Agenda Item

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Shetland Islands Council

Meeting:	Integration Joint Board
Date:	10 March 2017
Report Title:	Scottish GP Patient Experience Survey
Reference Number:	CC-18-17 D1
Author / Job Title:	Lisa Watt / Service Manager Primary Care

1.0 Decisions / Action required:

1.1 The IJB are asked to DISCUSS and COMMENT on the results of the 2015/16 Scottish GP Patient Experience Survey for Shetland.

2.0 High Level Summary:

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

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

2.3 The survey supports the three quality ambitions of the 2020 vision (Safe, Effective and Person-centred) “by providing a basis for the measurement of quality as experienced by service users across Scotland”.

2.4 This paper presents the individual practice results, broken down by locality area. Practices were asked to comment on their result areas, so this paper also gives information received from practices, including individual action

plans where these have been developed. The Practice comments are shown as received and members are asked to note that for future years, a proforma template will be developed to aid consistency of responses.

2.5 The improvement in the views of patients, of the care received, is noted and the positive impact has been fed back to the workforce.

3.0 Corporate Priorities and Joint Working:

3.1 The 2015/16 Scottish GP Patient Experience Survey is in line with the following National Health and Wellbeing outcomes:

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

It is anticipated that the survey will expand in future years to cover more aspects of Health & Social Care, building on the work already undertaken in this survey which asks Carers for their experience of services. The next survey is due to take place in November 2017, although exact details have yet to be confirmed.

4.0 Key Issues:

4.1 The survey focuses on access to GPs and Nurses, as well as looking at care and help provided by local authorities. At the present time, the survey does not ask for feedback on access to Advanced Nurse Practitioners or other healthcare staff, nor does it differentiate between different types of appointment systems e.g. triage.

4.2 The survey shows differences in results between 2013/14 and 2015/16 in percentage points, as well as comparing Shetland results with the rest of Scotland. Overall, the survey results mainly show improvement, particularly in relation to carers feeling supported to continue caring.

Implications :	
Service Users, Patients and Communities:	This paper will also be presented to the Patient Focus Public Involvement group for discussion and comment.
Human Resources and Organisational Development:	None
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications in this regard. The scope of the patient survey supports and promotes equalities, health and human rights.
Legal:	None
Finance:	None
Assets and Property:	None
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Embedding a culture of continuous improvement and customer focus are key aspects to meeting the aspirations of the IJB. Failure to promote and embed a continuous improvement culture increases the risk of the Council and NHS Shetland working inefficiently, failing to focus on customer needs and along with the IJB being subject to negative external scrutiny.

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

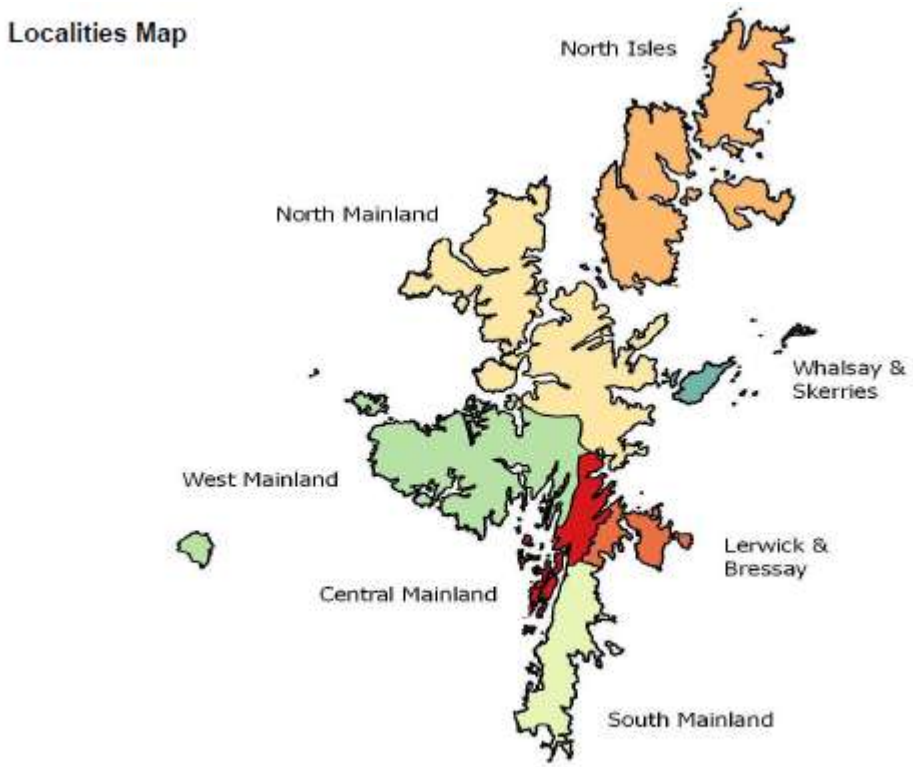
APPENDIX 1

This paper gives further information to the results of the 2015/16 GP Patient Survey. Questionnaires were sent out to randomly selected patients across Scotland, using a postal questionnaire and patients were asked to only respond to the survey if they had had contact with their GP surgery in the last 12 months. The survey asked patients about their experience of accessing their GP Practice, making an appointment, visiting reception, seeing either a nurse and/or doctor at the surgery, receiving prescribed medicine and care provided overall by the practice. This year the survey was widened to include other areas of care and help provided by local authorities and other organisations to support the national outcomes for health and wellbeing proposed under The Public Bodies (Joint Working) (Scotland) Bill. It also included questions aimed specifically at carers about their experiences of caring and support.

The results of the survey have been separated into the seven planning localities in Shetland which are:

- North Isles
- North Mainland
- West Mainland
- Whalsay and Skerries
- Central Mainland
- Lerwick and Bressay
- South Mainland

These are shown on the map below.



In terms of staffing, there is a notional figure of between 1200 and 1400 patients per whole time GP in Scotland; the amount of GP time available to each practice is shown, together with any vacancies. The ten practices vary in size, as shown by the patient registration table below and four of the practices (Hillswick, Unst, Yell and Whalsay) also provide their own out of hours cover. The remaining GP practices (Lerwick, Levenwick, Scalloway, Bixter, Walls and Brae) have out of hours provided through a local arrangement, whereby patients call NHS24 if they require assistance and there is one on call GP for those areas who responds to requests for visits, advice calls etc.

The survey did not ask about Advanced Nurse Practitioners nor did it make any differentiation between types of appointment system e.g. triage. Where different types of appointment systems are in place, this will noted in the narrative for that particular practice.

Shetland Practice's Patient Registrations

	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Bixter	90	140	132	278	309	131	70	17	1167
Brae	146	252	318	627	751	273	96	29	2492
Hillswick	59	77	86	198	212	95	32	19	778
Lerwick	436	962	1078	2263	2495	944	538	178	8894
Levenwick	128	323	286	592	815	321	164	48	2677
Scalloway	248	456	346	993	949	338	156	72	3558
Unst	28	70	37	100	178	118	49	18	598
Walls	46	94	85	160	199	86	52	24	746
Whalsay	59	132	122	251	274	139	97	32	1106
Yell	43	116	93	192	347	149	94	26	1060
Total	1283	2622	2583	5654	6529	2594	1348	463	23076

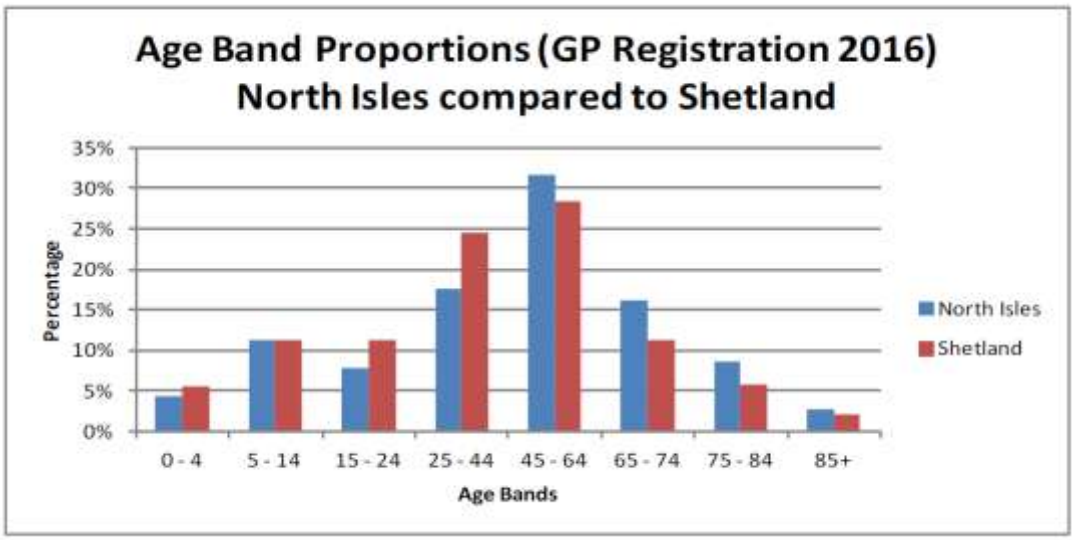
North Isles
Age Profile of the North Isles Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Unst and Yell practices within a number of different age groups.

North Isles Practice's Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
North Isles	71	186	130	292	525	267	143	44	1658

The graph below shows that the age profile of the patients registered with the Unst and Yell in 2016 is slightly different to the rest of Shetland with fewer young people and adults in the 15-44 age group and then more in all the older age groups, compared to Shetland as a whole. There are some differences between the age profiles in the Unst and Yell population, but the actual numbers are small. Having a slightly larger population of older people and a slightly smaller population of working age people could mean that the implications of an aging population for the provision of health and care services in the North Isles could be even more marked in this area compared to the rest of Shetland. The data is from 1st July 2016.



Unst Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	100%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	100%
I am treated with compassion and understanding	98%
Overall, how would you rate the care provided by your GP practice?	98%

The Unst practice has 598 patients and the 2015/16 Patient Survey was sent to 422 patients from the practice, of which 114 were returned (27% of those who received a questionnaire). The practice has 1 full time GP equivalent. At the time of the survey, the practice had no GP vacancies.

The Unst Practice have reviewed their results and commented as follows:

Our summary of results showed clearly that the arrangements provided by the Unst Health Centre in order to make appointments to see either the GP or the Nurse are appreciated by the patients as both were scored at 100%. We were also graded highly, at 98%, by the patients for feeling they were treated with compassion and understanding and for the care provided by the GPs at the Unst Health Centre. We feel extremely proud of these scores as the Health Centre has recently been undergoing a number of changes, in both how it is run and the personnel working here. We hope that these high marks will continue next year.

Looking at the bottom 5 responses for the Health Board as a whole, we couldn't comment on the two regarding carers as Unst must not have had enough questionnaires completed with those questions answered as they did not appear in our report.

- *For dealing with mistakes, the Unst Health Centre scored 5% negative and 95% positive. This is quite a significant difference to the overall Health Board score. However, it is very reassuring for us as we take errors extremely seriously. We have blank Significant Event Analysis forms in reception for members of staff to jot down anything they feel needs further discussion. These are then examined in full at our monthly practice meetings and acted upon accordingly.*

- *The Unst Health Centre only scored 3% negative for seeing the preferred GP. As we only had 2 doctors, patients are normally pretty good at seeing whoever was on. We have started to see a shift in this as we use more locums.*

- *Making appointments 3 or more working days in advance scored us 100% positive, again quite difference to the overall Health Board score. We found doing our patient access work last year that a patient could almost always get an appointment within 48 hours.*

Yell Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	87%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	92%
I am treated with compassion and understanding	95%
Overall, how would you rate the care provided by your GP practice?	91%
Overall, how would you rate the care you experienced out of hours?	67%

The Yell practice has 1060 patients and the 2015/16 Patient Survey was sent to 397 patients from the practice, of which 91 were returned (23% of those who received a questionnaire). The practice has 1 full GP equivalent. At the time of the survey, the practice had a full time vacancy and was being covered by locums.

The Yell Practice have reviewed their results and commented as follows:

Arranging to see a doctor. *Although 87% is a good percentage if has fallen from the previous year by 12%. This could be due to the fact our permanent GP left the practice halfway through the year and we had to rely on locums to fill the gap. We have, under the supervision of Dr Gardner, changed the appointment times and have increased the number of appointments available.*
Arranging to see a nurse. *Again 92% is a positive score. The nurse works Monday to Friday but only 30 hours a week. We have asked for a further 7.5 hours to make her full time as a few patients are asking to see her later in the working day or see her on a Saturday as they work off island. This might reflect the 8%. It is not viable for the nurse to work on Saturday to deal with chronic conditions, as the bloods taken will be too old to give accurate readings. If her finishing time was extended to 5pm this would help some patients as they would not have to take a lot of their working day off.*
Compassion and understanding *- We received 100% in the 2013/14 survey so it was disappointing to lose 5%. This may be due to having a variety of locums and patients not having continuity of care with their own GP. We hope this will improve when we get a permanent GP.*
GP Practice Care. *Again this has fallen by 9% which again is disappointing, but can be attributed to the fact of not have a permanent doctor in place.*
Out of Hours. *Not a good score at all. A solution would be to take back the out of hours. This will be a big decision to make but maybe worth speaking to the next GP. We have filed all NHS 111 calls in months so all calls can be reviewed and see if the Out of Hours service has stopped any unnecessary call to the GP.*

North Mainland

Age Profile of the North Mainland Population

North Mainland Practices Patient Registrations North Mainland overall has roughly the same age distribution as Shetland, with slight differences – slightly more 15-64 year olds and slightly fewer 75 year olds and older. However, the differences are small scale (1 or 2%).

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
North Mainland	205	329	404	825	963	368	128	48	3270

Hillswick Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	99%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	98%
I am treated with compassion and understanding	98%
Overall, how would you rate the care provided by your GP practice?	99%

The Hillswick practice has 778 patients and the 2015/16 Patient Survey was sent to 471 patients from the practice, of which 95 were returned (20% of those who received a questionnaire). The practice has 1 full time GP equivalent. At the time of the survey, the practice had no GP vacancies.

The Hillswick practice have reviewed their results and commented as follows:

All of the above four results were good. Its difficult to assess how much store to put on the small changes this survey highlights as numbers are small, and it could be those contacted were all pretty happy last time, and less so this time.

The overall arrangements for getting to see a doctor was down 12% (with 12% negative) from 2012

Given that access was easy with night surgeries and Saturday surgeries we wondered how that could be, especially as no one is turned down. We wondered whether it was arrangement to see a particular doctor.

There was slightly reduced confidence in nurses and slightly more reduced confidence in doctors

There has been a change of nurses since early 2014, and the new nurse has been on maternity leave twice, and so four changes. We lost a doctor again, who was much liked, and have had frequent different locums since then.

There was a -8% drop in patient involvement with care and treatment. Which was interesting as we have tried very much to involve patients more.

There was a -6% satisfaction with the way patents receive their results

The old system was no new is good news, and we will get in touch if there is an issue. The new system where we comment on all results before filing, and as before the GP contacts the patients who have abnormal results. If the patient phones the

admin can reassure that results are normal. We have decided to make a change in that the nurses or doctors taking the result will be very explicit as to how the patient will receive them, that they should contact the practice in 2-3 weeks to make sure everything is in order, and that we will contact them if there is an abnormal result.

Brae Health Centre

Statement	**Result 2015-16**
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	90%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	97%
I am treated with compassion and understanding	84%
Overall, how would you rate the care provided by your GP practice?	91%
Overall, how would you rate the care you experienced out of hours?	80%

The Brae practice has 2492 patients and the 2015/16 Patient Survey was sent to 651 patients from the practice, of which 118 were returned (18% of those who received a questionnaire). The practice has 1.8 GP WTE and at the time of the survey had 0.4 WTE vacancy. The practice was operating a triage system at the time of this survey in order to deal with demand and this meant that each patient spoke with a GP on the day.

West Mainland

Age Profile of the West Mainland Population

The information below is based on GP practice registrations: it shows the number of people registered with the Walls and Bixter practices within a number of different age groups.

The chart shows that the age profile of the patients registered with the West Mainland practices is similar to the rest of Shetland with slightly fewer adults in the 25-44 and 45-64 age groups.

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
West Mainland	136	234	217	438	508	217	122	41	1913

Bixter has a similar rate, or less, in the older age groups compared to the rest of Shetland, and more in the youngest age groups. Walls has a higher rate of people in the older age groups, and more in the very youngest age groups.

Walls Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	97%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	97%
I am treated with compassion and understanding	96%
Overall, how would you rate the care provided by your GP practice?	94%
Overall, how would you rate the care you experienced out of hours?	76%

The Walls practice has 746 patients and the 2015/16 Patient Survey was sent to 493 patients from the practice, of which 105 were returned (21% of those who received a questionnaire). The practice has 1 full time GP in post and at the time of the survey had no GP vacancies.

Bixter Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	99%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	100%
I am treated with compassion and understanding	95%
Overall, how would you rate the care provided by your GP practice?	95%
Overall, how would you rate the care you experienced out of hours?	No result shown

The Bixter practice has 1167 patients and the 2015/16 Patient Survey was sent to 427 patients from the practice, of which 87 were returned (20% of those who

received a questionnaire). The practice has 1 full time GP in post and at the time of the survey had no GP vacancies.

The Bixter practice have reviewed their results and commented as follows:

Overall we achieved positive scores and we are happy with the results.

Bottom 5 Responses (Highest % negative scores) **2013/14**
2015/16

1. Pg 5 - Referrals - Arrangements for getting to see other health and care services 87%
   82%
2. Pg 6 – Doctors - Patients feel that Doctors have all the information they need to treat them 85%
   89%
3. Pg 6 – Doctors - Doctors take account of the things that matter to patients 88%
   86%
4. Pg 7 – Care & Treatment - Patients are involved as much as they want to be in decisions about their care and treatment 72%
   76%
5. Pg 8 - Tests arranged – Patients are satisfied with the way they receive results 83%
   89%
6. Pg 9 – Medicines – Patients know enough about side effects of medicines 82%
   79%

	Comments
1	Patient expectations are high with increasing demand on all services. GP's continue to explain to patients of waiting times and ensure they understand the urgency of the appt – if routine/urgent etc. Mental health service has been difficult to access due to lack of service available but appointment of clinical psychologist should help to address that.
2	Score improved on previous survey.
3	Difficult to know what this refers too & in what context? A number of changes have been made in this practice including changes to GPs. Importance of continuity of care and handovers to GP colleagues.
4	Score improved on previous survey.
5	Score improved on previous survey.
6	Patients on regular medications and chronic diseases registers are invited to attend for an annual review and advised to bring their regular medications with them. We will discuss at our next meeting the option of issuing patients with medication charts at their annual review. Medications are always dispensed with a patient information leaflet enclosed which details side effects of a drug and patients are advised to return unwanted medications to the dispensary for safe destruction. Patients are advised to contact the surgery immediately if they experience an adverse reaction and to report this to the Yellow Card. More and more patients are being prescribed medications for preventative measures and this has led to increase in prescribing overall.

