

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

Exempt and/or confidential information:	
None.	
Implications :	
Service Users, Patients and Communities:	A robust approach to risk management at all levels of the Community Health and Social Care Directorate is essential in order to prevent or reduce potentially negative impacts on the Community.
Human Resources and Organisational Development:	Risk management promotes best practice and seeks to protect staff across the Health & Social Care Directorate.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
Legal:	There are no legal implications arising directly from this report. Legal issues are considered as an integral part of the risk management process.
Finance:	There are no financial consequences arising directly from this report.
Assets and Property:	There are no implications for major assets and property.
ICT and new technologies:	There are no ICT issues arising from this report.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Risk management is a continuous process which requires that risk information be presented periodically for consideration. The Community Health and Social Care Risk Register ensures that we are actively managing risks, mitigating negative impacts and promoting positive risk taking.
Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. The IJB Audit Committee has responsibility to review risk management and insurance arrangements and receive regular risk management updates and reports (Scheme of Administration and Delegations – Audit Committee Terms of Reference, Section 5.2).
Previously considered by:	This report has not been presented to any other formal meeting.

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3 November 2016

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

Background Documents:
Community Health & Social Care Directorate Plan

Risk Assessment - Community Health & Social Care

Responsible Officer: Simon Bokor-Ingram

Category
Corporate Plan

Directorate
F1. Our "20 by '20" - Leadership & Management

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

EM0007 - Partnership working failure - Conflict of interest between roles of NHS and Council.	Possible	Significant	Medium	• There is a mechanism for calling an informal Liaison Group at a senior level for members of the Council, Health Board and IJB to discuss issues which cannot be resolved through other channels and where the Group can then inform any remedial action required. The Joint Staff Forum provides an opportunity to exchange information affecting the integrated workforce.	Unlikely	Minor	Low
EM0018 - Legal / Compliance - Other - NHS and SIC are required to comply with Scottish Social Services Council and National Care Standards	Possible	Significant	Medium	• Regular inspections; Staff aware of the standards required. Recent joint inspection of older people's services will give overview of quality.	Rare	Significant	Low
EM0023 - Business continuity plan inadequate - Response to an emergency situation	Possible	Significant	Medium	• Business continuity plans in place for community health and social care services. Involvement in planning and exercises. Refresh of Caring for People Plan nearing completion.	Possible	Minor	Medium
EM0021 - Legal - Other - Inability to provide consistent, high quality, sustainable Out of Hours Care leading to inability to respond to need in the community.	Likely	Major	High	• Opportunities to extend ANP model. National review of out of hours primary care delivery with local project in place. Community Nursing review will consider level of out of hours provision. Small group of GPs covering Out of Hours Rota.	Unlikely	Significant	Medium
EM0002 - Deadlines - failure to meet - Delayed Discharges	Possible	Significant	Medium	• Create capacity through use of Integrated Care Fund. Create capacity through use of Integrated Care Fund with rapid access to resources which avoid unnecessary hospital admission and expedite timely discharge. Whole system approach to reducing bottlenecks in the pathway.	Possible	Minor	Medium
EM0004 - Staff number/skills shortage - Reduced response to an emergency situation on Remote areas of Shetland and the outer islands	Unlikely	Major	Medium	• • Emergency response arrangements in place. Coastguard Search and Rescue Helicopter will respond to life and limb threatening injuries/illness Memorandum of Understanding in place with Direct Flight for transfer of “walking wounded” NHS Shetland continuing discussions with SAS and GAMA regarding additional helicopter coverage, especially for urgent (rather than emergency) transfer Temporary control measure (for managing situation short term) to ensure staff on NDI have increased stock of Oxygen and consumables Longer term need to conduct training needs analysis and increase staff skill set to support ill patients for longer period of time (if timeliness of air evacuation options not enhanced) Continue to develop First Responder schemes on NDIs to support the nurse in caring for critically ill patient GP locums in place to cover vacancies	Unlikely	Major	Medium
EM0014 - Key staff - loss of - Inability to recruit to key posts	Likely	Significant	High	• Work closely with both HR departments on recruitment and retention. Schemes developed to attract people to health and care work. More joint health and care roles being developed.	Possible	Minor	Medium

EM0013 - Economic - Other - Adult Protection Issues	Possible	Minor	Medium	• The professional leads are tasked with ensuring that there are adequate levels of skill and capacity to manage protection issues. Training is a key requirement for staff working in services so they have the knowledge to raise issues. Training on Adult Protection being prioritised. Adult Protection included in the clinical and care governance framework.	Unlikely	Minor	Low
EM0010 - Contractual Liabilities Assumed/Imposed - Lack of robust contracting arrangements	Possible	Significant	Medium	• SLAs in place. Joint Commissioning & Procurement Strategy being developed.	Unlikely	Minor	Low
EM0016 - Economic - Other - Not achieving full use of the Integrated Care Fund	Likely	Significant	High	• Plans are reflected in the Strategic Plan. Early development of plans.	Possible	Minor	Medium
EM0045 - Failure of Key supplier - Budgets / Service planning. Planning process does not adequately quantify levels of need and resources are not directed appropriately.	Likely	Significant	High	• The Strategic Plan sets out direction and more detailed plans on how to spend specific funds. Need to better co-ordinate service planning and budget setting through the IJB to ensure budget is aligned to agreed service priorities.	Possible	Minor	Medium
EM0046 - Customer / Citizen - Other - Task Duplication	Almost Certain	Significant	High	• Agreement for lead organisation for functions or on use of one template and/or system. Clinical and care governance framework in place.	Possible	Minor	Medium

Shetland Islands Health and Social Care Partnership

Agenda Item

5

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	23 November 2016
Report Title:	Financial Monitoring Report to 30 September 2016	
Reference Number:	CC-79-16	
Author / Job Title:	Karl Williamson / Chief Financial Officer	

1.0 Decisions / Action required:

1.1 The IJB is asked to:

1. Note the Management Accounts for the 2016/17 year as at the end of the second quarter and the requirement to accelerate the Recovery Plan.
2. Confirm that the Chief Officer and Chief Financial Officer should initiate urgent discussion with the Local Partnership Finance Team (LPFT) to agree the mechanism for dealing with the projected in year overspend (as set out in the Integration scheme).
3. Recommend that the Chief Officer and Chief Financial Officer initiate discussion with SIC and NHSS to update the IJB Financial Regulation to reflect the first full year of operation (as set out in the Integration scheme).

2.0 High Level Summary:

2.1 The current projected outturn to the end of March 2017 for the IJB is an overall adverse variance of £1,665k which represents an under spend in the SIC arm of the budget of £323k and an over spend in NHSS arm of £1,988k.

3.0 Corporate Priorities and Joint Working:

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

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

4.0 Key Issues:

4.1 Current projected outturn to the end of March 2017 for the IJB is an overall adverse variance of £1,665k which represents an under spend in the SIC arm of the budget of £323k and an over spend in NHSS arm of £1,988k.

4.2 As the recovery plan will not be successful in 2016/17 the Integration Scheme instructs the Chief Officer (CO) and the Chief Financial Officer (CFO) to work with the Local Partnership Finance Team (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.

4.3 It is proposed that the CO/CFO discusses with LPFT the options available to address the in year overspend. Detailed proposals would then be presented in a further report to the IJB with recommendations for decision by the IJB, the Council and NHSS as required.

4.4 The Integrated Resources Advisory Group (IRAG) financial guidance identifies the following options for consideration where there is an overspend/ projected overspend:

(a) Utilising an underspend on the other arm of the operational Integrated Budget to reduce the payment to that body; and/or

(b) Utilising the balance on the general fund, if available, of the Integration Joint Board in line with the reserves policy.

(c) Make additional one-off payments to the Integration Joint Board; or

(d) Provide additional resources to the Integration Joint Board which are then recovered in future years, subject to scrutiny of the reasons for the overspend and assurance that there is a plan in place to address this.

4.5 The Integration Scheme states that, "*The (IJB) detailed Financial Framework is an integral part of the Supplementary Documentation to the Integration Scheme. The Financial Framework will be maintained in line with the Integrated Resource Advisory Group (IRAG) Financial Guidance. The Financial Framework will be kept under review and updated annually with details of the budgets allocated for the functions delegated to the IJB. Work in this regard is managed by a Local Partnership Finance Team (LPFT) as part of the Corporate Services Support arrangements for the IJB.*"

4.6 The annual review of the IJB Financial Regulations will include a review of all financial activity with regard to the IJB including the treatment of under/over spends and the detail required in a competent Recovery Plan.

5.0 Exempt and/or confidential information:
None

6.0 Implications :	
6.1 Service Users, Patients and Communities:	May be affected should services be redesigned. However appropriate consultation procedures will be followed should any changes have an impact on this group.
6.2 Human Resources and Organisational Development:	None arising directly from this report. There may be implications for the workforce depending on the options considered to meet the NHSS budget shortfall.
6.3 Equality, Diversity and Human Rights:	None

6.4 Legal:	(a) There are legal implications with regard to the delegation of statutory functions of the Council and the Health Board to the IJB and the budget allocated to the IJB by each Party in order to deliver the delegated functions for that Party. These are set out in the Public Bodies (Joint Working) (Scotland) Act 2014, the associated Regulations and Guidance. (b) The Council, the Health Board and the IJB must adhere to the terms of the Integration Scheme approved by the Scottish Government under the terms of the Public Bodies Act. This includes a section on Finance with details regarding the treatment of under/over spends.
6.5 Finance:	(a) This report identifies significant risks with regard to the budget allocation from the NHS to the IJB. (b) The report identifies the process whereby options to address these issues will be developed and presented to a future meeting of the IJB (c) Based on the experiences of 2015/16 when additional funds were required from NHSS in order to meet the overspend which could not be met through the Recovery Plan proposed in year and given the current projected outturn shows almost £2M overspend in the NHS arm of the IJB budget, it is essential that the options are considered as soon as possible so that the IJB can consider remedial action and make representation to NHSS and the Council as appropriate.
6.6 Assets and Property:	None arising directly from this report. There may be implications for assets and property depending on the projects/ options considered to meet the NHSS budget overspend.
6.7 ICT and new technologies:	None arising directly from this report. There may be implications for ICT depending on the projects/ options considered to meet the NHSS budget overspend.
6.8 Environmental:	None arising directly from this report. There may be implications for the environment depending on the projects/ options considered to meet the NHSS budget overspend e.g. regarding carbon footprint.
6.9 Risk Management:	(a) There are numerous financial risks involved in the delivery of services and the awareness of these risks is critical to successful financial management. (b) From a financial perspective, risks are an integral part of planning for the future as assumptions are required to be made. These assumptions can be affected by many internal and external factors, such as supply and demand, which may have a detrimental financial impact. (c) The IJB has a Risk Management Strategy in place and

	considers the risks regarding the activities of the IJB itself as a body corporate and also the risks associated with the services provided to meet the obligations of the IJB with regard to the functions delegated by the Council and NHSS on a regular basis. Specific issues and risks to the IJB associated with this report are those concerning failure to deliver the Strategic Plan within the budget allocation specifically regarding the delegated functions and budget allocation from NHSS. These risks are articulated in the IJB Risk Register and the Health and Social Care Risk Register.
6.10 Policy and Delegated Authority:	(a) This report presents information with regard to the budgets allocated to the IJB including the NHSS "set aside" allocation. The IJB has delegated authority to deliver the approved Strategic Plan within the budget allocated. (b) This report presents information with regard to projected over spends in the NHSS budget allocation. Under the Integration Scheme, the IJB must approve a Recovery Plan for a projected over spend and where the IJB seeks to address the over spend by actions that will "change the budget allocated by the Parties for a delegated function" then this "must be reported to the IJB and the Parties as appropriate for their agreement. This applies equally to the "set aside" budget allocations" (c) Once the options for addressing the projected over spends have been considered by the LPFT and a detailed recovery Plan prepared, a further report must be presented to the IJB for approval and/or recommendation to the Council and/or NHSS.
6.11 Previously considered by:	The proposals in this report have not been presented to any other committee or organisation.