Whalsay and Skerries

Age Profile of the Whalsay and Skerries Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Whalsay practice within a number of different age groups.

Whalsay Practice Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Whalsay & Skerries	59	132	122	251	274	139	97	32	1106

Whalsay and Skerries have slightly fewer adults in the 25-64 age group – although this equates to around 30 individuals – not a huge figure. They also have slightly more older adults in the 65-85+ age groups, compared to Shetland as a whole – these are only 1 or 2 %. We see an aging population which is slightly higher than the Shetland average, with fewer (than the Shetland average) middle aged working adults.

Whalsay Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	94%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	96%
I am treated with compassion and understanding	94%
Overall, how would you rate the care provided by your GP practice?	95%
Overall, how would you rate the care you experienced out of hours?	95%

The Whalsay practice has 1106 patients and the 2015/16 Patient Survey was sent to 433 patients from the practice, of which 103 were returned (24% of those who received a questionnaire). The practice has 1 full time GP in post and at the time of the survey had no GP vacancies. However, the staffing model on Whalsay is slightly different to the rest of Shetland, in that there are three GPs who rotate on a rota to provide cover.

The Whalsay practice have reviewed their results and commented as follows:

Several of our results scored 100%. For the five listed above, we were pleased with our results:

	% Score	*% Difference*	*Difference Statisically significant compared to Scotland*
Arranging to see a doctor	*94%*	*+23*	√
Arranging to see a nurse	*96%*	*+15*	
Compassion &	*94%*	*+9*	√

Understanding			
GP Practice Care	*95%*	*+9*	
Out of Hours Care	*95%*	*+24*	

ACTION PLAN – Bottom 5 scoring questions.

Point 1 - Arrangements for getting to see other health and care services.

This point scored 75% positivity which is a -18% change from 2013/14 results.
As this seems quite a vague question, we are unable to pin point where we fall down e.g. is it a specific service, does it relate to waiting times, etc. We wonder how we could improve this without going in to more detail relating to the question.

Currently, we actively promote self referral to physio, podiatry, social services as well as walk in clinics for x-ray, sexual health etc and will continue to do so.

Point 2 - Patients are involved as much as they want to be in decisions about their care and treatment.

This point scored 78% positivity which is a 2% increase on 2013/14 results.
Again we feel this is another vague question, what specific part of the patients care does this relate too? Does this refer to care and decisions within our Health Centre or within secondary care. Without clarification we are unsure how to progress with action.

Point 3 - Can usually see preferred doctor.

This scored 83% positivity which is a -18% change from 2013/14 result.
Given the fact we are a single handed remote rural practice covering our own out of hours, operating on a rotational basis with three GP's, this point may be difficult to act upon. The rota covers approx 3 week blocks working 3 in every 9 weeks thus making it impossible to allow choice of GP when booking appointments.

The community are now aware of our rotational GP's and we will endeavour inform patients of scheduled dates for Dr Mungwira, Dr Fishwick and Dr Stevens, giving patients the opportunity to book future appointments if clinical reason allows.

Point 4 - Test results are explained to patients in a way they can understand.

This point scored 85% positivity

Point 5 - Patients are satisfied with the way they receive results.

This point scored 87% positivity

n.b. Points 4 & 5 relate to test results and will be address together.

Patients who are awaiting test results are told that if the result is normal then they will not hear from the surgery. The GP has facility within EMIS to "comment" on any result waiting to be filed, comments include:

- *Normal – no action*
- *Just out of normal range*
- *Abnormal*

The GP also has facility to type any comment out with choice menu so each result should have some sort of comment/action on abnormal results. Admin staff will relay said comment on test result however cannot expand as none are trained in reading investigation results. Due to this survey, clinicians are now aware that patients are

unhappy with the way they currently receive test result and will endeavour to improve on this by:

- *Admin staff will offer phone consults with GP to patients who are unhappy/require/wish further information of explanation on "comment" attached to result.*
- *Research the use of Patient Information Leaflets relating to certain test result where applicable.*
- *We will continue to offer clinic appointments to patients who would like face to face consult with GP to discuss investigation/test results.*

Central Mainland

Main Report

Age Profile of the Central Mainland Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Scalloway practice within a number of different age groups.

Central Mainland Practices Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Central Mainland	248	456	346	993	949	338	156	72	3558

Central mainland has an age distribution roughly similar to the whole of Shetland. The 15-24 and 65- 74 age groups are very slightly smaller in central mainland, whereas the 25-44 age group is larger, but the differences are small.

Scalloway Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	89%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	92%
I am treated with compassion and understanding	98%
Overall, how would you rate the care provided by your GP practice?	100%
Overall, how would you rate the care you experienced out of hours?	58%

The Scalloway practice has 3558 patients and the 2015/16 Patient Survey was sent to 556 patients from the practice, of which 105 were returned (18% of those who received a questionnaire). The practice has 2.5 full time GPs in post and at the time of the survey had no GP vacancies.

The Scalloway practice have reviewed their results and commented as follows:

Overall we have an excellent report.

The survey reflects that Patients have good service provided by clinicians and administration staff. With the introduction of the ANP this year our access for appointments has improved.

Bottom 5

1. *Out of Hours care 58%*
2. *Patients involved as much as they want to be in decisions about treatment and care 67%*
3. *Arrangements for getting to see other health care services 84%*
4. *Patients are satisfied with the way they receive results 87%*
5. *Overall arrangements for seeing GP 89%*

Reflection on the bottom 5- Out of hours, access to patients' notes would make things easier for the out of hour's doctor. Patients tend to think that once referred by the Doctor that they will be seen immediately in secondary care. The waiting times

are explained to the patients but they do tend to return before the appointment in secondary care due to the wait and need more urgent referral. Receiving results is *satisfactory here. Sometimes xrays and ultrasounds can be lengthy in coming back, patients do not understand this as the xray department often tell them that we will have the result in a few days.*

Lerwick and Bressay

Age Profile of the Lerwick and Bressay Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Lerwick practice within a number of different age groups.

Lerwick Practice's Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Lerwick & Bressay	436	962	1078	2263	2495	944	538	178	8894

Lerwick and Bressay have an age distribution very similar to the whole of Shetland. The 15-44 age group is fractionally larger in Lerwick and Bressay.

Lerwick Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	34%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	87%
I am treated with compassion and understanding	84%
Overall, how would you rate the care provided by your GP practice?	79%
Overall, how would you rate the care you experienced out of hours?	83%

The Lerwick practice has 8894 patients and the 2015/16 Patient Survey was sent to 717 patients from the practice, of which 118 were returned (16% of those who received a questionnaire). The practice has 4 full time GPs in post and at the time of the survey had 2 full time GP vacancies. The practice operates an on the day Advanced Nurse Practitioner appointment system which deals with most minor ailments but it should be noted that the survey did not ask about ANP access, it only asked for GP and Practice Nurse access. A patient survey undertaken on the ANP system at the same time as the national survey showed a very high satisfaction rate with the service and with access, which is not reflected in the national survey.

The Lerwick practice have reviewed their results and commented as follows:

Summary of results: *Arranging to see a doctor 34% (minus 37 on Scottish average)*

Action: *We are currently creating more locum appointment with a template redesign and also redesigning GP's templates to make more efficient use of GP time resulting in more appointments.*

Summary of results: *Arranging to see a nurse 87% (plus 5 on Scottish average)*

Action: *ANP appointment are easy to book and we are looking to increase capacity when a fifth ANP begins in post in March 2017.*

Summary of results: *Compassion and understanding 84% (minus 1 on Scottish average)*

Action: *Although the score in this area is average I believe that we can improve it by making sure our reception team keeps patient care & communication as a top priority. This message will be conveyed to reception staff regularly at team meetings.*

Summary of results: *GP Practice Care 79% (minus 7 on Scottish average)*

Action: *By improving our communication with patients we improve the perception of care provided. This will be implemented by making sure we facilitate prescriptions, letters, requests for notes and other correspondence in a timely manner and making sure that workflow does not 'build up' during staff shortages.*

Summary of results: *Out of hours care 83% (plus 11 on Scottish average)*

Action: *Out of LHC control .*

Survey result: *Can usually see preferred doctor? 55% negative response*

Action: *There is considerable scope to 'even up' the GP's appointment templates so that the number of available appointments with a particular GP matches that GP's number (in an even ratio) of 'named patients'. e.g. a GP may have 1000 named patients but is designated duty doc & supervising doc too many times each week giving them less appointments. I am currently monitoring this to ensure equality across all GP's templates.*

Survey result: *Able to book a doctors appointment 3 or more working days in advance? 38% negative response*

Action: *I am currently working along with the salaried GP's to redesign the template we use for locum doctors. The current locum template provides too many 'admin' slots and we should be able to utilize locums to see up to 3 or 4 more patients per day. This will open up more appointments on a regular basis.*

Survey result: *Overall arrangements for getting to see a doctor? 38% negative response*

Action: *As above. Also we are redesigning the salaried GP's appointment templates with the aim of removing some of the lesser used slots i.e. home visits, to make more efficient use of GP time & create more appointments where possible.*

Survey result: *Time waiting to be seen at GP practice? 33% negative response*

Action: *I will be conducting a periodic EMIS audit to determine if waiting times dissatisfaction is driven by a specific type of patient appointment or if it is clinician specific. We can then review the need to alter appointment lengths or intersperse appointments*

types that regularly run over time with less time consuming appointments.

Survey Result: *Is it easy to get through on the phone? 19% negative response*
Action: *I am currently reviewing the possibility of repositioning a second member of reception staff from another station (i.e. scripts/scanning) and having them work on the phone appointment line for one hour each day at the peak times. This will match supply & demand on the appointment line at peak times.*

South Mainland
Age Profile of South Mainland Population

South Mainland has slightly more people in the 45-64 age group, and slightly fewer in the 25-44 age group, compared to Shetland as a whole, but overall the age distribution is similar to Shetland.

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
South Mainland	128	323	286	592	815	321	164	48	2677

Levenwick Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	75%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	94%
I am treated with compassion and understanding	92%
Overall, how would you rate the care provided by your GP practice?	93%
Overall, how would you rate the care you experienced out of hours?	65%

The Levenwick practice has 2677 patients and the 2015/16 Patient Survey was sent to 514 patients from the practice, of which 133 were returned (26% of those who received a questionnaire). The practice has 2 full time GPs in post and at the time of the survey had no GP vacancies.

The Levenwick practice have reviewed their results and have the following comments:

Arranging to see a doctor = 75% positive feedback	*This is a change of -16% from 2013/14 survey result.* *As mentioned in response to last year's survey the Practice lost a third full-time GP in March 2013 due to NHS Shetland withdrawing the funding for a third GP. This had a knock-on effect to the availability of patient appointments at that stage. This still continues. The Practice employed a part-time GP but this does not fulfil the void of the loss of a full-time GP.* *The patient base has increased as has the patient demand.*
Arranging to see a nurse = 94% positive feedback	*This has improved +13% since 2013/14. Practice happy with that.*
Compassion and	*We are pleased to have received a high*

understanding = 92%	*percentage which is 7% better than Scotland although note that this is -3% less than we received in the 2013/14 survey.*
GP Practice Care = 93%	*Again, this is a high percentage and 7% better than Scotland, although we note that it is -3% lower than 2013/14 survey. The Practice delivers a high standard of care to its patients and will continue to strive to do the same.*
Out of hours care = 65% -16% change from 13/14	*This is outwith the control of the Practice*

Shetland Islands Health and Social Care Partnership

Agenda Item

2

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	10 March 2017
Report Title:	Directorate Response to Audit Scotland: Reshaping Care Impact Report	
Reference Number:	CC-14-17 F	
Author / Job Title:	Laura Mcleod / Project Manager for Shetland Health and Social Care Partnership	

1.0 Decisions / Action required:

1.1 The IJB is asked to:

a) NOTE the Audit Scotland: Reshaping Care Impact Report; and
b) CONSIDER the extent to which the current local arrangements address the issues raised in the Report; and
c) INVITE the Chief Officer to report back on the significant issues arising from the report that require local action, namely:
   I. clarification on the decision making framework for investment / disinvestment decisions on the commissioning of services and priority services areas, at a time of diminishing resources;
   II. clarification on how a 'whole system' approach to health and social care service can underpin the 10 strategic programme areas; and
   III. clarification that the Annual Performance Report, to be presented for the first time in June 2017, will focus on the National Health and Wellbeing Outcomes; and
   IV. clarification on the balance of the current and future use of the Integrated Care Fund and the capacity to use it for pump priming for new and innovative solutions.

2.0 High Level Summary:

2.1 The purpose of this paper is to present the IJB with the findings of the Audit Scotland Reshaping Care For Older People: Impact Report (2016) and to present an appropriate response.

2.2 The Impact Report summarises the impact made by the joint Accounts Commission and Auditor General for Scotland performance audit '*Reshaping care for older people'* published on *6th of February 2014*.

The key messages, highlighted within the impact report, are that;

1. *"Transformational change takes a substantial amount of time and investment and this approach has been made significantly more difficult in times of austerity with the increased pressure placed on public services with the reduction in budgets and increase in demand. This takes strong and effective leadership, both nationally and locally, to ensure that health and care partnerships stay on course.*

2. *To implement RCOP[1] successfully – more needs to be done to ensure that resources are targeted at prevention or delaying ill health. There is little evidence of progress in moving money to community based services and health prevention. We need to begin to look at health and care as a whole system and really targeted resources effectively to where the need is greatest. This is where strategic commissioning plays out.*

3. *National performance measures have not kept pace with policy changes and a greater focus on outcomes is needed. The Public Bodies (Joint Working) (Scotland) Act 2014, for the first time, prescribes a set of National Outcomes measures in law. There are a set of core indicators which aim to measure progress in delivering these outcomes. However, the process of mapping the indicators to outcomes can vary locally and nationally and the indicators do not fully take account of all the expected benefits of integration. For example, they do not measure any move to more community based, preventative services.*

4. *The Change Fund was a powerful lever to support local innovations and partnership working between third sector, NHS, Local Authorities and the independent sector, however a greater emphasis on strong governance and accountability is required if the RCOP programme and the Integration Fund is to be successful long term. Strategic Commissioning will be critical in achieving this".*

An excerpt from the RCOP programme document 2010;

"Delivery of this programme will take collaboration, commitment, stamina, enterprise and innovation. Success has as much to do with shifting our attitudes and expectations as it has about shifting resources, care institutions, providers and workforce. Achieving these aims will require all of us to work together, to resolve our differences and transcend traditional boundaries; to recognise our shared aspirations and responsibilities; to share our skills, talents and resources; and to familiarise ourselves with an exciting new dynamic where we are all both contributors and beneficiaries alike – giving meaning to this mutual care approach."[2]

3.0 Corporate Priorities and Joint Working:

3.1 Shetland's population is expected to change over the next 20 or so years. The number of older people is expected to rise significantly. It is generally felt that higher demand will increase the cost of providing care. The Corporate Plan sets out a different viewpoint based on efforts to encourage healthy and active lifestyles that will help people to be independent and reduce the need for care as they get older.

[1] Reshaping Care For Older People
[2] Ministerial Foreword- RCOP 2010

4.0 Key Issues:

4.1 The key issues to consider:

- Effective leadership;
- Health and Social Care as a Whole System;
- Measuring Outcomes; and
- Effectiveness of Specific Funding Streams.

4.2 Each of these topics will be considered in turn.

4.3 Effective Leadership

The IJB recently approved, in principle, an update of the Strategic Commissioning Plan. The IJB itself has now been active since June 2015. The national Audit Report lays down a challenge to determine if there is 'strong and effective leadership' both nationally and locally to help the services stay on course, particularly with regard to making significant savings. The IJB may wish to reflect on whether or not the updated Joint Strategic Commissioning Plan provides adequate vision and direction to enable staff to work together, effectively, towards a common goal. Equally, the IJB may wish to consider if the Plan is effective in setting out how decisions might be made around investment and disinvestment decisions at a time of reduced funding.

4.4 Health and Social Care as a Whole System

The national audit report sets out how resources should be targeted at the prevention of or delaying ill health, through investment in community based services and health prevention.

The Public Bodies (Joint working) (Scotland) Act 2014 speaks to an ambitious agenda that needs to be routed in prevention and alleviating health inequalities. Funding for Public Health initiatives have not kept pace with inflation and in fact have seen a decrease in funding in real terms. For 2016-17 there was no longer a ring-fenced allocation, and the funding that did come for preventative work was 7.5% less than the year before. The wording that came with the government letter was that 'individual programmes would lose their financial identity', and that NHS Boards were expected to achieve the defined National Outcomes as well as the prescribed efficiency savings.

There is a **significant** risk that if the IJB continues to reduce investment in public health and community based services, the increased pressure and cost on our acute and specialist services will become untenable.

The Strategic Commissioning Plan, recently approved in principle, sets out an ambitious programme of redesign to secure sustainable services.

The 10 Strategic Programmes have been organised by service area and although the principle of integration runs throughout the Strategic Commissioning Plan, on reflection the approach to undertaking the 10 Strategic Programmes from a 'whole system' perspective might not be as robust as it could have been. The IJB may wish, therefore, to seek reassurance through the Chief Officer that the programmes will be developed from a 'whole system' perspective.

In addition, while the NHS delegated services remains unfunded to the value of about £2.5m in 2017-18, the IJB is not able to complete its whole systems analysis of the overall proportion of resources to be invested in the acute and hospital

services and that to be invested in community health and health improvement. This must be noted as a **significant risk** to the successful implementation of the strategic commissioning plan.

4.5 Measuring Outcomes

The findings in the Audit Report ask each partnership to seek evidence of the extent to which the Strategic Commissioning Plan and the Performance Management arrangements support a focus on continuous improvement towards the National Health and Wellbeing Outcomes.

Nationally, there has been much discussion centred on performance monitoring and the absence of solid data relating to shifting the balance of care from acute settings to community based settings and delayed discharges.

Each Integration Authority is required to publish an annual performance report, which will set out how they are improving the National Health and Wellbeing Outcomes. These reports will all need to include information about the core suite of indicators, supported by local measures and contextualising data to provide a broader picture of local performance.

There is **a significant risk** that because the wording is not specified in law that partnerships may not monitor performance in the spirit that the RCOP programme and the following Public Bodies legislation was meant to be taken. See SSI 2014 No. 326.

It is a legislative requirement that IJBs use performance indicator data to effectively monitor performance towards the 9 National Health and Wellbeing Outcomes, however Shetland's IJB may wish to consider how best to do this. Specifically, this might focus on how resourcing decisions might impact on service performance and outcomes.

4.6 Effectiveness of Specific Funding Streams

The national audit report invites local partnerships to reflect on the extent to which the specific grant funding arrangements has supported innovation and promoted partnership working.

The IJB may therefore wish to seek a report on the current and future planned use of the Integrated Care Fund in terms of its capacity to support pump priming innovation and new initiates and the arrangements for mainstreaming the funding of services, at an appropriate point in the future years.

5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	Any significant changes to funding streams or management arrangement will of course be of interest to services users, patients and communities, particularly in respect of accessibility and availability of health and care services.
6.2 Human Resources and Organisational	There are no specific human resources and organisational development issues arising from this report.

Development:	
6.3 Equality, Diversity and Human Rights:	There are no specific equality, diversity or human rights issues arising directly from this report.
6.4 Legal:	Under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014,; The IJB has responsibility for the planning of the Integrated Services. This will be achieved through the Strategic Plan. The IJB is also responsible for the operational oversight of Integrated Services and through the Chief Officer will be responsible for the operational management of Integrated Services. In addition, the IJB is responsible for the planning of Acute Hospital services delegated to it but the Health Board will be responsible for the operational oversight of Acute Services and through a responsible Director for the operational management of all Acute Services. The IJB is responsible for the development and maintenance of a set of performance measures including the national outcomes, national targets, the national inspection processes and locally developed targets. The Strategic Plan will include any performance framework developed by the IJB. The IJB must publish an Annual Report as required by the legislation.
6.5 Finance:	There are no financial implications arising directly from this report.
6.6 Assets and Property:	There are no issues associated with Assets, Property or Equipment arising from this report.
6.7 ICT and new technologies:	There are no new issues associated with ICT and new technologies arising from this report.
6.8 Environmental:	There are no environmental implications arising from this report.
6.9 Risk Management:	Risk management is a continuous process which requires that risk information be presented periodically for consideration. The Strategic Commissioning Plan includes a section on risk factors and has identified a range of governance, financial, partnership and capacity issues.
6.10 Policy and Delegated Authority:	As a separate legal entity the IJB has full autonomy and capacity to act on its own behalf and can, accordingly, make decisions about the exercise of its functions and responsibilities as it sees fit.

	It is the duty of the Integration Joint Board, through the strategic plan, to direct the parties how it deems services to be structured, managed and delivered, in the best possible way in order to meet the 9 National Health and Wellbeing Outcomes.	
6.11 Previously considered by:	None	

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Links to documents:
Reshaping care for older people: Impact report
http://www.audit-scotland.gov.uk/uploads/docs/report/2016/ir_160510_reshaping_care_impact.pdf
http://isdscotland.org/Health-Topics/Health-and-Social-Community-Care/
http://www.improvementservice.org.uk/

Shetland Islands Health and Social Care Partnership

Agenda Item

3

Shetland NHS Board	Shetland Islands Council

Meeting(s):	IJB Audit Committee IJB	1 March 2017 10 March 2017
Report Title:	NHS Internal Audit Report: Strategic Planning - September 2016	
Reference Number:	CC-09-17	
Author / Job Title:	Hazel Sutherland / Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 The IJB Audit Committee is asked to:

a) CONSIDER and COMMENT on the findings of the Internal Audit Report on Strategic Planning; and
b) AGREE the Management Responses included in the Action Plan; and
c) RECOMMEND to the IJB that the Action Plan is accepted.

1.2 The IJB is asked to:

a) AGREE the Management Responses included in the Action Plan; and
b) DIRECT the parties to implement the actions required to improve the process of strategic planning with regard to the preparation of the Strategic Plan for the IJB.

2.0 High Level Summary:

2.1 The purpose of this paper is to present the Committee with the findings of a recent NHS Internal Audit study carried out on the topic of Strategic Planning, which focussed on the production of the Strategic Plan for the IJB referred to in the report attached at Appendix 1 as the Joint Strategic Commissioning Plan.
The NHS Internal Audit Report is broadly positive in its findings with no significant areas of risk highlighted. The NHS Internal Audit Report highlighted four recommendations for improvement, all which are supported for implementation and an Action Plan has been drawn up to address the issues. Some recommendations have already been addressed with the update of the Strategic Commissioning Plan for 2017-20 and it is the intention that all outstanding actions will be complete by April 2017.

2.2 From an IJB perspective, it would have been more appropriate for the scope of the audit to have included all the strategic planning arrangements, rather than focus

only on NHS Shetland activity. In order to provide a complete overview of its strategic planning arrangements, the IJB's internal audit service is currently undertaking a holistic review and will draw on the Scott Moncrieff report in reaching their conclusions. Their findings and recommendations will be the subject of a separate report to a future meeting of the IJB Audit Committee.

2.3 The Integration Scheme states that, "*The Parties (Shetland Islands Council and NHS Shetland) will provide support for strategic planning through their respective strategic planning and corporate support systems*". By local arrangement, the strategic planning process is led by the NHS through the Head of Planning and Modernisation. Overall responsibility for strategic planning for the IJB rests with the IJB itself.

3.0 Corporate Priorities and Joint Working:

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

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

3.3 There is a need to ensure that the integrated planning function focuses on the needs of individual service users, their families and unpaid carers within each local community and works across organisational boundaries.

4.0 Key Issues:

4.1 The NHS Internal Audit report acknowledges that the strategic planning process is evolving in response to the integration arrangements. The study is limited in its scope in that it only addresses the arrangements in place within NHS Shetland. The recommendations include three priority three actions (moderate risk exposure) and one priority two action (limited risk exposure). The Action Plan has been drawn up to address all the recommendations by April 2017. The Table below provides a summary of the progress made towards implementing the recommended actions.

Recommendation	Management Response	Progress Report
NHS Shetland should ensure the Joint Strategic Commissioning Plan identifies the strategic direction and objectives of the health board and the IJB, in line with their established vision. NHS Shetland should consider the use of supporting strategies (e.g. Clinical Strategy) in the strategic planning process and ensure that the service plans sit at the correct level within the framework.	Note that the recommendation is limited to NHS Shetland arrangements. Recommendation agreed. The arrangements for carrying out an annual refresh of the Strategic Commissioning Plan include: - establishing a clear strategic direction; - setting short and medium term objectives; and - mapping the overall policy framework. By April 2017	Complete. The recommendations have been accommodated in the updated Strategic Commissioning Plan for 2017-20.
NHS Shetland should ensure that action plans are clearly aligned to strategic objectives. Arrangements for monitoring and reporting on progress should be clearly established and aligned to the reporting of other key information, such as financial data and performance measures.	Note that the recommendation is limited to NHS Shetland arrangements. Recommendation Agreed. The overall objective of the refresh of the Strategic Commissioning Plan for 2017-18 is to ensure that: - the strategic objectives; - the financial plan and budget; and - the projects and action plans are aligned. By April 2017	Partially complete. The updated Plan includes key strategic objectives. The outstanding work relates to aligning the Strategic Commissioning Plan with the Financial Plan and this is in hand.
NHS Shetland should ensure sufficient financial information is available during the development and monitoring of the Joint Strategic Commissioning Plan. The Plan should provide context on the financial position of NHS Shetland and the impact of objectives and planned activity.	Note that the recommendation is limited to NHS Shetland arrangements. Recommendation Agreed. At the Integration Joint Board (IJB) meeting ... the process and strategic drivers for updating the Strategic Commissioning Plan were approved. This process recognises the need to align strategic planning with financial planning. While the processes are two separate systems, there will be key points at which the two systems reconnect for reporting to the IJB and its supporting committees, to make sure the planning process is well aligned and decision makers have all the information they need. By April 2017	Partially Complete. The outstanding work relates to aligning the Strategic Commissioning Plan with the Financial Plan and this is in hand.
NHS Shetland should ensure the Joint Strategic Commissioning Plan identifies SMART performance measures, which are aligned to strategic objectives. Arrangements for reporting progress and performance to management and the Board should be clearly established.	Note that the recommendation is limited to NHS Shetland arrangements. Recommendation Agreed. The refresh of the Strategic Commissioning Plan for 2017-18 and beyond will include reference to the agreed indicators which measure progress against the national Health and Wellbeing Outcomes and set specific performance improvement targets, where necessary. The reporting arrangements are being updated as part of the internal audit Performance Management Report from July 2016. By April 2017	Partially complete. Performance against the National Health and Wellbeing Outcomes and Key Performance Indicators for each service are identified and included in the updated Plan. The outstanding task is to consider specific targets and this work is in hand.

5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The overall objective of the strategic planning process is to align the health and social care needs of the population with the resources which the partners have made available. Decisions are made, through the planning process, on the level, quality and location of services. The process of internal audit provides the IJB Audit Committee with an opportunity to reflect on Shetland's Health and Social Care Partnership performance with regard to the effectiveness of strategic planning with reference to relevant legislation, national guidance and best practice arrangements from elsewhere. The IJB Audit Committee is, in essence, checking performance on behalf of all current and potential future users of health and care services in Shetland to make sure that the strategic planning process confirms that the resources will be used wisely and effectively.
6.2 Human Resources and Organisational Development:	There are no specific human resources and organisational development issues arising directly from the Report.
6.3 Equality, Diversity and Human Rights:	There are no specific equality, diversity or human rights issues arising directly from the Report.
6.4 Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 placed a duty on NHS Shetland and Shetland Islands Council to work together to integrate services around the needs of individuals, their unpaid carers and their families to get the right care, in the right place and at the right time. There is a requirement to produce a Strategic Commissioning Plan, based on at least two localities and updated on at least an annual basis. There is Scottish Government Guidance to follow on the production of the Strategic Commissioning Plans. NHS Shetland must also produce a Local Delivery Plan each year, guidance for which is submitted separately to the Health and Social Care Integration guidance.
6.5 Finance:	There are no financial implications arising directly from this Report. One of the key recommendations is to make sure that the Strategic Commissioning Plan and the Financial Plan are well aligned and this work is in progress.
6.6 Assets and Property:	There are no issues associated with Assets, Property or Equipment arising from this Report.
6.7 ICT and new technologies:	There are no new issues associated with ICT and new technologies arising from this Report. Aspects of the recommendations on performance monitoring will be addressed through a separate, but connected, project which will utilise existing systems in an integrated way.

6.8 Environmental:	There are no environmental implications to address.	
6.9 Risk Management:	The risk of not implementing the agreed NHS Internal Audit Action Plan is low.	
6.10 Policy and Delegated Authority:	The IJB Audit Committee has a key role in ensuring the efficient and effective performance of Shetland's Health and Social Care Partnership in order to deliver the outcomes set out in the Integration Scheme. The IJB is responsible on behalf of the parties for the planning of the Integrated Services. This is achieved through the Strategic Plan and supported by the Strategic Planning Group. The Integration Scheme states that, "the Parties will provide support for strategic planning through their respective strategic planning and corporate services support systems".	
6.11 Previously considered by:	NHS Audit Committee	29 November 2016

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24 January 2017

Appendices:
Appendix 1 - NHS Internal Audit Report: Strategic Planning - September 2016

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

NHS Shetland

Internal Audit Report

Strategic Planning

September 2016

Scott-Moncrieff
business advisers and accountants

NHS Shetland

Internal Audit Report

Strategic Planning

Introduction

Background

NHS Shetland is working to deliver sustainable, high quality local health and care services that are suited to the needs of the population. The board aims to deliver this by providing person-centred care whilst at the same time eliminating waste, reducing harm and managing variation.

Effective planning and reporting is particularly important in the current financial climate, where service redesign, cost pressures and funding constraints are some of the key pressures the board has to deal with.

Scope

We have reviewed strategic planning arrangements at NHS Shetland, focusing on the process used to prepare and monitor the Joint Strategic Commissioning Plan. We have also reviewed how progress is reported and scrutinised by management and non-executives.

The control objectives for this audit, along with our assessment of the controls in place to meet each objective, are set out in the Summary of Findings.

Acknowledgements

We would like to thank all staff consulted during this review for their assistance and co-operation.

Summary of findings

The table below summarises our assessment of the adequacy and effectiveness of the controls in place to meet each of the objectives agreed for this audit. Further details, along with any improvement actions, are set out in the Management Action Plan.

No	Control Objective	Control objective assessment	Action rating				
			5	4	3	2	1
1	Strategic planning forms part of a formal, robust framework, with clearly documented protocols and explicit linkage to the vision and objectives	YELLOW			1		
2	Strategic planning is informed via input from a range of appropriate stakeholders and partners, and subject to periodic review and update	GREEN					
3	NHS Shetland's strategic planning arrangements and accountabilities are appropriately integrated with the IJB framework	GREEN					
4	Actions to achieve strategic objectives are documented and agreed, taking cognisance of the internal resources available and the external environment in which NHS Shetland operates	YELLOW				1	
5	There is clear and direct linkage between the narrative and financial aspects of strategic planning and reporting	YELLOW			1		
6	Sufficient and appropriate arrangements are in place to track progress with delivering the strategy, including management and Board reporting	YELLOW			1		

Assessment	Definition
BLACK	Fundamental absence or failure of key control procedures - immediate action required.
RED	The control procedures in place are not effective - inadequate management of key risks.
YELLOW	No major weaknesses in control but scope for improvement.
GREEN	Adequate and effective controls which are operating satisfactorily.

Conclusion

NHS Shetland has responsibility for strategic planning for integrated and non-integrated activity and planning arrangements are still developing within the IJB framework. As integrated strategic planning is a new process there are opportunities for improving the content of strategic planning and the arrangements for monitoring progress.

Main Findings

NHS Shetland's strategic plan is documented within the Local Delivery Plan (LDP) and, following the introduction of the IJB, the Joint Strategic Commissioning Plan (SCP). NHS Shetland has responsibility for preparing the SCP on behalf of the IJB. The SCP includes non-integrated NHS services as well as all integrated activity, and is the key strategic document for both NHS Shetland and the IJB.

Strategic planning arrangements appear to be well integrated with the IJB framework, responsibilities have been identified and agreed, timeframes and sufficient opportunities for scrutiny and review by key stakeholders and partners, such as the Joint Staff Forum and the Clinical, Care and Professional Governance Forum have been established.

Areas for improvement

The development of the SCP is a new process and NHS Shetland has acknowledged that there is room for improvement. A Head of Planning has recently been appointed and is responsible for reviewing the current process and making any required improvements. The current SCP is based on the outputs from 39 service plans. Minimal guidance was provided by senior management on the strategic direction and, as a result, the service plans have been developed at an operational level. NHS Shetland plans to streamline the number of service plans and as a result planning will be completed by senior managers who will be able to provide more of a strategic insight.

Whilst NHS Shetland has identified a number of actions to improve the SCP, further work is required to ensure that it is fully compliant with Scottish Government guidance, including the following areas:

- The SCP does not set out clear objectives that cover the aims of both NHS Shetland and the IJB;
- There are a number of strategies in place, such as the Clinical Strategy, that cover the same activity as the service plans, but at a more strategic level, these strategies are not considered during the strategic planning process;
- NHS Shetland has not identified where they will document the actions required to achieve the strategic objectives and how these will be monitored by management and the Board;
- No financial context has been provided for NHS Shetland or the IJB, and limited financial information was available during planning; and
- No performance measures were identified within the SCP, which has resulted in there being no mechanism in place for NHS Shetland to measure and demonstrate achievement against the strategic objectives.

Further details of the points noted above are included in the Management Action Plan.

Management Action Plan

Risk rating	Definition
5	Very high risk exposure - Major concerns requiring immediate Board attention.
4	High risk exposure - Absence / failure of significant key controls.
3	Moderate risk exposure - Not all key control procedures are working effectively.
2	Limited risk exposure - Minor control procedures are not in place / not working effectively.
1	Efficiency / housekeeping point.

1. Control objective: Strategic planning forms part of a formal, robust framework, with clearly documented protocols and explicit linkage to the vision and objectives

Observation and Risk	Recommendation	Management Response
1.1 Strategic objectives and direction NHS Shetland has identified objectives and strategic priorities within the Local Delivery Plan (LDP). However, the SCP does not refer to these objectives/priorities, nor does it establish a strategic direction for the IJB. The SCP is structured around 39 service plans which are at an operational level. In addition, each service was considered in isolation, as there was insufficient time allocated to identifying key priorities and drivers across all services. NHS Shetland is aware of these weaknesses and intends to address them; however, further work is still required to ensure the SCP is compliant with Scottish Government guidance: • Strategic direction and objectives have not been set within the SCP. Subsequently, services will still be required to plan activity without an understanding of the IJB's objectives. • NHS Shetland has a number of supporting strategies, for example, the Mental Health and the Clinical Strategy, which identify the services' strategic priorities and are more strategic than the service plans, however,	NHS Shetland should ensure the Joint Strategic Commissioning Plan identifies the strategic direction and objectives of the health board and the IJB, in line with their established vision. NHS Shetland should consider the use of supporting strategies (e.g. Clinical Strategy) in the strategic planning process and ensure that the service plans sit at the correct level within the framework.	Agreed. The arrangements for carrying out an annual refresh of the Strategic Commissioning Plan include: - establishing a clear strategic direction; - setting short and medium term objectives; and - mapping the overall policy framework. **To be actioned by:** Head of Planning and Modernisation **No later than:** April 2017
		Priority **3**

1. Control objective: Strategic planning forms part of a formal, robust framework, with clearly documented protocols and explicit linkage to the vision and objectives

they are not considered during the strategic planning process. There is a risk that the SCP is ineffective due to its lack of strategic direction. With no clear objectives or priorities, it is difficult for services to plan appropriately and there is a risk that NHS Shetland are duplicating aspects of their planning process.			

2. Control objective: Strategic planning is informed via input from a range of appropriate stakeholders and partners, and subject to periodic review and update

No significant weaknesses identified.

Stakeholder engagement is well established within the planning and budgeting cycle for the health board and the IJB. Draft plans and budgets will be presented to the following groups for consultation and review; the Strategic Planning Group; the Joint Staff Forum; the Local Partnership Finance Team; the Clinical, Care & Professional Governance Committee.

The Joint Strategic Commissioning Plan and the Local Delivery Plan are subject to annual review and update. NHS Shetland will present all iterations of these documents to key stakeholder groups for scrutiny, to ensure they remain relevant and up to date.

3. Control objective: NHS Shetland's strategic planning arrangements and accountabilities are appropriately integrated with the IJB framework

No significant weaknesses identified.

NHS Shetland has taken responsibility for the IJB's planning function and the production of the initial draft Joint Strategic Commissioning Plan. There are still some discussions required to ensure that the health board, local authority and IJB's expectations are fully aligned, however the arrangement is deemed to be well established. NHS Shetland has clearly identified how the planning process is integrated with the IJB framework and the level at which the IJB will be involved. Whilst the arrangements are deemed appropriate, it should be noted that we have raised a number of recommendations specifically regarding the Joint Strategic Commissioning Plan.