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7 November 2016

APPENDIX 1

1. Background

1.1 The 2016/17 Integration Joint Board (IJB) budget was agreed as part of the Joint Strategic Commissioning Plan 2016-19 on 28th June 2016.

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

1.3 This report represents the management accounts as at the end of the second quarter of 2016/17.

2. Executive Summary

2.1 The Management Accounts for the 6 months to 30 September 2016 have been compiled following financial analysis and budget monitoring at Shetland Islands Council (SIC) and NHS Shetland (NHSS).

2.2 These accounts are based on projected outturn position which is consistent with SIC financial reporting. NHSS favours year-to-date reporting but for the purposes of IJB reporting it has been decided to adopt the outturn approach.

2.3 Appendix 2 details the consolidated year-end outturn forecast for the IJB as a whole. Current projected outturn to the end of March 2017 is an adverse variance of £1,665k.

2.4 Appendix 3 details the annual budgets by organisation as per the Joint Strategic Commissioning Plan 2016-19.

3. Financial Commentary

3.1 Mental Health - projected outturn overspend of (£178k) (7.4%)

Off island Service Level Agreement overspend due to patient that required treatment outside the Grampian area. This ceased in June so no further overspend in this area forecast (£50k)

The remaining overspend is made up of a range of issues including one off (£6.3k) overspend as a fixed term Band 3 is being utilised to support the admin review. A (£63k) cost pressures in Psychiatry based on Project Manager requirements from mid September to end of December. A (£16k) overspend in Community Psychiatric Nursing due to sick leave and maternity cover. A further (£29k) potential cost pressure for consultancy fees under review.

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

3.3 Oral Health - projected outturn breakeven
This service area is expected to be on budget.

3.4 Pharmacy & Prescribing - projected outturn overspend of (£171k) (2.90%)
The projected overspend is almost equal to the proposed savings schemes which will have been removed from the budget by year end. This suggests that pharmacy expenditure is growing at the anticipated rate as assumed in the budget setting but the proposed level of savings anticipated by these schemes have not yet been generated. Further analysis is required to ensure that any savings achieved can be accurately identified and measured and to confirm the reasons behind this overspend.

3.5 Primary Care - projected outturn overspend of (£288k) (6.3%)
GP locum costs are now expected in Yell until the end of the financial year (£91k). There will be continued locum requirements in Lerwick to cover 1.88 WTE vacancies until the end the year and the appointment of a practice manager from November (£17k). There is a requirement for continued locum cover in Whalsay (£48k) which is provided under an SLA at a lower cost than agency rates. Locum costs anticipated for the remainder of the year in Unst (£80k) following the practice being handed back to the Board to manage from August 2016. Police surgeon overspend of (£24k) for day time cover – the OOH cover for police work is provided by GP on call. OOH cover (£13k) based on average year to date spend.

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

3.7 Directorate - **projected underspend of (£31k) (4.4%)**
The projected underspend relates to SIC training due to a change in priorities - for example, using e-learning rather than classroom training.

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

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

3.10 Adult Services – projected outturn underspend of £201k (3.9%)
The projected underspend relates to employee costs £133k, due to vacant posts at Eric Gray Resource Centre, Supported Living & Outreach (SL & O) Managers and SL & O Central during the first six months of the year. These posts have now largely been filled, with the exception of two Social Care Worker posts (each 28hr per week) which have been deleted. This is off-set by the expected cost of holiday pay due to Adult Services employees for the year (£85k). Due to the re-profiling of

the funding of the Eric Gray Replacement Project, it is expected that there will be an underspend of £171k in borrowing costs in the year.

3.11 Adult Social Work – projected outturn overspend of (£485k) (2.2%)

The projected overspend mainly relates to Off Island placements (£423k), for which SIC contingency of £350k is available if required, but the cost is currently being met from underspends in the Directorate. There is also a projected overspend in Self Directed Support packages (£72k) based on the current level of demand. This projection includes the full use of the £348k Additional IJB Funding agreed by the IJB in June 2016.

3.12 Community Care Resources – projected outturn underspend £639k (6.3%)

The projected underspend is mainly due to employee costs £825k, with the largest variance projected in Care at Home (Central) (£436k), where rotas have been reviewed and revised and hours of care delivered are less than budgeted. There have also been rolling vacancies across the service, which sometimes take a number of months to fill and also some difficulty in recruiting, particularly to Care at Home posts.. This underspend is partly off-set by the expected cost of holiday pay due to Community Care Resources employees for the year (£231k). There is also a projected over-achievement of income from Board & Accommodation and Non-Residential Charging income of £254k, which can vary significantly dependant on the financial circumstances of those receiving care. This is also offset by a projected overspend on Independant Sector Placements (£186k) based on current level of agreed packages, for which SIC contingency of £150k is available if required, but the cost is currently being met by underspend in the Directorate.

3.13 Criminal Justice – projected outturn underspend of £7k (24.1%)

There are no significant variances in this service area.

3.14 Speech & Language Therapy - projected outturn breakeven

This service area is expected to be on budget.

3.15 Dietetics - projected outturn breakeven

This service area is expected to be on budget.

3.16 Podiatry - projected outturn breakeven

This service area is expected to be on budget.

3.17 Orthotics - projected outturn breakeven

This service area is expected to be on budget.

3.18 Physiotherapy - projected outturn breakeven

This service area is expected to be on budget.

3.19 Occupational Therapy - projected outturn overspend (£15k) (0.9%)

There are no significant variances in this area.

3.20 Health Improvement - projected outturn overspent

This service area is expected to be on budget.

3.21 Unscheduled Care - projected outturn overspend £449k (13.9%)

Ward 3 overspend on nursing pay costs due to fixed term contracts which were only budgeted for in 2015/16 running into 16/17 due to delays in substantive recruitment and bank costs being incurred as these posts come to an end. There have also been continued increases in acuity levels – for example, mental health patients etc who often require one on one care (£144k).

Cost pressures in Accident & Emergency (£22k) and in Ronas Ward (£21k) due to sickness cover.

Overspend in relation to consultant locums required to cover sickness and restricted duties and locum requirements to cover junior doctor rotas (£262k).

3.22 Renal - projected outturn breakeven

This service area is expected to be on budget.

3.23 Scottish Government Additionality Funding - projected outturn underspend of £43k, (8.40%)

The proposed use of the Additionality funding is set out in Appendix 5 and was approved by the IJB on 28th June 2016. The £0.512m Scottish Government Additionality Funding for Adult Social Care represents 50% of the £1.024m received by NHS Shetland as a result of the additional £250m funding announced for health & social care partnerships. The balance of the fund (£0.512m) was used to cover existing cost pressures such as national living wage compliance and pension and national insurance increases within the Social Care (SIC budgets).

It was agreed that £348k of the additional funding would be used to fund the increased level of demand for Self-Directed Support Packages. Based on the current level of support packages in place, it is projected that this funding will be spent in full. Analysis of the increased level of packages shows that the majority of the increase relates to demographic change, with increased requests for support, not just for older people, but also for adults under 65 years with physical and learning disabilities.

Further funds were set aside for the recruitment of two therapist posts (1 FTE Physiotherapist and 1 WTE Occupational Therapist) for the Re-ablement Programme in Care Homes. This only began in August 2016 and it is therefore projected this £86k budget will underspend by £43k

It was agreed that the remainder of the additional funding would be utilised to cover the cost of one full-time social worker and one full-time administration worker who will specifically focus on expediting timely hospital discharges. It is anticipated that the £78k allocation will be spent in full.

3.24 Integrated Care Funding - projected outturn breakeven

The plan for use of the Integrated Care Fund this year was developed alongside the development of the Joint Strategic (Commissioning) Plan for 2016/17. The proposed spend is shown in Appendix 4.

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

3.25 Recovery Plan - projected outturn unachieved (£970k)

A Recovery Plan has been put in place for the IJB to address the efficiency savings required within the Health budgets for directly managed and set-aside services. A full update on the progress of the recovery plan was provided for IJB Members in October 2016. As at 30 September 2016 there is a projected underachievement of £970k against the Recovery Plan.

	Directly Managed Services	Set-Aside Services	TOTAL
Savings Required by Recovery Plan	£1,356,924	£420,162	£1,777,086
Savings Achieved for year-to-date	£95,798	£140,199	£235,997
Saving proposed for remainder of year	£445,896	£125,056	£570,952
Unacheived Savings	£815,230	£154,907	£970,137

Of the £806,949 savings identified above, £448,530 represents recurring savings and £358,419 are non-recurrent. Further details of the Recovery Plan can be found in Appendices 6 & 7.

4. Overall Year End Projection

4.1 Current projected outturn to the end of March 2017 for the IJB is an overall adverse variance of £1,665k which represents a projected under spend in the SIC arm of the budget of £323k and a projected over spend in NHSS arm of £1,988k. This £1,988k NHSS variance consists of the unachieved savings against the Recovery Plan of £970k from Para. 3.25 plus overspends in Managed Services £525k and Set Aside £493k.

4.2 As the recovery plan will not be successful in 2016/17 the Integration Scheme (see section 8 page 27) indicates that the Chief Officer (CO) and the Chief Financial Officer (CFO) will work with the Local Partnership Finance Team (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.

It is therefore proposed that the CO/CFO discusses with LPFT how the in year overspend will be dealt with and reports back to the IJB as a matter of urgency.

The LPFT have the following options available to them under the Integrated Resources Advisory Group (IRAG) financial guidance, which the introduction to section 8 (Finance) of the Integration scheme (page 23) indicates will be used to underpin the IJB's Financial framework.

(a) Utilising an underspend on the other arm of the operational Integrated Budget to reduce the payment to that body; and/or

(b) Utilising the balance on the general fund, if available, of the Integration Joint Board in line with the reserves policy.

(c) Make additional one-off payments to the Integration Joint Board; or

(d) Provide additional resources to the Integration Joint Board which are then recovered in future years, subject to scrutiny of the reasons for the overspend and assurance that there is a plan in place to address this.

It is also proposed that the CO/CFO initiate discussion with SIC and NHSS to update the IJB Financial Regulation to reflect the first full year of operation. This annual update is a requirement stated in the Integration scheme and the ongoing management of Over and under spends, in light of current experience, should be factored into the update.

5. Conclusions

5.1 The projected outturn position is an adverse variance of £1,665k for the IJB as a whole. This position highlights the financial challenge we are facing over the next few years and beyond. It is crucial that services are redesigned in a manner that continues to deliver quality health care but at lower cost. As the Strategic Commissioning Plan, and associated budgets, is revised for 2017/18 the IJB must play a key role in redesigning the future of health and social care in Shetland.

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

Contact Details:
For further information please contact:
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7 November 2016

Appendices:

2 Consolidated Financial Monitoring Report – Year end outturn forecast

3 Annual Budget by Organisation

4 2016/17 Integrated Care Fund

5 2016/17 Scottish Government Additionality Funding

6 Directly Managed Services Savings Position

7 Set Aside Service Savings Position

Appendix 2

Consolidated Financial Monitoring Report
Year end outturn forecast

Service	**2016/17 Revised Annual Budget £000s**	**Projected Outturn at Quarter 1 £000s**	**Budget v Proj. Outturn Variance (Adv)/ Pos £000s**
Mental Health	2,412	2,620	(208)
Substance Misuse	661	661	0
Oral Health	3,177	3,177	0
Pharmacy & Prescribing	6,367	6,538	(171)
Primary Care	4,594	4,882	(288)
Community Nursing	2,432	2,432	0
Directorate	712	681	31
Pensioners	78	78	0
Sexual Health	38	38	0
Adult Services	5,209	5,008	201
Adult Social Work	2,173	2,658	(485)
Community Care Resources	10,176	9,537	639
Criminal Justice	29	22	7
Speech & Language Therapy	83	83	0
Dietetics	112	112	0
Podiatry	207	207	0
Orthotics	143	143	0
Physiotherapy	595	595	0
Occupational Therapy	1,593	1,608	(15)
Health Improvement	244	244	0
Unscheduled Care	3,235	3,684	(449)
Renal	144	144	0
Scottish Gov Additionality	512	469	43
Integrated Care Funding	410	410	0
Recovery Plan	(1,777)	(807)	(970)
Total	**43,559**	**45,224**	**(1,665)**