4. Control objective: Actions to achieve strategic objectives are documented and agreed, taking cognisance of the internal resources available and the external environment in which NHS Shetland operates

Observation and Risk	Recommendation	Management Response
4.1 Action plans not clearly aligned to strategic objectives NHS Shetland has documented actions within the Corporate Action Plan (CAP), the individual service plans and the newly established strategic plans. However, the actions are not clearly aligned to the strategic objectives and NHS Shetland has not yet identified how progress will be monitored. Without documenting clear action plans that are aligned to the Joint Strategic Commissioning Plan, there is a risk that NHS Shetland will not be able to achieve its strategic objectives, or be able to demonstrate progress. As a result, the strategic planning process becomes ineffective.	NHS Shetland should ensure that action plans are clearly aligned to strategic objectives. Arrangements for monitoring and reporting on progress should be clearly established and aligned to the reporting of other key information, such as financial data and performance measures.	Agreed. The overall objective of the refresh of the Strategic Commissioning Plan for 2017-18 is to ensure that: - the strategic objectives; - the financial plan and budget; and - the projects and action plans are aligned. **To be actioned by:** Head of Planning and Modernisation **No later than:** April 2017
		Priority **2**

5. Control objective: There is clear and direct linkage between the narrative and financial aspects of strategic planning and reporting

Observation and Risk	Recommendation	Management Response
5.1 Lack of financial context Financial planning is completed in parallel with strategic planning. However, no financial context has been provided for NHS Shetland or the IJB in the Joint Strategic Commissioning Plan. The SCP is based on 39 services plans. Currently service managers receive minimal financial information to inform the planning process. As a result, there is a risk that they are planning activity which could be outwith their budget. NHS Shetland has acknowledged that this is an issue and members of finance have been included within a support team for service managers during the planning process. However, their involvement in the planning cycle is not compulsory and they will only provide guidance if requested. There is a risk that planned activity is not achievable and is beyond the financial limit of the health board.	NHS Shetland should ensure sufficient financial information is available during the development and monitoring of the Joint Strategic Commissioning Plan. The Plan should provide context on the financial position of NHS Shetland and the impact of objectives and planned activity.	Agreed. At the Integration Joint Board (IJB) meeting on 26 September 2016, the process and strategic drivers for updating the Strategic Commissioning Plan were approved. This process recognises the need to align strategic planning with financial planning. While the processes are two separate systems, there will be key points at which the two systems reconnect for reporting to the IJB and its supporting committees, to make sure the planning process is well aligned and decision makers have all the information they need. **To be actioned by:** Head of Planning and Modernisation **No later than:** April 2017
		Priority **3**

6. Control objective: Sufficient and appropriate arrangements are in place to track progress with delivering the strategy, including management and Board reporting

Observation and Risk	Recommendation	Management Response
6.1 Insufficient arrangements for monitoring delivery As raised under MAP 1.1 and MAP 4.1, the Joint Strategic Commissioning Plan (SCP) does not clearly identify objectives, nor the actions required to achieve them, nor any SMART performance measures. The Scottish Government's Strategic Commissioning Plan guidance provides a list of suggested indicators, however these have not been utilised. As a result, it is not possible for NHS Shetland, or the IJB, to objectively measure or demonstrate progress in delivering the SCP or to identify and address risks and issues that may affect the achievement of its aims and vision in a timely and effective manner. It should be noted that our Performance Management report (July 2016) raised issues and recommendations regarding performance management across NHS Shetland.	NHS Shetland should ensure the Joint Strategic Commissioning Plan identifies SMART performance measures, which are aligned to strategic objectives. Arrangements for reporting progress and performance to management and the Board should be clearly established.	Agreed. The refresh of the Strategic Commissioning Plan for 2017-18 and beyond will include reference to the agreed indicators which measure progress against the national Health and Wellbeing Outcomes and set specific performance improvement targets, where necessary. The reporting arrangements are being updated as part of the internal audit Performance Management Report from July 2016. **To be actioned by:** Head of Planning and Modernisation **No later than:** April 2017
		Priority **3**

Shetland Islands Health and Social Care Partnership

Agenda Item

4

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	10 March 2017
Report Title:	Financial Monitoring Report to 31 December 2016	
Reference Number:	CC-16-17 D1	
Author / Job Title:	Karl Williamson / Chief Financial Officer	

1.0 Decisions / Action required:

The IJB is asked to:

1.1 Note the Management Accounts for the 2016/17 year as at the end of the third quarter and the requirement to minimise expenditure during the remaining three months of the financial year.

2.0 High Level Summary:

2.1 The current projected outturn to the end of March 2017 for the services delegated to the IJB is an overall adverse variance of £901k which represents an under spend in the Shetland Island Council's (SIC) arm of the budget of £523k and an over spend in NHS Shetland's (NHSS) arm of £1,424k.

2.2 The £523k under spend in the SIC arm of the budget is unplanned and in line with the Integration Scheme will be returned to SIC.

2.3 NHSS has agreed to provide the IJB with a one off additional payment to cover the year end over spend in the NHSS arm of the budget. The final value of this payment will have to be agreed between the IJB Chief Officer, IJB Chief Financial Officer and the NHSS Director of Finance at the end of the financial year once the outturn position is known.

2.4 It is important to note that should NHSS be unable to contain costs and their break even position becomes possible only through the use of "brokerage" then further discussion on repayment of this will be required between NHSS and the IJB.

2.5 As a result of the above the IJB will reach a break even position for the financial year 2016/17.

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:

Background

4.1 The 2016/17 Integration Joint Board (IJB) budget was agreed as part of the Joint Strategic Commissioning Plan 2016-19 on 28th June 2016.

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

4.3 This report represents the management accounts as at the end of the third quarter of 2016/17.

Executive Summary

4.4 The Management Accounts for the 9 months to 31 December 2016 have been compiled following financial analysis and budget monitoring at SIC and NHSS.

4.5 These accounts are based on projected outturn position which is consistent with SIC financial reporting.

4.6 Appendix 1 details the consolidated year-end outturn forecast for the services delegated to the IJB. Current projected outturn to the end of March 2017 is an adverse variance of £901k. It is important to note that the adverse variance relates to the services delegated to the IJB but the IJB itself will show a breakeven position in its annual accounts for 2016/17 as a result of the additional one-off balancing payment from NHSS.

The table below details the original IJB budget, the SIC under spend of £523k being returned to SIC, the NHSS additional one off payment to the IJB of £1,424k and the resultant break even position of the IJB

£000s	Original Budget	Adjustment	Revised budget	Year end expenditure forecast	IJB variance
SIC	21,270	(523)	20,747	20,747	0
NHS	22,278	1,424	23,702	23,702	0
Total	43,458	901	44,449	44,449	0

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

Financial Commentary

4.8 Mental Health - projected outturn overspend of (£67k) (2.8%)
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 projected overspend relates to underachievement of income from Meal sales & Non-residential charges

4.9 Substance Misuse - projected outturn overspend of (£3k) (0.5%)
There are no significant variances in this service area.

4.10 Oral Health - projected outturn under spend of £6k (0.2%)
There are no significant variances in this service area.

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

4.12 Primary Care - projected outturn overspend of (£315k) (6.8%)
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 out of hours cover for police work is provided by GP on call. Out of hours cover (£13k) based on average year to date spend.

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

4.14 Directorate – projected outturn under spend of £118k (14.4%)
The projected under spend relates to SIC training due to a change in priorities - for example, using e-learning rather than classroom training, combined with inadequate cover in some areas to allow training to occur.

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

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

4.17 Adult Services – projected outturn under spend of £268k (5.1%)
The projected under spend relates mainly to employee costs £207k, 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 (£88k). Due to the re-profiling of the funding of the Eric Gray Replacement Project, it is expected that there will be an under spend of £171k in borrowing costs in the year.

4.18 Adult Social Work – projected outturn overspend of (£372k) (17.0%)
The projected overspend mainly relates to Off Island placements (£404k), for which SIC contingency of £350k is available if required, but the cost is currently being met from under spends in the Directorate, off set by a projected underspend on employee costs due vacant posts in the service during the year which have taken a number of months to fill, including savings where maternity leave has not been fully back-filled, £56k.

4.19 Community Care Resources – projected outturn under spend £470k (4.6%)
The projected overspend relates primarily to employee costs £822k, with the largest variance projected in Care At Home Central £388k, 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 under spend is off-set by the expected cost of holiday pay due to Community Care Resources employees for the year (£194k) and a projected overspend in essential Equipment/Furniture Purchases and Repair and Maintenance (£123k) mainly in relation to replacement kitchen equipment at ET House, costs associated with upgrading nurse call systems in care homes, equipment replacement and flooring at Fernlea and Isleshaven and refurbishments at North Haven.. There is a projected over-achievement of Board & Accommodation income of £298k which can vary significantly dependent on the financial circumstances of those receiving care. This off-set by a projected overspend on Independent Sector Placements (£199k) based on the current level of agreed packages, for which a Council contingency of £150k is available if required, but the cost is currently being met by under spend in the Directorate.

4.20 Criminal Justice – projected outturn under spend of £11k (37.9%)
There are no significant variances in this service area.

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

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

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

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

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

4.26 Occupational Therapy - projected outturn under spend £13k (0.8%)
There are no significant variances in this area.

4.27 Health Improvement - projected outturn overspent
This service area is expected to be on budget.

4.28 Unscheduled Care - projected outturn overspend £449k (14.8%)
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 and dementia patients etc who often require one on one care (£85k).

Cost pressures in Accident & Emergency (£22k) and in the Rehabilitation Unit (£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 (£321k).

4.29 Renal - projected outturn breakeven

This service area is expected to be on budget but has received non recurrent additional funding in 2016/17 to increase staffing levels and redesign the skill mix in the unit as there is a growing demand for this service.

4.30 Scottish Government Additionality Funding - projected outturn under spend of £79k, (15.4%)

The proposed use of the Additionality funding is set out in Appendix 6 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. The physiotherapist was only began work in February 2017 and the Occupational Therapist is currently being advertised (continued recruitment challenges). It is therefore projected this £86k budget will under spend by £79k.

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.

4.31 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 5.

For 2016/17, working closely with Acute and Specialist Services, the proposed spend of the Integrated Care Fund is to continue building the capabilities to shift the balance of care further to community settings. Supporting people to maintain

and enhance independence is key to enhancing people's lives, whilst maintaining service provision for those that most need it in the face of diminishing resources.

4.32 Recovery Plan - projected outturn unachieved (£670k)

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. As at 31 December 2016 there is a projected underachievement of £660k 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	£815,831	£224,594	£1,040,425
Savings proposed for remainder of year	£77,000	£0	£77,000
Unachieved Savings	£464,093	£195,568	£659,661

Of the £1,117,425 savings identified above, £221,973 represents recurring savings and £895,452 are non-recurrent. Further details of the Recovery Plan can be found in Appendices 6 & 7.

Overall Year End Projection

4.33 Current projected outturn to the end of March 2017 for services delegated to the IJB is an overall adverse variance of £901k which represents a projected under spend in the SIC arm of the budget of £523k and a projected over spend in NHSS arm of £1,424k. This £1,424k NHSS variance consists of the unachieved savings against the Recovery Plan of £660k from Para. 4.32 plus overspends in Managed Services £314k and Set Aside £450k.

4.34 Despite the variances in the operational budgets of both SIC and NHSS the IJB will achieve a break even position at the end of the financial year 2016/17 as a result of the SIC under spend being returned to SIC and the additional one off payment being received from NHSS.

4.35 This report is based on assumptions at the end of the third quarter of 2016/17. There are many internal and external factors which may affect these assumptions as we enter the final three months of the year.

5.0 Exempt and/or confidential information:

None

6.0

6.1 Service Users, Patients and	May be affected should services be redesigned. However appropriate consultation procedures will be followed should any

Communities:	changes have an impact on this group.
6.2 Human Resources and Organisational Development:	There are no HR implications arising directly from this report.
6.3 Equality, Diversity and Human Rights:	None
6.4 Legal:	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. 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:	NHSS has agreed to provide the IJB with a one off additional payment to cover the year end over spend in the NHSS arm of the budget. The final value of this payment will have to be agreed between the IJB Chief Officer, IJB Chief Financial Officer and the NHSS Director of Finance at the end of the financial year once the outturn position is known. It is important to note that should NHSS be unable to contain costs and their break even position becomes possible only through the use of "brokerage" then further discussion on how the repayment of this will be required between NHSS and the IJB.
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:	There are numerous financial risks involved in the delivery of services and the awareness of these risks is critical to successful financial management. From a financial perspective, risks are an integral part of planning for the future as assumptions are required to be made. These assumptions can be affected by many internal and external factors, such as supply and demand, which may have a detrimental financial impact. 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:	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. 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*". Once the options for addressing the projected over spends have been considered by the Local Partnership Finance Team 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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20th February 2017

Appendices:

1 – Year end outturn forecast
2 - Annual Budget by Organisation
3 – Recovery Plan, Directly Managed Services Savings Position
4 – Recovery Plan, 'Set Aside' Services Savings Position
5 - 2016/17 Integrated Care Fund
6 - 2016/17 Additionality Funding Held by IJB for Adult Social Care

Appendix 1

Consolidated Financial Monitoring Report
Year end outturn forecast

Service	**2016/17 Revised Annual Budget £000s**	**Projected Outturn at Quarter 3 £000s**	**Budget v Proj. Outturn Variance (Adv)/ Pos £000s**
Mental Health	2,399	2,466	(67)
Substance Misuse	661	664	(3)
Oral Health	3,177	3,171	6
Pharmacy & Prescribing	6,372	6,372	0
Primary Care	4,621	4,936	(315)
Community Nursing	2,492	2,492	0
Directorate	816	698	118
Pensioners	78	78	0
Sexual Health	38	38	0
Adult Services	5,213	4,945	268
Adult Social Work	2,186	2,558	(372)
Community Care Resources	10,193	9,723	470
Criminal Justice	29	18	11
Speech & Language Therapy	83	83	0
Dietetics	112	112	0
Podiatry	201	201	0
Orthotics	143	143	0
Physiotherapy	571	571	0
Occupational Therapy	1,593	1,580	13
Health Improvement	244	244	0
Unscheduled Care	3,037	3,486	(449)
Renal	144	144	0
Scottish Gov Additionality	512	433	79
Integrated Care Funding	410	410	0
Recovery Plan	(1,777)	(1,117)	(660)
Total	**43,548**	**44,449**	**(901)**

Appendix 2

Consolidated Financial Monitoring Report
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**

Recovery Plan **Appendix 3**

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		17,516		1,338,008
Non recurrent savings from band 6 vacancy in non doctor island Community Nursing		37,539		1,300,469
Non recurrent savings from band 6 vacancy in Podiatry		26,934		1,273,535
Non recurrent savings from band 7 vacancy in Physiotherapy		38,012		1,235,523
Non recurrent savings from band 6 vacancy in Psychological Therapy		28,846		1,206,677
Remove band 4 post from Primary Care Admin and uplift Community Nursing Admin post - balance to savings			6,364	1,200,313
Remove non pay budget from Primary Care Admin for consumables			6,600	1,193,713
Continence savings (Procurement - move to new national contract)			6,999	1,186,714
BUPA to Health at Home savings (Procurement – move to a new national contract)			20,000	1,166,714
National prescribing scheme resulting in a savings per patient due to dosage reduction (6 patients)			51,500	1,115,214
Non recurring fortuitous gains allocated to Community Health Directorate (2015/16 Board under spend / sale of properties etc)		365,121		750,093
AME to address failure to achieve savings (technical accounting issue)		209,000		541,093
Savings proposed for remainder of year				
Remaining months of Physiotherapy vacancies		40,000		501,093
Remaining months of Psychological Therapies vacancy		37,000		464,093
Unachieved savings for year				**464,093**
Total recurrent savings achieved			92,863	
Total non recurrent savings achieved		799,968		

Recovery Plan

Appendix 4

'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	232,845	41,843	232,845	0	263,209
Outpatients – skill mix change	7,659	0	7,659	0	263,209
Ronas – non pay savings	14,000	14,000	0	14,000	249,209
Non recurring fortuitous gains allocated to Acute & Specialist Services Directorate (2015/16 Board under spend / sale of properties etc)	202,800	53,641	202,800	0	195,568
Increase ECR Income target (income from charging other Boards / Trusts for treatment of their patients who required treatment whilst in Shetland	100,000	0	0	100,000	195,568
Savings proposed for remainder of year					
Nil					
Unachieved savings for year					**195,568**
Total recurrent savings achieved		129,110			
Total non recurrent savings achieved		95,484			

Appendix 5

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 6

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**	

Shetland Islands Health and Social Care Partnership

Agenda Item

5

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	10 March 2017
Report Title:	Performance Overview	
Reference Number:	CC-15-17 F	
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care	

1.0 Decisions / Action required:

1.1 That the IJB is asked to COMMENT, REVIEW and DIRECT on any issues which they see as significant to sustaining and progressing service delivery in order to meet the objectives in the Strategic Plans.

2.0 High Level Summary:

2.1 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.

3.0 Corporate Priorities and Joint Working:

3.1 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.

4.0 Key Issues:

4.1 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.

4.2 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**
  Though the Sickness Absences indicator has slightly increased this quarter Team Leaders and Managers continue to work with their respective staff groups with the support of both HR departments.

  FoISA responded to within 20 days has reached 100% (excellent) again for Quarter 3.

— **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.

CCR009 – This is a new indicator to show the number of people waiting for a permanent residential placement.

AC001 – This is a new indicator to show Hospital Inpatient Bed Occupancy rates.

CN003 – Up to the third quarter this year, as no catheter associated infections have been shown, this audit will be undertaken six monthly moving forward.

DS002 – A decrease in the ratio of WTE primary dentists has been due to a loss of dentists however this should balance out in quarter 4.

— **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 a balanced view of the number of complaints received in community health and social care directorate.

— **Appendix F**
Measuring Performance Under Integration. This Government report shows how Shetland benchmarks compared with the rest of Scotland and flags some areas where we perform particularly strongly.

5.0 Exempt and/or confidential information:

5.1 None

6.0 Implications :

6.1 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.
6.2 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.
6.3 Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
6.4 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.
6.5 Finance:	Performance monitoring allows the IJB to make decisions on priorities and to direct expenditure to particular areas through the strategic planning process.
6.6 Assets and Property:	There are no implications for major assets and property.
6.7 ICT and new technologies:	There are no implications for ICT and new technologies.
6.8 Environmental:	There are no environmental issues arising from this report.
6.9 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,
6.10 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.