Appendix 3

Annual Budget by Organisation

Service	NHS Managed £000	SIC £000s	NHS Set Aside £000s	Total £000s
Mental Health	1,354	1,058	0	2,412
Substance Misuse	402	259	0	661
Oral Health	3,177	0	0	3,177
Pharmacy & Prescribing	5,899	0	468	6,367
Primary Care	4,594	0	0	4,594
Community Nursing	2,432	0	0	2,432
Directorate	191	521	0	712
Pensioners	0	78	0	78
Sexual Health	0	0	38	38
Adult Services	66	5,143	0	5,209
Adult Social Work	0	2,173	0	2,173
Community Care Resources	0	10,176	0	10,176
Criminal Justice	0	29	0	29
Speech & Language Therapy	83	0	0	83
Dietetics	112	0	0	112
Podiatry	207	0	0	207
Orthotics	143	0	0	143
Physiotherapy	595	0	0	595
Occupational Therapy	185	1,408	0	1,593
Health Improvement	0	0	244	244
Unscheduled Care	0	0	3,235	3,235
Renal	0	0	144	144
Scottish Gov Additionality	0	512	0	512
Integrated Care Funding	410	0	0	410
Recovery Plan	(1,357)	0	(420)	(1,777)
Total	**18,493**	**21,357**	**3,709**	**43,559**

Appendix 4

2016/17 Integrated Care Fund

Product	2016/17 Integrated Care Fund Allocation	Comments
Proactive Care and Support		
- Intermediate Care Service	459,247	Estimated cost for a full year.
- Medical input and clinical expertise to support community initiatives including Intermediate Care and Anticipatory Care Planning.	30,000	
- Identifying unmet need for long-term neurological conditions using a neurophysiotherapist to work with primary care and voluntary sector.	16,906	1 year appointment started in Aug'15. Balance of funding carried into 2016/17 to meet the 1 year contract.
	506,153	
Preventative and Anticipatory Care		
- Accelerated rate of anticipatory care plan development across primary care, housing and social care.	15,627	Balance of funding from 2015/16 carried forward into 2016/17 for ongoing ACP development
	15,627	
Supportive Enablers		
- Third sector provided Independent Living Support at Home across seven localities to provide ongoing reablement and social engagement.	30,000	Require balance of 2015/16 contract funding £12,408 to be carried into 2016/17 to cover remainder of 1 yr contract. 2016/17 allocation to cover to end of financial year.
- Contingency to fund priorities that emerge from Strategic Planning process.	30,000	
	60,000	
TOTAL : Integrated Care Fund 2016/17 Planned Spend	**581,780**	
Less Total Integrated Care Fund Allocation for 2016/17	**581,780**	
Balance of 2016/17 Funding Remaining	**0**	

Note:

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

2016/17 Integrated Care Fund = £410,000

TOTAL 2016/17 Allocation = £581,780

Appendix 5

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

Product	2016/17 Integrated Care Fund Allocation	Comments
Social Work – Hospital discharge liaison Specifically to focus on expediting timely hospital discharges co-ordinating all agencies to ensure that rehabilitation is prioritised.	78,330	1 FTE Social Worker at K2 plus mileage/phone allowance; 1 FTE Admin at G2
Reablement Programme to support Care Centres To focus primarily on Montfield Support Services and develop the rehabilitation model further.	86,100	1 FTE Physio at Band 6; 1 FTE OT at Band 6 plus recruitment and mileage costs.
Self-Directed Support Packages Increase in uptake of Option 1 of Self Directed Support	347,570	Costing based on current self-directed support packages at 31/05/16 for the remainder of 2016/17; takes into account increased hourly direct payment rates approved by Council for 2016/17. Increase in uptake of packages – October 2015 = 30 packages. June 2016 = 37 packages
TOTAL : 2016/17 Additionality Funding Proposals	**512,000**	
2016/17 Additionality Funding	**512,000**	
Balance of 2016/17 Funding Remaining	**0**	

Recovery Plan — Appendix 6

Directly Managed Services Savings Position		Non Recurrent	In Year Recurrent	Savings outstanding
Opening savings Target	1,356,924			
Savings achieved in year				
Skill mix - Lerwick Health Centre Receptionist 0.60 band 3 post reduced to 0.60 band 2			1,400	1,355,524
Non Recurrent savings from band 5 vacancy in Community Nursing		11,020		1,344,504
Non recurrent savings from band 6 vacancy in non doctor island Community Nursing		37,539		1,306,965
Non recurrent savings from band 6 vacancy in Podiatry		17,777		1,289,188
Non recurrent savings from band 7 vacancy in Physiotherapy		15,098		1,274,090
Remove band 4 post from Primary Care Admin and uplift Community Nursing Admin post - balance to savings			6,364	1,267,726
Remove non pay budget from Primary Care Admin for consumables			6,600	1,261,126
Savings proposed for remainder of year				
Pharmacy - Empowering Patients			44,000	1,217,126
Pharmacy - National Consensus			10,000	1,207,126
Pharmacy - Biologicals			88,000	1,119,126
Pharmacy - Diabetes			18,000	1,101,126
Pharmacy - Respiratory			10,000	1,091,126
Pharmacy - Polypharmacy			24,000	1,067,126
Remaining months of Physiotherapy vacancy		24,259		1,042,867
Remaining months of Podiatry vacancy		18,133		1,024,734
Psychological Therapist vacancy		35,000		989,734
Non Dr Islands vacancies offset by bank useage		31,504		958,230
Redesign of primary care service following approval of primary care strategy. This includes previous project on specific Lerwick Health Centre staffing.		80,000		878,230
Review of Community Nursing Service, including District Nursing, ANPs, Out of Hours. This now includes the previously separate project on non-doctor islands.		63,000		815,230
Unachieved savings for year				**815,230**
Total recurrent savings achieved			208,364	
Total non recurrent savings achieved		333,330		

Recovery Plan

Appendix 7

'Set Aside' Services Savings Position	Total	Attributable to IJB	Non Recurring	In Year Recurring	IJB Savings outstanding
Opening savings Target					
Acute Services	1,110,340	293,685			
Off Island Clinical Services	477,246	11,367			
Public Health	115,110	115,110			
Total	**1,702,696**	**420,162**			
Savings achieved in year					
Director of Public Health Redesign	115,110	115,110	0	115,110	305,052
Child Health - replace band 7 with band 6	6,127	0	0	6,127	305,052
Infection Control Team - band 6 0.62 WTE reduced to 0.53 WTE	7,459	0	3,400	4,059	305,052
Central Decontamination Unit - band 4 reducing hours by 0.1 WTE	3,116	0	0	3,116	305,052
Medical Imaging - skill mix change	5,578	0	0	5,578	305,052
Theatres - band 6 replaced by band 5	2,085	0	0	2,085	305,052
Child Health - skill mix change	118	0	0	118	305,052
Funding bundles allocated to savings	160,991	25,089	160,991	0	279,963
Savings proposed for remainder of year					
Specialist Nursing bundle	31,511	0	31,511	44,000	279,963
Outpatients Department - skill mix change	17,659	0	10,000	7,659	279,963
Hospital Management Team	20,000	5,290	0	20,000	274,673
Specialist & Rehabilitation Services	202,800	53,641	0	202,800	221,032
Pathways / Patient Travel	250,000	66,125	0	250,000	154,907
Unachieved savings for year					**154,907**
Total recurrent savings achieved		240,166			
Total non recurrent savings achieved		25,089			

Shetland Islands Health and Social Care Partnership

Agenda Item

6

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board – Audit Committee Integration Joint Board	23 November 2016 23 November 2016
Report Title:	Internal Audit Plan 2016/17	
Reference Number:	CC-85-16 F	
Author / Job Title:	Crawford McIntyre – Executive Manager – Audit, Risk & Improvement	

Decisions / Action required:

1.1 That the IJB Audit Committee RECOMMENDS that the IJB APPROVES the final Internal Audit Plan 2016/17

High Level Summary:

2.1 This report presents additional detail regarding the planned internal audit activities for the IJB in 2016/17 in response to a request made by the IJB Audit Committee at its meeting on 27 May 2016 [Min. Ref. 05/16].

2.2 As agreed at that meeting further discussion has been held to more clearly specify and agree what can be done with the resources currently allocated for internal audit activities for the IJB.

Corporate Priorities and Joint Working:

3.1 The audit process plays a key role in helping the IJB to maintain good governance and accountability and can provide some assurance around financial stewardship.

3.2 There is an expectation from Scottish government set out in guidance prepared by the Integrated Resource Advisory Group (IRAG), that audit activities will include due diligence around budget allocations, made by the Council and the Health Board, with regard to the functions delegated to the IJB. The available resources are to be directed by the IJB so that the outcomes specified nationally in the Public Bodies (Joint Working) (Scotland) Act 2014, and locally through the approved Strategic Commissioning Plan are delivered. Discussion will be held with Deloitte LLP, the 2016/17 appointed external auditor for Shetland Islands IJB.

3.3 The IJB Audit Plan supports the role of the IJB Audit Committee which is a mandatory element of the governance framework for Shetland's Health & Social Care Partnership (H&SCP). Full details of the governance structure for the H&SCP are set out in the Integration Scheme (link below) and Supplementary Documentation.

Key Issues:

4.1 2016/17 is the first full financial year for the IJB. This is the first time that the IJB will have directed the Council and the Health Board to deliver services to meet the outcomes set out in the Strategic plan, monitored progress, assessed risks and considered remedial actions for any areas where there are concerns.

2016/17 planned work

4.2 The work undertaken for 2015/16 focussed on ensuring that the necessary governance arrangements are in place. The acid test for the IJB will be that the governance arrangements are efficient and effective enabling the IJB to fulfil its obligations by delivering the outcomes required locally in line with legislation and guidance.

4.3 It is intended that for 2016/17 our work will centre on reviewing the decisions taken by the IJB to determine that these are made in accordance with the various governance arrangements now in place. We will also follow up on a sample of the decisions to confirm actual implementation

4.4 More specifically this work will focus on :

- Whether the Strategic Commissioning Plan is being delivered (work undertaken by NHS Internal Audit will be considered as part of this review).
- Whether the NHS Shetland Financial Recovery Plan for 2016/17 is SMART (Specific, Measurable, Achievable, Relevant and Timely)
- A review of the administration of the Integrated Care Fund

4.5 Twenty days have been allocated by Shetland Islands Council within the SIC Annual Audit plan for internal audit work in relation to the IJB. It is anticipated the majority of the time will be allocated to work around the Strategic Commissioning Plan. The work will be undertaken during the final quarter of the financial year.

Exempt and/or confidential information:

None

Implications :	
Service Users, Patients and Communities:	The IJB must ensure Best Value in the delivery of services to meet the health and care needs of the local population. The work of internal Audit and of the IJB Audit Committee can provide assurance in this regard.
Human Resources and Organisational Development:	The inclusion of the internal audit role for the IJB in the work of the Council's Internal Audit Service is an opportunity cost for the Council in terms of the work of the staff involved. However, it provides diversity from purely Council related functions at a time when partnership arrangements across the public sector are increasingly expected to deliver Best Value to meet the needs of the most vulnerable people in the community. The local arrangements and activities of Shetland's Health and Social Care Partnership will provide valuable experience for staff undertaking the work set out in the IJB Internal Audit Plan 2016/17.