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28 February 2017

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
Appendix F – Measuring Performance Under Integration

Background Documents:
Community Health & Social Care Directorate Plan

Appendix A - Projects and Actions - Integrated Joint Board

Report Type: Actions Report

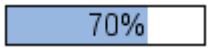
Generated on: 02 March 2017

Report Layout: IJB Simple Actions

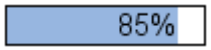
Code & Title	Description	Desired Outcome	Dates		Progress	Progress Statement	Lead
DP017b Implement findings outlined within Mental Health review	Implement findings outlined within Mental Health review (2014)	People are able to access a mental health service which is able to respond appropriately to need.	Planned Start	06-Jan-2015		Refreshed action plan in place. A number of actions completed with remainder at varying stages of progression. Additional management resource in place to support completion of actions.	Community Health & Social Care Directorate
			Actual Start	06-Jan-2014	49%		
			Original Due Date	31-Mar-2015	Expected Success		
			Due Date	31-Dec-2017			
			Completed Date		Likely to meet or exceed 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		Strategic Plan in process of being refreshed for 2017/18-2020 which includes locality information.	Community Health & Social Care Directorate
			Actual Start	02-Nov-2015	90%		
			Original Due Date	31-Mar-2015	Expected Success		
			Due Date	31-Mar-2017			
			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	100%		
			Original Due Date	31-Mar-2015	Expected Success		
			Due Date	31-Dec-2016			
			Completed Date	24-Jan-2017	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 and being consulted on across both organisations.	Community Health & Social Care Directorate
			Actual Start	11-Nov-2015			
			Original Due Date	31-Mar-2016	Expected Success		
			Due Date	31-Mar-2017			
			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			
			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		Rate of development has increased. Capacity identified through the Meridian Productivity Programme has been diverted to supporting further development of Anticipatory Care Plans.	Community Health & Social Care Directorate
			Actual Start	12-Nov-2015			
			Original Due Date	31-Mar-2016	Expected Success		
			Due Date	31-Mar-2017			
			Completed Date		Likely to meet or exceed target		

Appendix B - Council-wide Indicators

Shetland Islands Council

Code & Short Name	Previous Years			Quarters				(past) Performance & (future) Improvement Statements
	2012/13	2013/14	2014/15	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	
	Value	Value	Value	Value	Value	Value	Value	
OPI-4A Staff Numbers (FTE) - Whole Council	2413	2224	2191	2169	2186	2189	2200	Managers continue to carefully manage staff numbers and associated costs and reflects recruitment pressures in some areas.
OPI-4A-E Staff Numbers (FTE) - Community Health & Social Care Directorate	642	530	517	493	494	498	507	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				634	638	641	651	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4C Sickness Percentage - Whole Council	4.1%	3.6%	4.2%	4.0%	2.6%	2.6%	3.1%	A reduction from previous year reflects a greater focus in maximising attendance.
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	5.6%	4.1%	4.1%	4.8%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.
OPI-4E Overtime Hours - Whole Council	74,808	71,020	83,510	22,705	21,159	21,394	24,528	Overtime and Overtime budgets are devolved to departmental level. Overtime is often the most cost effective way to utilise existing teams and ensure prompt service to our customers.
OPI-4E-E Overtime Hours - Community Health & Social Care Directorate	2,470	1,856	5,675	1,218	246	550	852	Q3 increase due to annual leave cover
E01 FOISA responded to within 20 day limit - Health & Social Care Services	93%	79%	91%	96%	92%	100%	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).

Generated on: 28 February 2017 10:33

	Previous Years				Last year	This year	
Code & Short Name	2012/13	2013/14	2014/15	2015/16	Q3 2015/16	Q3 2016/17	(past) Performance & (future) Improvement Statements
	Value	Value	Value	Value	Value	Value	
OPI-4C Sickness Percentage - Whole Council	4.1%	3.6%	4.2%	3.7%	3.5%	3.1%	A reduction from previous year reflects a greater focus in maximising attendance.
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.4%	6.0%	6.0%	5.6%	5.3%	4.8%	Managers are working with both HR teams to ensure consistent application of the Maximising Attendance policies.

Appendix C - Directorate Performance Report – Local Delivery Plan

Shetland Islands Council

Generated on: 24 February 2017

Local Delivery Plan

	Years				Quarters				
Code & Short Name	2014/15		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	(past) Performance & (future) Improvement Statements
	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%	43.7%	100%	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%	75.7%	76.6%	80%	90%	The Consultant Psychologist is now in post and work is underway to make the most efficient use of psychological therapy resources.
LDP003a Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery			90%	90%	75%	100%	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%	77.8%	100%	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	42	82	134	195	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	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	97.4%	98%	96.6%	98%	94.7%	94.6%	97.6%	98%	602 presentations out of 617 left A&E Department within four hours

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

Shetland Islands Council

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		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Target	Value	Value	Value	Target	
ASW003 Percentage of outcomes for individuals are met									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		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Target	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%		42.25%	30%	47%	50%	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	199	200	195	208	209	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.

	Years				Quarters				
Code & Short Name	2014/15		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Target	Value	Value	Value	Target	
CN002 Percentage of early supported discharges with no readmission in 30 days by Intermediate Care Team		100%	94%	100%	100%	91%	100%	100%	11 patients in the quarter, 9 early supported discharge, 2 prevention of admission, no re-admissions but 1 death.
CCR009 Number of people waiting for a permanent residential placement.			12	10	9	9	4	10	Target to have less than 10 people waiting for a permanent residential placement. Currently well within target at the end of December 2016.
MH002 Admission rates to Psychiatric Hospitals			15	24	6	3	2	6	This will help us consider the effectiveness of our local service provision.
MH003 People with a diagnosis of dementia on the QOF dementia register			170		169	173	174	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)			657	599	670	672	663	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).
AC001 Hospital Inpatient Bed Occupancy rate			62.7%		60.3%	62.4%	48.2%		New measure added to allow monitoring of inpatient occupancy rates in GBH. Relatively low level of occupancy reflects positive progress in supporting shift in the balance of care

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		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	
	Value	Target	Value	Target	Value	Value	Value	Target	
CJ002 Percentage of new Community Payback Orders (Supervision) seen within 5 working days of the order being made			94.65%	100%	100%	100%	100%	100%	Target being met.
ASW001 Percentage of assessments completed on time			82.05%	100%	100%	92%	92.5%	100%	Each instance of missed target analysed by line manager
ASW002 Percentage of reviews completed on time			92%		91%	90%	87.3%	100%	All statutory reviews (annual reviews) were completed on time but we missed 12.7% of 6 monthly reviews, due to a lack of social worker availability or family availability.

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		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	
	Value	Target	Value	Target	Value	Value	Value	Target	
DS004 Number of people who are waiting to register with Public Dental Service (PDS) for ongoing Care			640		753	704	613	500	Source: Local data. Despite waiting, all these people are able to access NHS dental care elsewhere.
CN001 Number of Anticipatory Care Plans in Place			718.33		917	940	981	700	Data shows an increase of 41 in the last quarter.

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		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	
	Value	Target	Value	Target	Value	Value	Value	Target	
AS003 Number of incidents of emergency respite provided for adults with Learning Disability/Autistic Spectrum Disorder			1		0	0	0	0	An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays. Source: Newcraigielea The risk of unscheduled care will be reduced.

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

Code & Short Name	Years				Quarters				(past) Performance & (future) Improvement Statements
	2014/15		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	
	Value	Target	Value	Target	Value	Value	Value	Target	
CCR001 Delayed discharge from Hospital - no delays exceeding 14 days			2		0	2	0	2	Intense work with acute services to work out delays in systems and processes
CJ001 Percentage of Criminal Justice Social Work Reports submitted to Courts on time					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%	80%	100%	The decrease is in relation to one individual being incarcerated, this is outwith service control.
PPS002 Percentage rate of antibiotic prescribing in relation to Scottish average			94.77%		98.8%	96.1%	104%	99%	In general we are expecting less antibiotics to be prescribed in Shetland than in the Scottish population. This is not always achievable and prevalence of infection in Shetland does not always coincide with national prevalence figures.
PPS003 Number of polypharmacy reviews completed			57	360	58	121	122	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

Code & Short Name	Years				Quarters				(past) Performance & (future) Improvement Statements
	2014/15		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	
	Value	Target	Value	Target	Value	Value	Value	Target	
									resource.
PPS004 Number of discharge prescriptions dispensed out of hours by nursing staff	114	98			47	34	41	48	Good discharge planning should reduce the need for nurses to dispense medicines out of hours. Dispensing by pharmacy always more appropriate.
CN003 Percentage of Catheter Associated Infections in individuals with an indwelling urinary catheter			2%	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.

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		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	
	Value	Target	Value	Target	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		2,048.75		2,167	2,167	2,438	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). Increase due to loss of dentists however this should balance out in Q4.
AHP001 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count)			7	10	6	12	24	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. Complexity of referrals has slowed down assessments and we are currently looking at capacity.
AHP002 Percentage Waiting Time from Referral to Treatment for Orthotics Services (18 weeks)			98.73%	90%	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%	97.93%	90%	99.2%	99.3%	99.3%	90%	Service consistently meets target. Significant pressures due to long term sickness absence, and increased number of referrals.

	Years				Quarters				
Code & Short Name	2014/15		2015/16		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q3 2016/17	(past) Performance & (future) Improvement Statements
	Value	Target	Value	Target	Value	Value	Value	Target	
AHP004 Percentage Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)			99.67%	90%	99.2%	100%	94.7%	90%	Each instance of missed target is analysed by line manager.
CCR005 Occupancy of care homes	88.7%	90%	91.2%	90%	88%	90.3%	84.7%	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%	87.05%	100%	63.6%	66.7%	100%	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			103.6%	99%	98.1%	96.6%	97.1%	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 E - Complaints - Community Health & Social Care

Shetland Islands Council

This shows all complaints that were open during the Quarter. Frontline complaints should be closed within 5 working days. Investigations should be closed within 20 working days

Failure to provide a service

ID	Stage Title	Title	Received Date	Closed Date	Service/ Directorate	Days Elapsed	Complaint Upheld?	Lessons learnt	The root cause of the complaint
COM-16/17-501	Frontline	Self Referral to the Occupational Therapy Service	17-Oct-2016	19-Oct-2016	Occupational Therapy (Council AHP + NHS)	2	Not Upheld	The service is currently reviewing responses to referrals to look at changing the process	Client did not understand the relationship between Occupational Therapy departments in Grampian and Shetland. Client was written to, to advise that Grampian therapists would be in touch with Shetland before client is discharged and an apology was provided if the letter sent caused the client anxiety.

Standard of service received

ID	Stage Title	Title	Received Date	Closed Date	Service/ Directorate	Days Elapsed	Complaint Upheld?	Lessons learnt	The root cause of the complaint
COM-16/17-545	Investigation	Client and family unhappy with stairlift provided	22-Nov-2016	16-Dec-2016	Community Health & Social Care Directorate	18	Partially Upheld	OT to speak to Hjaltland Housing Association and Robertson and Peterson to ensure that when a stairlift is measured for, appropriate advice is given to the recipient about whether minor adaptations might be required on installation.	Insufficient information given to client by installer about whether of not minor adaptations to a property might be required to enable stairlift to be installed.

ID	Stage Title	Title	Received Date	Closed Date	Service/ Directorate	Days Elapsed	Complaint Upheld?	Lessons learnt	The root cause of the complaint
COM-16/17-554	Frontline	Care for Client	12-Dec-2016	20-Dec-2016	Community Health & Social Care Directorate	6	Not Upheld	Ensuring a copy of care plans are provided to clients	Slight confusion over change in care staff and changes to rota for care.

Disagreement with decision made

ID	Stage Title	Title	Received Date	Closed Date	Service/Directorate	Days Elapsed	Complaint Upheld?	Lessons learnt	The root cause of the complaint
COM-16/17-516	Frontline	Earlier Assessment Required	06-Nov-2016	10-Nov-2016	Community Health & Social Care Directorate	3	Upheld	Specific risk factors were identified which meant that the client has been moved up the waiting list. Possible solutions to the problems experienced in the bathroom have also been offered to the client.	On waiting list – reviewed and now moved up the list.
COM-16/17-543	Investigation	Alteration to property for installation of a bath	22-Nov-2016	16-Dec-2016	Community Health & Social Care Directorate	18	Not Upheld	OT to ensure a holistic approach is taken to collating information, including from specialist sources and other professionals involved in case.	

Summary of complaints for community services in 2016/17

A summary of formal complaint activity for NHS Shetland from 1 April 2016 to 2 March 2017 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 2 March 2017 the Board received a total of 55 formal complaints. Complaints and feedback staff have also handled 93 patient feedback contacts. Of the 55 formal complaints received in year to date, 31 relate to the community health and social care directorate and five 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**	**Quarter 4 (to date)**	**Total**
	1.4.16 – 30.06.16	**01.07.16 – 30.09.16**	**01.10.16 – 31.12.16**	**01.01.17 – 02.03.17**	
Directorate of Acute and Specialist Services	6	4	5	3	18
Directorate of Community Health and Social Care	10	11	4	6	31
Acute & Community	1	1	2	1	5
Board HQ Services	1	0	0	0	1
Other	0	0	0	0	0
Withdrawn	0	0	0	0	0
Total	**18**	**16**	**11**	**10**	**55**
Outcome	Upheld: 5 Partly upheld: 8 Not upheld: 5	Upheld: 10 Partly upheld: 5 Not upheld: 1	Upheld: 3 Partly upheld: 4 Not upheld: 4	Upheld: 3 Not upheld: 1 Open: 6	

Community Health and Social Care Directorate Complaints received 1 April 2016 to 2 March 2017

	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	Lack of support and failure to transition correctly between services	CAMHS / CMHS	N	Meeting held with complainant and key staff members to better understand issues	Upheld	• Apology given that the service had been sporadic with staff absences the previous year • Team asked to review procedures for changing patient medication and the necessary follow up appointments • Adult team to provide a second contact to provide better continuity for staff absences
11	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						
12	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
13	Dissatisfaction with diagnosis and staff attitude	GP	N	Additional details required to be checked at latter stage	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

				of investigation		how to improve for future consultations
14	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
15	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
16	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
17	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

18	Examination without chaperone, communication	GP	Y		Part upheld	• GP asked to ensure chaperones are present as appropriate • Suggestions made re communication challenges
19	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
20	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
21	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
22	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
23	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						
24	Poor communication and inability to pre-book GP appt	LHC	Y		Upheld	• Formal apology given. • Meeting held with Practice Manager and Medical Director following complaint response. • Patients to always be informed of test results which require further investigation/treatment • Explanation of trial for electronic transmission of x-ray and ultrasound reports

						• Clinicians reminded by Medical Director that results from referrals for CT scans will go to hospital consultants
25	Lack of physical examination and missed symptoms	GP and secondary care	N	Slight delay in receiving all required clinical information	Partly upheld	• Significant Event Analysis carried out by GP and discussed by the full practice team at LHC to determine if anything had been missed • Medical reasoning found to be appropriate at the time of presentations
26	Access to treatment	Orthodontics	Y		Not upheld	• Explanation that final assessment and decision making is at consultant level and in this instance the service user did not meet the required criteria
27	Lack of examination in A&E, review of condition sought, GP attitude and refusal of home visits and lack of privacy at LHC	A&E and LHC	Y		Not upheld	• No issue found with clinical treatment • Investigation not able to substantiate any concerns about staff attitude • Explanation about alternative appointment booking arrangements as required
28	Poor communication regarding removal from waiting list	Dental	Y		Partly upheld	• Explanation given that registration at a different practice would mean a patient would need to re-register again, however the PDS waiting list is now closed • Apology given about perceived staff demeanour
29	Delay in diagnosis	Primary and secondary care clinicians	N	Complex investigation involving numerous clinicians including from out with the Board area	Partly upheld	• Diagnosis pathway found to be reasonable, however communication could have been improved upon. Review to be carried out with clinicians involved to identify additional learning in this regard.
Quarter 4						
30	Delay in accessing treatment	Orthodontics	Y		Upheld	• Challenges regarding orthodontic provision explained • Apology given that a communication issue meant the patient had been documented as routine rather than priority and a quicker appointment date provided

31	Delay in accessing treatment	Orthodontics			Open	
32	Access to psychological therapies	CMHT			Open	
33	Treatment provided	CMHT			Open	
34	Treatment	Dental			Open	
35	Poor nutritional care and difficulty with community nursing visit	GBH and community nursing			Open	
36	Access to GP appointment and staff attitude	LHC			Open	

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COSLA

To: Chief Officers – Integration Authorities

19 January 2017

Dear Colleagues

MEASURING PERFORMANCE UNDER INTEGRATION

The Ministerial Strategic Group for Health and Community Care (MSG) discussed how to measure progress under integration at its meetings on 16 November and 21 December.

At the meeting on 21 December MSG agreed that for 2017/18 we will track across Integration Authorities:

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) A&E performance;
(4) delayed discharges;
(5) end of life care; and
(6) the balance of spend across institutional and community services.

You are each invited to set out your local objectives for each of the indicators for 2017/18 by the end of February. MSG has agreed that it will receive a quarterly overview on progress across the whole system and you are asked to produce your objectives on that basis. We are meeting with the Executive Group of Chief Officers on Friday and will discuss what national support you would want us to offer for this process. Our objective will be to adapt and use existing data collection methodologies where possible and to establish a clear process for the work.

When we met on 16 December we had indicated that as a minimum we would provide data for each partnership covering each of the indicators. The data would show the position for all partnerships to enable individual Integration Authorities to understand the shape and

nature of their service relative to others. We are still working on the structure and format of that data. For now, we attach high level data covering a number of the areas (**Annex A**). Again we would intend to use the conversation on Friday to discuss the structure and format of the data with the intention of writing shortly after to all Chief Officers with the necessary material.

MSG noted that the approach for future years may change as a consequence of the Review into Targets and Indicators being undertaken by Sir Harry Burns and also as data sources for particular areas of service delivery improvement. It also noted that most key service delivery areas under integration have a direct impact on these higher level system indicators. In particular, it is important that we are able to understand both the contribution of social care and primary care services to these higher level system indicators, but also how they support important outcomes in respect of independent living and the protection and maintenance of health.

Local partnerships are already using a wide range of data to support their commissioning and delivery activity and will continue to operate under the duties in the 2014 Act in respect of public reporting. This process is not intended to duplicate or substitute for that process.