Equality, Diversity and Human Rights:	The Strategic Commissioning plan should be designed to be consistent with Shetland's Local Outcomes Improvement Plan (LOIP) promoted by the Shetland (Community Planning) Partnership with a focus on early intervention, prevention and inequalities. The proposed Internal Audit plan has the Strategic Plan as a key focus.
Legal:	The IJB is established in accordance with the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014, related Regulations and Guidance. The IJB as a public body with its own legal personality is responsible for governance and management of its affairs. It is required by the legislation, regulations and guidance to have its own Audit Committee and to appoint a Chief Internal Auditor. The IJB in Shetland has appointed the Executive Manager – Audit, Risk & Improvement as its Chief Internal Auditor. The IRAG states that the internal audit service should undertake its work in compliance with the Public Sector Internal Audit Standards (PSIAS). The Council's Internal Audit Service undertakes its work in accordance with PSIAS and was subject to independent review in 2015. The findings of the review were presented to the Council's Audit Committee on 17/11/15 (Min Ref 32/15) (Link below). Following the implementation of some minor recommendations the Executive Manager – Audit, Risk & Improvement confirmed full compliance with PSIAS in his annual report to the Council's Audit Committee on 15 June 2016. (Min Ref 14/16 (link below) The Chartered Institute of Public Finance and Accountancy (CIPFA) / Chartered Institute of Internal auditors (CIIA) require the preparation of a risk-based plan. This should be fixed for a period of no more than one year
Finance:	The NHS Shetland Financial Recovery Plan for 2016/17 will be subject to review as part of the internal audit process.
Assets and Property:	None arising directly from this report. However, the use of property and the fixed costs associated with property and major assets could be a consideration in the financial viability of the Strategic Commissioning Plan and may be critical to the options available to achieve financial balance.
ICT and new technologies:	None arising directly from this report.
Environmental:	None arising directly from this report.
Risk Management:	There is a risk that the current allocation of 20 days for the work will be insufficient to undertake a comprehensive review and assessment. Any difficulties in this regard will be reported to the IJB Audit Committee.

	Whilst no specific risk to service delivery can be attributed to this report, internal audit activities support services by identifying risks which can then be addressed as appropriate.	
Policy and Delegated Authority:	The IJB Audit Committee has a specific area of responsibility to review and recommend the annual internal audit plan to the IJB. (Audit Committee Term of Reference 5.2). Shetland's Integration Joint Board (IJB) assumed responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting on 24 November 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB has overall responsibility for the commissioning, delivery and performance of integrated services.	
Previously considered by:	IJB Audit Committee	27 May 2016

Contact Details:
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7 November 2016

Appendices:
Web links:
http://www.shetland.gov.uk/coins/Agenda.asp?meetingid=4707
http://www.shetland.gov.uk/coins/Agenda.asp?meetingid=5128
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/SHSCPartnershipIntegrationScheme15May2015.pdf

Shetland Islands Health and Social Care Partnership

Agenda Item

7

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	23 November 2016
Report Title:	IJB Business Programme 2016/17 - Update	
Reference Number:	GL-55	
Author / Job Title:	Team Leader - Administration (SIC) On behalf of the Chief Officer	

1.0 Decisions / Action required:

1.1 That the IJB considers its business planned for the remaining quarters of the current financial year (1 April 2016 to 31 March 2017), and RESOLVES to approve any changes or additions to the business programme.

2.0 High Level Summary:

2.1 The purpose of this report is to inform the Board of the planned business to be presented to the Board for the remaining quarters of the financial year 1 April 2016 to 31 March 2017, and discuss with Officers any changes or additions required to that programme.

2.2 The presentation of the Business Programme 2016/17 on a quarterly basis provides a focussed approach to the business of the Board, and allows senior Officers an opportunity to update the Board on changes and/or additions required to the Business Programme in a planned and measured way.

3.0 Corporate Priorities and Joint Working:

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

4.0 Key Issues:

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

4.2 The Business Programme for 2016/17 will be presented on a quarterly basis for discussion and approval, particularly in relation to any remaining projects and reports which are listed at the end of the business programme and which are still to be scheduled.

5.0 Exempt and/or confidential information:	
None	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The Business Programme provides the community and other stakeholders with important information, along with the Strategic Commissioning Plan, as to the planned business for the coming year.
6.2 Human Resources and Organisational Development:	(a) There are no direct impacts on staffing or organisational development matters with regard to approval of the Business Programme. However approval of the Business Programme will give direction and assurances to staff with regard to the timing and requirements for decisions and public reporting that the IJB has agreed. (b) It has been agreed that support for the Business Programme function for the IJB and its committees will be co-ordinated by the Council's Corporate Services Department as part of the corporate services support for the IJB. This will be achieved within existing resources.
6.3 Equality, Diversity and Human Rights:	(a) There are no direct impacts on equality, diversity or human rights with regard to approval of the Business Programme, although individual items will have to have regard to those in terms of any outcomes and associated risks. (b) The recommendation in this report does not require an Equalities Impact Assessment.
6.4 Legal:	(a) The IJB and its Committees are advised to establish a Business Programme, but there is no legal requirement to do so. (b) There are no direct legal impacts with regard to approval of the Business Programme, although individual reports will have to have regard to current and impending legislation and the impact on the IJB, and the services which the NHS and SIC deliver, in terms of outcomes and legal risks.
6.5 Finance:	(a) The there are no direct financial implications by approving the Business Programme, but indirect costs may be avoided by optimising time spent by officers and members at scheduled meetings. Regular financial and performance reporting will ensure that the IJB fulfils the terms of the Integration Scheme. (b) Any costs associated with the development and maintenance of the IJB Business Programme will be met from within existing budgets of the Council and the Health Board.
6.6 Assets and Property:	There are no implications for major assets and property. Where possible, all meetings of the IJB will be held in either the

	premises of the Council or the Health Board and that the costs will be covered accordingly by the Council and the Health Board.
6.7 ICT and new technologies:	There are no implications for ICT and technologies. Where possible, all meetings of the IJB will be held in either the premises of the Council or the Health Board and will have facilities to allow members to attend meetings remotely. Any associated costs will be covered accordingly by the Council or the Health Board.
6.8 Environmental:	There are no environmental issues arising from this report.
6.9 Risk Management:	The risks associated with setting the Business Programme are around the challenges for officers meeting the timescales required, and any part of the Business Programme slipping and causing reputational damage to the IJB, the Council or the NHS. Equally, not applying the Business Programme would result in decision making being unplanned and haphazard and aligning the IJB's Business Programme with the objectives and actions contained in the IJB's Strategic Plans could mitigate against those risks.
6.10 Policy and Delegated Authority:	(a) Shetland's Integration Joint Board (IJB) was formally constituted on 27th June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. (b) The IJB assumed responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting on 24 November 2015. (c) Maintaining a Business Programme will ensure the effectiveness of the IJB's reporting framework, and its planning and performance management, by monitoring and reviewing the achievement of key outcomes and objectives as set out in its Strategic Plans, . (d) The IJB has the authority to approve its Business programme 2016/17 as set out in this report.
6.11 Previously considered by:	The last update of the Business Programme for 2016/17 was considered by the IJB at its meeting on 7 September 2016.

Contact Details:
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Appendices:
Appendix 1 – Integration Joint Board Meeting Dates and Business Programme 2016/17

Background Documents:
None.

Shetland Health and Social Care Partnership

Integration Joint Board
Meeting Dates and Business Programme 2016/17

Chair: Mr Cecil Smith, SIC / Vice-Chair: Dr Catriona Waddington, NHS
as at Friday, 18 November 2016

Integration Joint Board		
Quarter 1 1 April 2016 to 30 June 2016	**Date of Meeting**	**Business**
	Wednesday 27 April 2016 at 2 p.m.	• Action Plan – Mental Health Review (CC21) • Audit Scotland – Care Home Inspectorate Reports (CC19 – Community Care) • SIC Policy Care and Support Charge 2016/19 (CC23) • Primary Care Strategy (to include high level implementation plan) (CC25) • Area Management (CC22) • Audit Scotland – Care Home Inspectorate Reports (CC24 Newcraiglea) • Shetland Autism Strategy (CC26) • 2016/17 Business Programme
	Wednesday 8 June 2016 at 2 p.m.	• Performance Report (CC34) • Audit Commission report on health and social care integration (CC28) • Risk Registers – IJB and Directorate (CC35) • Shetland Local Outcomes Improvement Plan 2016-20 (CC33) • Joint Staff Forum Terms of Reference (CC37) • 2016/17 Business Programme (CC36)
	Tuesday 28 June 2016 at 11 a.m.	• Draft 2015/16 Accounts (CC47) • Oral Health Strategy (CC48) • Strategic Commissioning Plan 2016-19 (CC41) • Budget 2016/17(in light of LDP submitted 31 May and NHS Board approving 21 June) (CC46) • Recovery Plan 2016/17 (CC42) • Integrated Care Fund 2016/17 and Additional Funding 2016/17 (CC43) • SADP – Revised Terms of Reference • Choosing a Care Home Policy (CC44) • Draft Hospital Based Complex Clinical Care Policy (CC45)
Quarter 2 – 1 July 2016 to 30 September 2016	Wednesday 7 September 2016 at 2 p.m.	• Delays in Discharge from Hospital to Community Setting (CC56) • Q1 Financial Accounts (CC57) • Primary Care Strategy Action Plan (CC54) • Effective Prescribing in Shetland (CC60) • 2016/17 Business Programme (CC59)
	Monday 26 September 2016 at 3 p.m.	• Final 2015/16 Accounts (CC70) • 2015/16 Annual Audit Report (CC69) • Performance Report Q1 (CC61) • Risk Registers – IJB and Directorate (CC62 + CC63) • Shifting the Balance of Care (CC72) • 2017/18 Budget Setting (CC71) • Joint Strategic Commissioning Plan Refresh Process (CC66) • Joint Strategic Commissioning Plan – Key Strategic Drivers (CC65)
Quarter 3 - 1 October to 31 December	Wednesday 19 October at 2 p.m.	• CSWO Annual Report • Mental Health Action Plan Refresh • Scottish GP Patient Experience Survey

Shetland Health and Social Care Partnership

Integration Joint Board
Meeting Dates and Business Programme 2016/17
Chair: Mr Cecil Smith, SIC / Vice-Chair: Dr Catriona Waddington, NHS
as at Friday, 18 November 2016

2016		• Recovery Plan Update
Quarter 3 - 1 October to 31 December 2016	Wednesday 23 November at 2 p.m.	• Public Health Annual Report (CC78) • Scotland's Charter for a Tobacco-Free Generation (CC80) • Q2 Financial Monitoring Report (CC79) • Q2 Performance Report (CC81) • Internal Audit Plan 2016/17 (CC85) - recommendation from IJB Audit Committee • APC Constitution (CC84) • 2016/17 Business Programme (GL
	Friday 9 December 2016 at 2 p.m.	• Budget 2017/18 • Draft Strategic (Commissioning) Plan 2017-18 • Update on proposal to develop an Extended Intermediate Care & Community Rehabilitation Team • Shetland Autism Strategy Action Plan • APC Biennial Report 2014 • Workforce & Organisational Policy • Choosing a Care Home Policy
Quarter 4 1 January 2017 to 31 March 2017	Wednesday 25 January 2017 at 2 p.m.	• Delays in Discharge from Hospital to Community Setting • 2016/17 Business Programme
	Wednesday 15 March 2017 at 2 p.m.	• Q3 Financial Accounts • Q3 Performance Report • Update EGRC

Planned business still to be scheduled - as at Friday, 18 November 2016

- Carers Strategy

END OF BUSINESS PROGRAMME as at Friday, 18 November 2016