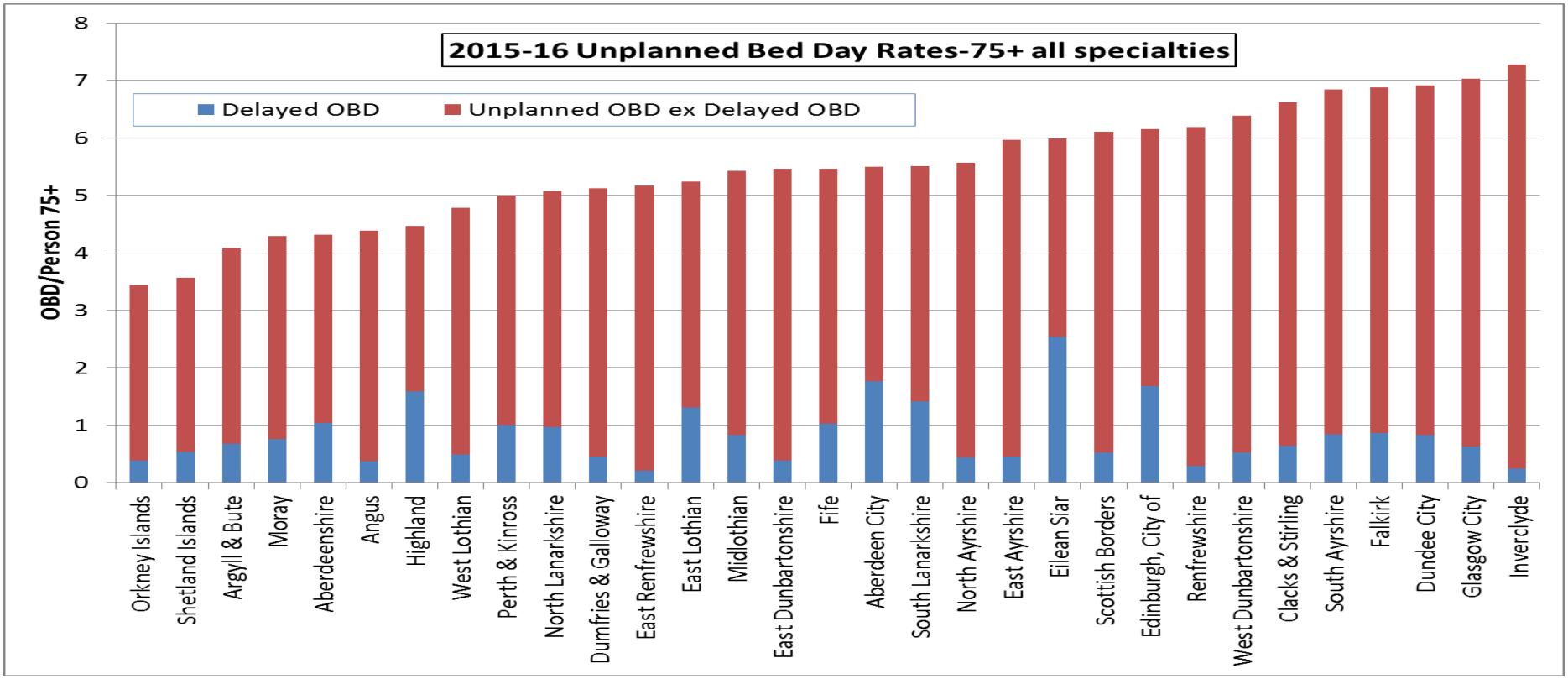
The Local Delivery Plan (LDP) Guidance for 2017/18 has been issued to NHS Chief Executives and sets the expectation that Boards and regional planning partnerships ensure that their objectives and plans are consistent with Integration Authority plans. Similarly, given the interaction with the hospital system you will need to ensure that your objectives and plans are consistent with NHS Board and regional plans for 2017/18.

Yours sincerely

GEOFF HUGGINS
Scottish Government

PAULA McLEAY
COSLA

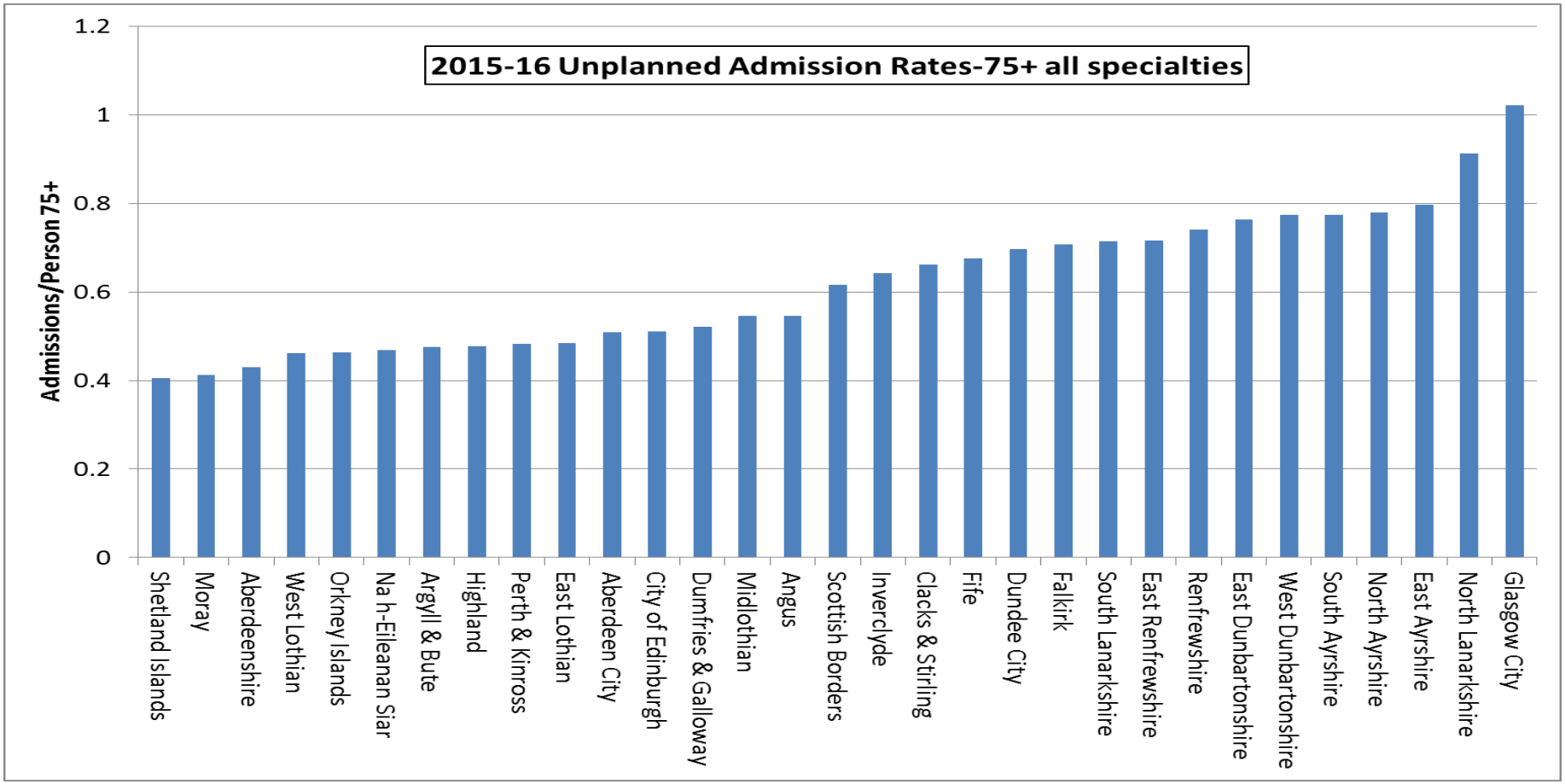
Unplanned Bed Days



Notes: This chart shows the unplanned bed days per capita for people aged 75+ for each partnership (in 2015/16). It is for unplanned bed days in all specialties and differentiates between the bed days used by delayed patients and other non-delayed bed days. A total of 2.5m bed days were used by people age 75+ of which 400k were by delayed patients, an average of 16% of the total bed days for this age group and varying across partnerships from 3.4% to 42%. There is a two-fold variation in the overall bed day rates across partnerships and a 12 fold variation in delayed bed

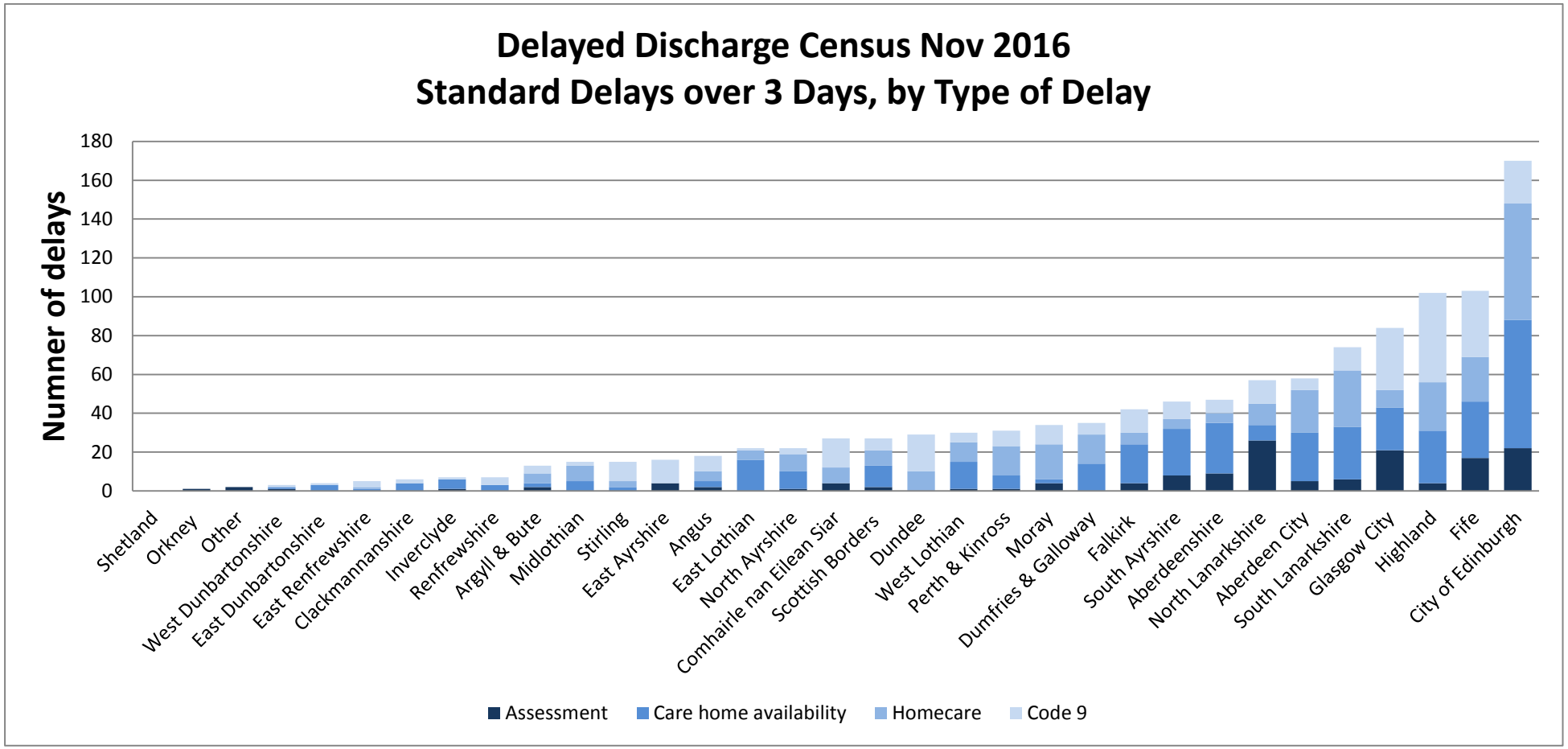
day rates. There is no association between delayed bed day rates and overall bed day rates. We can develop this analysis to include other age groups and to differentiate between specialties and type of delay.

Unplanned admissions



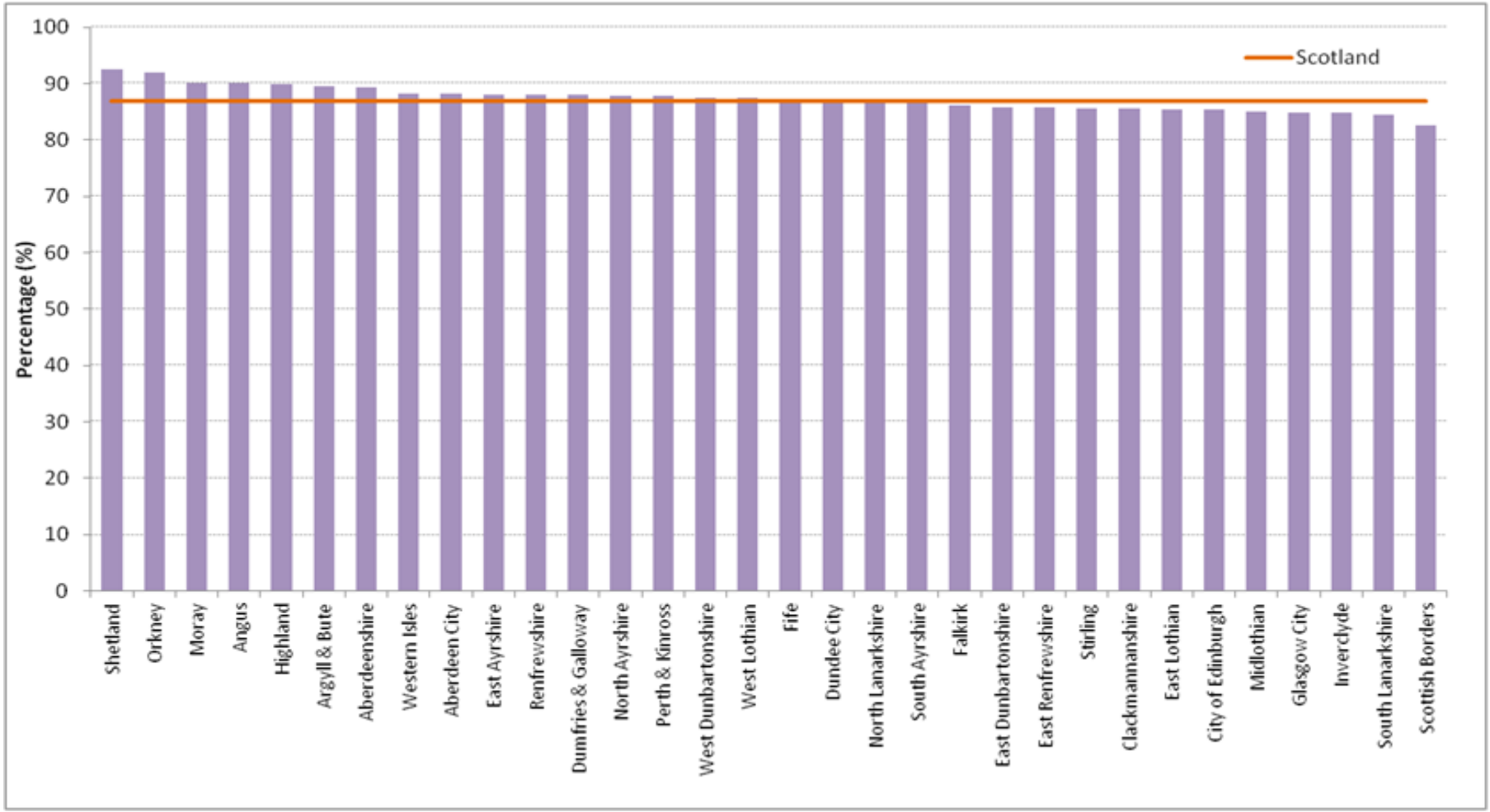
Notes: This chart shows the unplanned admissions per person aged 75+ in all specialties in 2015/16. We can see that the two fold variation seen in the bed days chart is evident here, although there is some slight re-ordering which is to be expected as bed day rates are a function of admission rates and length of stay. We can develop this analysis to consider different age groups and specialties.

Delayed Discharge Census: Standard Delays > 3 days by type of delay



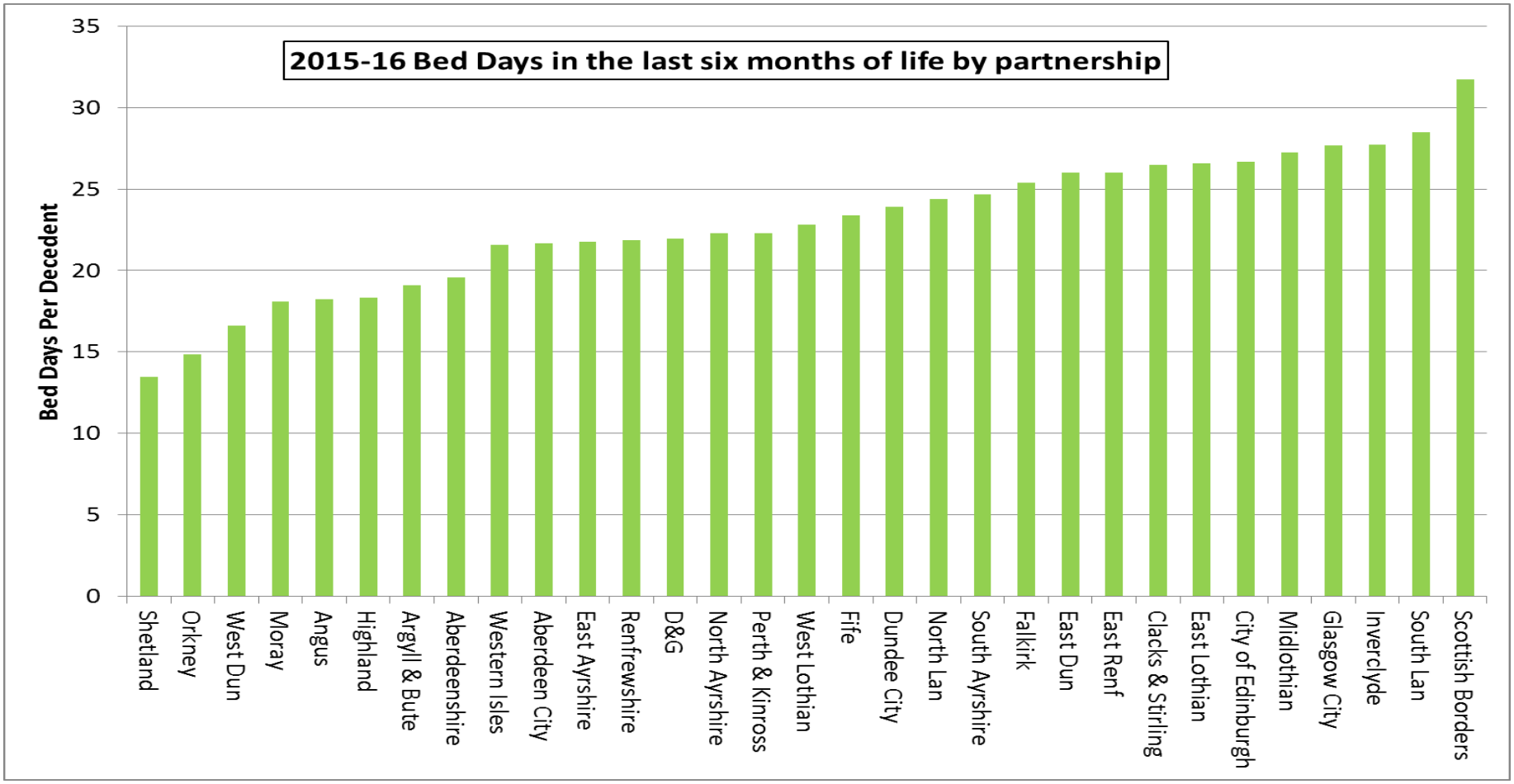
Notes: this chart shows the number of delays by type of across all partnerships. These figures exclude family reasons. There is considerable variation across partnerships. There are also differences in the main reason for delays. For example while care home and home care are key reasons for some partnerships, Code 9 categories appear to be the main reason for others

End of Life (a)



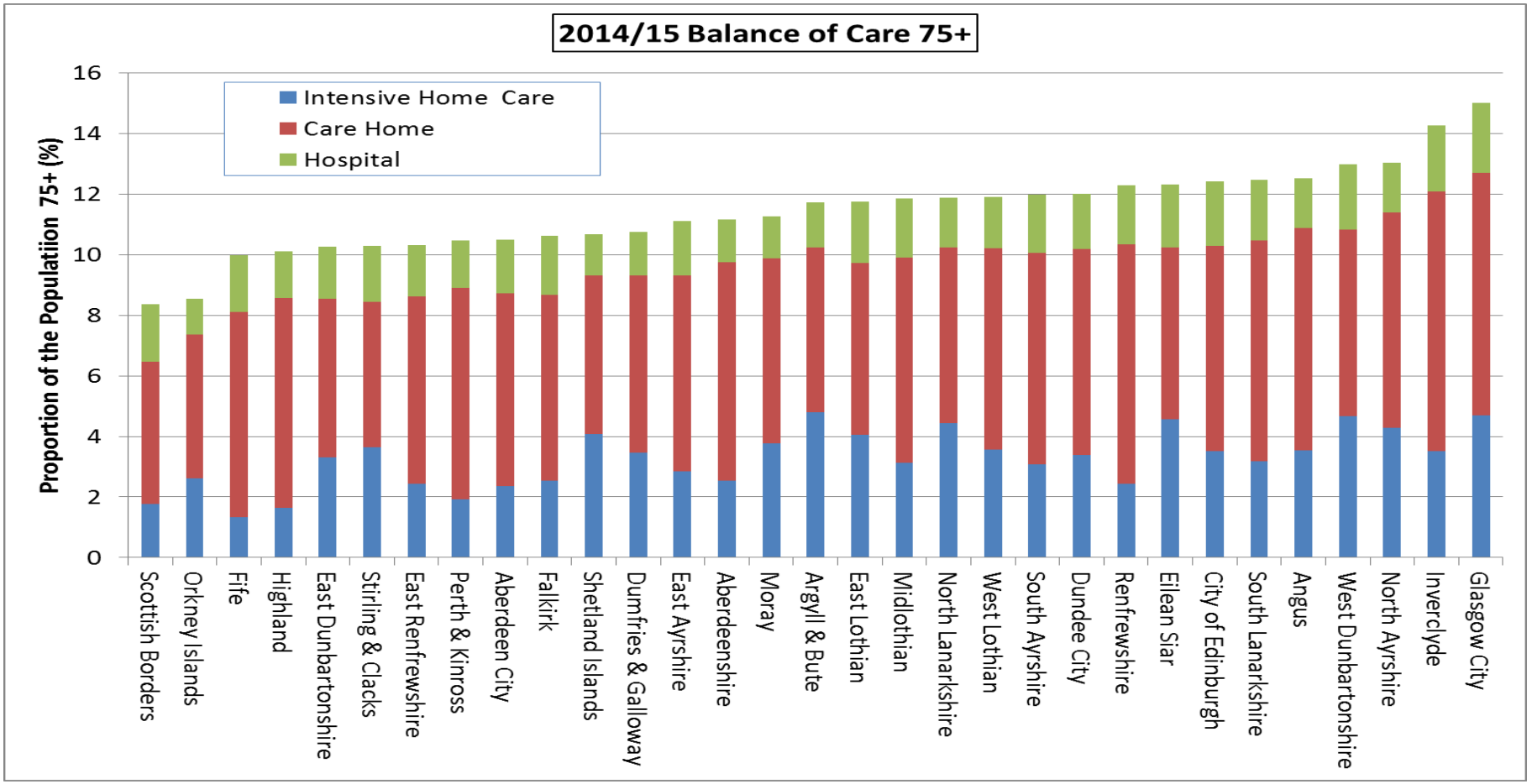
Notes: This chart shows the proportion of the last six months of life spent at home or in a community setting for people who died in 2015/16. There is a difference of 10% across partnerships. We can develop this analysis by considering different age groups and by differentiating between settings.

End of Life (b)



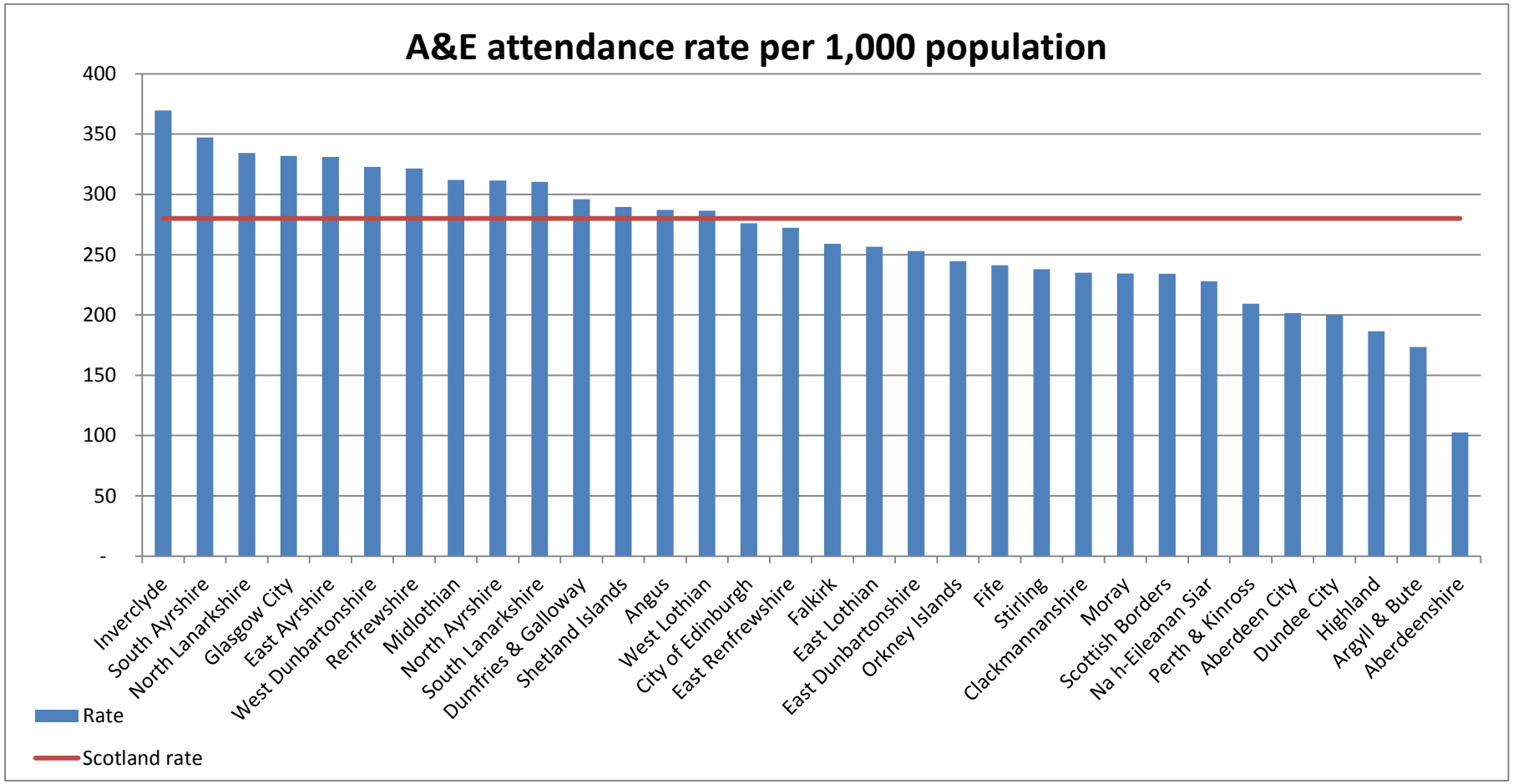
Notes: This chart shows the average unplanned bed days in the last six months of life for people who died in 2015/16. There is a two- fold variation across partnerships. If all Scottish partnerships could attain the same bed days per decedent as Shetland, half a million bed days could be saved-equivalent to the 10% commitment in the Delivery Plan.

Balance of Care



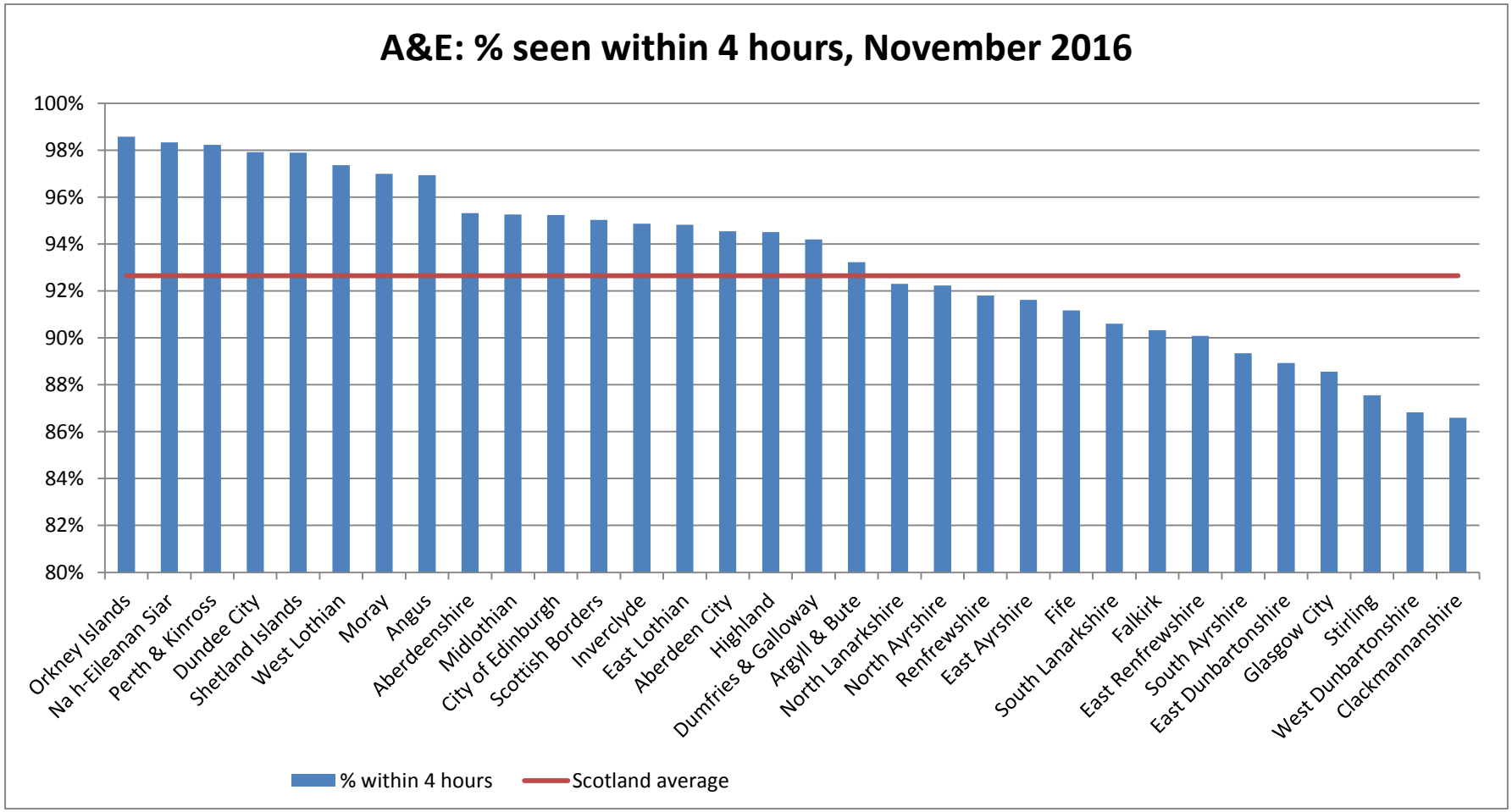
Notes: This chart looks at balance of care for people aged 75+ and shows the proportion of partnership populations aged 75+ who were either in hospital, in a care home or in receipt of 10+ hours home care in 2014/15. There is an almost two-fold variation (8% c/w 15%). Across Scotland, 8.5% of people aged 75+ were either a care home or hospital varying from 5.9% to 10.7% across partnerships. We can develop this analysis to include other age groups and to reflect the balance of care as a spectrum of settings; we can also look at spend across the spectrum.

A&E (a) : **A&E attendance rate per 1,000 population by Partnership 2015/16**



Notes: this shows the attendance rate at A&E per 1000 population by Partnership. There is considerable variation between Partnerships –370 per 1000 population in Inverclyde while 102 attendees per 1000 population in Aberdeenshire (Scotland – 280 per 1000). The difference is likely to reflect a range of issues including demographic factors, proximity of population to A&E facility as well as other healthcare provision .

A&E % seen within 4 hours



Notes: This chart shows performance on the 4 hour wait target by partnership. There is a difference of 11% between the highest performing area and the lowest performing area. The Scotland average is 93%. We can also provide A&E data on conversion rate- eg the proportion of A&E attendances which result in admission to hospital

Shetland Islands Health and Social Care Partnership

Agenda Item

6

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	10 March 2017
Report Title:	Risk Register – IJB	
Reference Number:	CC-12-17 F	
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care	

1.0 Decisions / Action required:

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

2.0 High Level Summary:

2.0 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

3.0 Corporate Priorities and Joint Working:

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

4.0 Key Issues:

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

4.2 Risk IJB024 has been created to highlight concerns around changes to the voting Membership.

4.3 Risk IJB023 relates to the Mental Health Service. The residual risk rating remains high whilst procedures and processes are embedded and until we have assessed their ongoing efficacy. A number of reviews of particular functions within the service have been carried out and action plans are being closely monitored to ensure that these are progressed.

5.0 Exempt and/or confidential information:

5.1 None.

6.0 **Implications :**

6.1 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.

6.2 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.
6.3 Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
6.4 Legal:	There are no legal implications arising directly from this report. Legal issues are considered as an integral part of the risk management process.
6.5 Finance:	There are no financial consequences arising directly from this report.
6.6 Assets and Property:	There are no implications for major assets and property.
6.7 ICT and new technologies:	There are no ICT issues arising from this report.
6.8 Environmental:	There are no environmental issues.
6.9 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.
6.10 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).
6.11 Previously considered by:	This report has not been presented to any other formal meeting.

Contact Details:
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15 February 2017

Appendices:
Appendix 1 – Integration Joint Board Risk Register

Background Documents:
Community Health & Social Care Directorate Plan

Integration Joint Board

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Target Probabilty	Target Impact	Target Risk Profile	Responsible Officer
Category	**Corporate**							
Corporate Plan	*F1. Our "20 by '20" - Leadership & Management*							
Integration Joint Board Membership, and availability of members, to attend meetings due to either short notice or resignations of posts. Trigger : Change in membership due cycle of time coming to end, resignation, etc. Consequences : Integration Joint Board unable to make decisions required Risk type : Partnership working failure Reference - IJB0024	Possible	Major	High	• Need to ensure Members understand their role. Ensuring induction programme is in place for new Members. Contingency arrangements for substitute Members.	Unlikely	Significant	Medium	Simon Bokor-Ingram Integration Joint Board
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*							
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. Trigger : Poor strategic planning Consequences : Poor outcome for individuals and communities Risk type : Policies - effect of Reference - IJB0003	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	Simon Bokor-Ingram Integration Joint Board
Strategic Planning for Health & Social Care is ineffective. The Strategic Plan does not reflect the needs of communities and identify appropriate communication strategies. Trigger : Consequences : Risk type : Policies - effect of Reference - IJB0017	Unlikely	Major	Medium	• Participation and Engagement Strategy in place. Actionplans developed for the preparation of the strategic plan. Strategic planning group in place. Work in localities is being developed engaging with a wide range of stakeholders including staff, service users, other service providers, community representatives.	Unlikely	Significant	Medium	Simon Bokor-Ingram Integration Joint Board
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. Trigger : Consequences : Risk type : Policies - effect of Reference - IJB0018	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	Simon Bokor-Ingram Integration Joint Board

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. Trigger : Consequences : Risk type : Partnership working failure Reference - IJB0019	Almost Certain	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.	Unlikely	Major	Medium	Simon Bokor-Ingram Integration Joint Board
Poor attendance or lack of commitment to the IJB from among its members. Trigger : Consequences : Risk type : Partnership working failure Reference - IJB0020	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	Simon Bokor-Ingram Integration Joint Board
Failure to provide adequate corporate services support to the IJB eg. finance, legal, committee services, ICT & HR Trigger : Consequences : Risk type : Technological - Other Reference - IJB0021	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	Simon Bokor-Ingram Integration Joint Board
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. Trigger : Failure to identify community needs Consequences : Cannot being to address issues arising within a defined community Risk type : Policies - effect of Reference - IJB0022	Possible	Major	High	• Locality planning in the development of the Strategic Plan. The planningprocess for the Strategic Plan 2016-19 included conversations at a locality level. Locality leads need to be identified.	Unlikely	Significant	Medium	Simon Bokor-Ingram Integration Joint Board
Unable to deliver the strategic aims and objectives for mental health as set out in the 2016/17-19 Strategic Commissioning Plan. Trigger : Consequences : Risk type : Modernisation - too slow Reference - IJB0023	Possible	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.	Unlikely	Significant	Medium	Simon Bokor-Ingram Integration Joint Board

Shetland Islands Health and Social Care Partnership

Agenda Item

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Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	10 March 2017
Report Title:	Risk Register – Community Health & Social Care Directorate	
Reference Number:	CC-13-17 F	
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care	

1.0 Decisions / Action required:

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

2.0 High Level Summary:

2.0 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.

3.0 Corporate Priorities and Joint Working:

3.0 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.

4.0 Key Issues:

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

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

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

4.4 Directorate risk EM0031 has been updated and the residual risk rating increased to reflect the current challenges that exist in the Mental Health service. A refreshed action plan has been put in place and additional management resource is in place to support completion of these actions.

5.0 Exempt and/or confidential information:

5.1 None

6.0 **Implications :**	
6.1 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.
6.2 Human Resources and Organisational Development:	Risk management promotes best practice and seeks to protect staff across the Health & Social Care Directorate.
6.3 Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications.
6.4 Legal:	There are no legal implications arising directly from this report. Legal issues are considered as an integral part of the risk management process.
6.5 Finance:	There are no financial consequences arising directly from this report.
6.6 Assets and Property:	There are no implications for major assets and property.
6.7 ICT and new technologies:	There are no ICT issues arising from this report.
6.8 Environmental:	There are no environmental issues arising from this report.
6.9 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.
6.10 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).
6.11 Previously considered by:	This report has not been presented to any other formal meeting.

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15 February 2017

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

Background Documents:

Risk Assessment - Social Care Services

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Target Probabilty	Target Impact	Target Risk Profile	Responsible Officer
Category	**Directorate**							
Corporate Plan	*F1. Our "20 by '20" - Leadership & Management*							
Management capacity issues Trigger : Aspects of Community Health and Social Care have been managed on an interim basis by Executive Managers. Consequences : Poor decision-making, poor outcomes for patients/ staff/ organisation, reputational risk Risk type : Strategic priorities wrong Reference - EM0039	Possible	Significant	Medium	• The structure will ensure that there is adequate management capacity including professional leadership. The structure will need to respond to changes in strategic direction to ensure that capacity is focused on priorities.	Unlikely	Minor	Low	Simon Bokor-Ingram Social Care Services
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. Trigger : Manual handling injury. Potential lack of, or inappropriate procedures. Staff not aware of procedures or training, not following training. Poor practice, corner-cutting because of pressure of work. lack of resources. ?Refresher training not given/ missed/ not available? Consequences : Injury or harm to individual employee, sickness absence, possible HSE investigation and/ or, civil claim, possible financial cost. Sickness absence, shortage of staff, impact on colleagues that are required to cover for absent employee, increased workload, stress. Impact on the service, possible service delivery failure because of a lack of staff. Risk type : Physical - People / Property - Other Reference - EM0048	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	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*							

Services operate within a complex legislative, contractual and compliance environment. Clients/ patients are many and varied in age, vulnerabilities and needs Trigger : Professional error or omission, possibly from a lack of, or inappropriate training, communication failure, poor assessment of need. Consequences : Failure to act appropriately with relation to Adult and Child Protection issues, harm or an adult or child, action by professional body/ HSE/ local authority/ govt, bad publicity, staff stress, civil claim Risk type : Professional Errors and Omissions Reference - EM0034	Unlikely	Significant	Medium	• Monitoring by professional leads re skills and capacity. Staff training plan developed each year. Incidentsfully investigated. Clinical, Care & Professional Governance Committee structure in place.	Rare		Significant	Low	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F6. Our "20 By '20" - Financial Management*								
Maintaining and improving the oral health of the local population Trigger : Inability to provide sufficient dental services to meet local needs Consequences : Inability to deliver sustainable, cost effective and affordable dental services Risk type : Demographic change Reference - EM0035	Likely	Major	High	• Review taking place of current Dental Service staffing levels and skill mix to ensure the model in place is working effectivelywith flexibility for the future. Encourage local development of independent NHS dental practices to help mitigate this risk	Possible		Minor	Medium	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F8. Our "20 by '20" - Efficient*								
Inability to deliver cost-effective, safe Mental Health Service Trigger : Inability to provide quality, effective and safe services, delivered in the most appropriate setting for the patient/client. Consequences : Inability to deliver cost-effective, safe Mental Health Service, impact on patients, financial cost, bad publicity Risk type : Modernisation - too slow Reference - EM0031	Possible	Major	High	• Following reviews of mental health and dementia, there are action plans in place which are being closely monitoredto ensure progress on strengthening the services. With the additional funding allocated from health, recruitment of staff has been successful.	Unlikely		Minor	Low	Simon Bokor-Ingram Social Care Services
Category	**Operational**								
Corporate Plan	*F2. Our "20 By '20" - Staff Value & Motivation*								

Difficulty in ensuring sustainable provision of services and retention of skills in small and remote communities. Trigger : A number of single handed posts exist which can be hard to recruit to. Consequences : Potential difficulties of recruiting staff to particular service areas Risk type : Key staff - loss of Reference - EM0044	Likely	Significant	High	• Cover provided using permanent or temporary staff. Targeted recruitment campaigns. Develop staff already in post to broaden their skills base.	Possible		Significant	Medium	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*								
Conflict of interest between roles of NHS and Council. Trigger : Failure to agree on certain issues which does not allow delivery to progress or parties disengaging leading to inability to deliver current services. Consequences : Poor service delivery and cohesive approach Risk type : Partnership working failure Reference - EM0007	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 IJBto 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	Simon Bokor-Ingram Social Care Services
NHS and SIC are required to comply with Scottish Social Services Council and National Care Standards Trigger : Poor inspection ratings, failure to comply with NC standards Consequences : Potential for closure of services, bad publicity, reputational damage Risk type : Legal / Compliance - Other Reference - EM0018	Possible	Significant	Medium	• Regular inspections; Staff aware of the standards requiredRecent joint inspection of older people's services will give overview of quality	Rare		Significant	Low	Simon Bokor-Ingram Social Care Services
Response to an emergency situation Trigger : Critical pressure on staff and resources in an emergency situation where services are unable to respond adequately. Consequences : Failure to provide service, impact on staff, service and communities Risk type : Business continuity plan inadequate Reference - EM0023	Unlikely	Major	Medium	• Business continuity plans in place for community health and social care services. Involvement in planning and exercises.Refresh of Caring for People Plan is now completed.	Rare		Major	Medium	Simon Bokor-Ingram Social Care Services
Category	**Strategic**								
Corporate Plan	*B2. Older People - Independent Living*								

Inability to provide consistent, high quality, sustainable Out of Hours Care leading to inability to respond to need in the community. Trigger : Failure to provide quality, effective and safe services, delivered in the most appropriate setting for the patient/client Consequences : Shetland community at risk Risk type : Legal - Other Reference - EM0021	Likely	Major	High	• Opportunities to extend ANP model. National review of out of hours primary caredelivery 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	Simon Bokor-Ingram Social Care Services
Corporate Plan	*B5. Older People - Integrated Health And Social Care Services*								
Delayed Discharges Trigger : Failure to meet key HEAT targets and interim trajectories for delayed discharges Consequences : Failure to comply with objectives and targets Risk type : Deadlines - failure to meet Reference - EM0002	Possible	Significant	Medium	• Create capacity through use of Integrated Care FundCreate 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	Simon Bokor-Ingram Social Care Services
Corporate Plan	*D1. Community Strength - Community Support*								
Reduced response to an emergency situation on Remote areas of Shetland and the outer islands Trigger : Potential reduction in availability of helicopter for air evacuation of unwell patients Consequences : Potentially increasing the risk to patient safety with subsequent risk to the reputation within the Community. Risk type : Staff number/skills shortage Reference - EM0004	Unlikely	Major	Medium	• Emergency response arrangements in placeCoastguard 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	Rare		Major	Medium	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F13. Our "20 By '20" - Workforce Planning*								
Inability to recruit to key posts Trigger : Failure to recruit staff with the right skills and in sufficient numbers to meet the needs of an ageing population Consequences : Shetland community put at greater risk due to reduced/lack of services, Inability to maintain service delivery Risk type : Key staff - loss of Reference - EM0014	Likely	Significant	High	• Work closely with both HR departments on recruitment and retention. Schemes develop to attract people to health and care work.More joint health and care roles being developed.	Possible		Minor	Medium	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F5. Our "20 by '20" - Standards of Governance*								

Adult Protection Issues Trigger : Failure to act appropriately with relation to Adult Protection Issues. Consequences : Current challenges in releasing staff to attend training due to overall capacity issues Risk type : Economic - Other Reference - EM0013	Possible	Minor	Medium	• The professional leads are tasked with ensuring that there are adequate levels of skill and capacity to manage protection issuesTraining 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	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F6. Our "20 By '20" - Financial Management*								
Lack of robust contracting arrangements Trigger : Contractual arrangements unclear between NHS and Council and external organisations providing services to NHS and Council. Consequences : Failure to provide services and value for money Risk type : Contractual Liabilities Assumed/Imposed Reference - EM0010	Unlikely	Significant	Medium	• Contracts and Service Level Agreements in place. Joint Commissioning & Procurement Strategy developed. System of scrutiny of performance in place.	Rare		Minor	Low	Simon Bokor-Ingram Social Care Services
Not achieving full use of the Integrated Care Fund Trigger : Pace of change required to implement the Integrated Care Fund programme is not achieved. Consequences : Reduced or withdrawn service provison Risk type : Economic - Other Reference - EM0016	Likely	Significant	High	• Plans are reflected in the Strategic Plan. Early development of plans.	Possible		Minor	Medium	Simon Bokor-Ingram Social Care Services
Budgets / Service planning. Planning process does not adequately quantify levels of need and resources are not directed appropriately. Trigger : Availability of funding or lack of alternative immediate/achievable management options, determines priorities rather than service need. Consequences : Availability of funding or lack of alternative immediate/achievable management options, determines priorities rather than service need. Risk type : Failure of Key supplier Reference - EM0045	Likely	Significant	High	• The Strategic Plan sets out direction and moredetailed 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	Simon Bokor-Ingram Social Care Services
Corporate Plan	*F8. Our "20 by '20" - Efficient*								
Task Duplication Trigger : Duplication or triplication of tasks to satisfy requirements the Council, Health Board and IJB. Consequences : Duplication or triplication of tasks to satisfy requirements of Council, Health Board and IJB Risk type : Customer / Citizen - Other Reference - EM0046	Almost Certain	Significant	High	• Agreement for lead organisation for functions or on use of one template and/or system. Clinical and care governanceframework in place.	Possible		Minor	Medium	Simon Bokor-Ingram Social Care Services

Shetland Islands Health and Social Care Partnership

Agenda Item

8

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Policy and Resources Committee Integration Joint Board (IJB) NHS Shetland Board	8 March 2017 10 March 2017 18 April 2017
Report Title:	Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan	
Reference Number:	CC-17-17 F	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That Shetland Islands Council Policy and Resources Committee recommends that Shetland Islands Council APPROVES the Shetland Islands Health and Social Care Partnership's Joint Strategic Commissioning Plan.

1.2 That NHS Shetland Board APPROVES the Shetland Islands Health and Social Care Partnership's Joint Strategic Commissioning Plan.

1.3 That the Integration Joint Board:

(a) APPROVES the Shetland Islands Health and Social Care Partnership's Joint Strategic Commissioning Plan, including the Service Delivery Plans; and

(b) NOTES that a separate report on today's agenda puts forward budget proposals for 2017-18 to deliver the Plan and address the funding gap on NHS Shetland funded services of £2.5m; and

(c) DIRECTS NHS Shetland and Shetland Islands Council to deliver the Strategic Commissioning Plan insofar as the extent of the authority delegated to them through the Integration Scheme by:

- providing the services as set out in the Service Plans;
- delivering the services within the budget and resources described in the Budget for 2017-18 (see separate Report);
- delivering the services within the overall strategic and policy framework;
- putting in place the necessary performance monitoring arrangements to reassure the IJB that:
  - services within the Strategic Commissioning Plan are being delivered;
  - that service standards and performance targets are being met;
  - that the services are provided within budget;

- the projects are being implemented on time; and
- remedial action is being taken as necessary if expected performance is not achievable.

- regularly reviewing the strategic and operational risks of delivering the plan and putting in place arrangements to reassure the IJB that the risks are well managed and appropriate mitigation is in place; and
- noting that specific authority will be sought from the IJB for any changes, as a consequence of the strategic programmes or recovery plan, which result in a significant impact on the current service model or performance outcomes; and

(d) NOTES that depending on the decisions on the Budget Report 2017-18, some NHS Shetland Service Plans may require to be amended to reflect anticipated changes in service delivery arrangements and performance outcomes and will therefore be resubmitted for further approval during the year.

2.0 High Level Summary:

2.1 In February 2017, the IJB, NHS Shetland and Shetland Islands Council approved, in principle, Shetland Islands Health and Social Care Partnership's Joint Strategic Commissioning Plan, excluding the Financial Plan and Service Delivery Plans.

2.2 The Financial Plan and Budget for 2017-18 was also considered at the meeting in February and the detailed work on how to bridge the funding gap in NHS Shetland funded services will be further considered at an IJB Seminar on 3 March 2017. The outcome of those deliberations will be included in a companion report on this agenda by the IJB's Chief Financial Officer.

2.3 The detailed service delivery arrangements are set out in the Service Plans. Ideally, there would have been time to adjust the service delivery arrangements to take account of the resourcing decisions as part of the budgeting process for 2017-18. However, the timing of the budget announcements and the decisions to be taken on how best to bridge the funding gap on the NHS Shetland funded services has meant that the service plans have had to be developed in parallel to the budget process. Where resourcing decisions are made which impacts directly and significantly on the service delivery models and performance outcomes, these will be amended and resubmitted to a future meeting for approval. The overall aim is to have in place a strategic plan, budget and set of service plans which are all aligned.

2.4 This Report therefore seeks the formal authority of the IJB to direct NHS Shetland and Shetland Islands Council to deliver the Strategic Commissioning Plan and associated services from 1 April 2017. It is the detailed service plans which provide the basis upon which the formal Directions are based.

3.0 Corporate Priorities and Joint Working:

3.1 The IJB Joint Strategic Commissioning Plan describes how health and care services can be delivered, jointly, across the services described in the Shetland Islands Health and Social Care Partnership's Integration Scheme.

3.2 The Plan is a significant part of public sector delivery in Shetland and supports the

Shetland Community Partnership's Local Outcome Improvement Plan, Shetland Islands Council's Corporate Plan and NHS Shetland's 2020 Vision and Local Delivery Plan.

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

3.4 It supports a fundamental shift in the philosophy of how public sector services should be designed and delivered with and for each community, based on natural geographical areas, or localities, and integrated around the needs of service users, rather than being built around professional or organisational structures.

4.0 Key Issues:

4.1 The Directions from the Integration Authority (IJB) to the Council and Health Board are required in order to action the IJB's Strategic Plan.

4.2 The formal directions are based on the Scottish Government's Good Practice Note on Directions. The Directions must clearly identify which of the integrated health and social care functions they relate to. The Integration Authority can direct the carrying out of those functions by requiring that a particular named service or services be provided.

4.3 The Integration Scheme sets out the extent of the delegated functions from NHS Shetland and Shetland Islands Council to the IJB. In summary, the services can be described as being within one of three categories, as set out below.

- **Category A** services - the community health and social care services which are wholly integrated and wholly delegated to the Integration Joint Board within the managerial responsibility of the Chief Officer;
- **Category B** services – specific acute and hospital and health improvement services which support integration, referred to as 'set aside' services and managed outwith the IJB;
- **Category C** services – other local health services which are included in the Plan in the interest of having a holistic oversight of all health and care services. These are also managed outwith the IJB.

4.4 The Integration Scheme is mainly for adults aged over 18. However, some services are not easily delineated between children and young people and adult services, and transition into adulthood is an intrinsic part of some service offerings (eg for adults with learning disabilities). The Service Plans have been built around natural groupings of services and those which may include children services are highlighted in the schedule below.

Service Area	Category A	Category B	Category C	Children and Young People
Adult Services	√			Transition
Adult Social Work	√			
Allied Health Professionals	√			Yes
Carers	√			Yes
Community Care Resources	√			
Community Nursing	√			
Criminal Justice	√			
Domestic Abuse	√			Yes
Health Improvement		√		
Intermediate Care	√			
Mental Health	√			
Oral Health	√			Yes
Pharmacy and Prescribing	√	√		Yes
Primary Care	√			Yes
Substance Misuse	√			Yes
Suicide Prevention	√			Yes
Unscheduled Care		√		Yes
Planned Care			√	Yes
Public Health			√	Yes
Human Resources and Support Services			√	
Finance			√	
Estates, Facilities and Medical Physics			√	

4.5 The Directions must set out how each integrated health and social care function is to be exercised and the budget associated with that. A complementary report on today's agenda sets out the budget for each of the services. The level of detail to give life to the delegation is set out in the Service Plans. Taking guidance from the Strategic Commissioning Plan, the Service Plans set out the detailed service delivery arrangements – how the service will be delivered, by whom and what performance outcomes can be expected.

4.6 The Directions must be revised in year to reflect any changes in how the delegated functions are to be carried out. Specifically, therefore, for 2017-18, it is expected that some of the detailed service plans for some Health Board funded services (Allied Health Professionals, Community Nursing, Mental Health, Pharmacy and Prescribing and Primary Care) may require to be resubmitted when the impact of the approval of the Budget for 2017-18 is clearer and decisions are taken on bridging the funding gap of £2.4m.

5.0 Exempt and/or confidential information:

5.1 None.

6.0 Implications :

6.1 Service Users, Patients and Communities:	The Strategic Commissioning Plan sets out the services to be delivered over the next 3 years. Any significant changes to services will be of interest to services users, patients, unpaid carers and communities, particularly in respect of quality, equality, accessibility and availability. It is expected that the current models of delivery will continue to evolve and change to reflect the policy direction of shifting the balance of care from hospital to community settings and supporting people to live independently at home. The service focus will also be on finding ways to help people to help themselves and by increasing self-help and self-care to help people to live in good health for longer.
6.2 Human Resources and Organisational Development:	At this stage, there are no direct impacts on Human Resources and Organisational Development. However, any significant changes to existing service models and methods of delivery may, in time, affect staffing – both in terms of the number of staff and the skills mix required – in order that service costs can be accommodated within the total budget allocation. There is a specific project to support Organisational Capacity and Resilience. It is also recognised that staff are at the forefront of any potential changes to services and they need to be well-informed to help them to deal with questions and queries from our service users.
6.3 Equality, Diversity and Human Rights:	The Impact Assessment is included at Appendix 5 of the Strategic Commissioning Plan. Within the Draft Plan, there is reference to individuals, or groups of individuals, who may face difficulties in accessing services. There is a clear focus on which individuals and groups of individuals the Plan intends to support. The Impact Assessment notes that further work may be required on data collection for Ethnic Minorities.
6.4 Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health and Social Care Partnership IJBs to produce a strategic commissioning plan and update it annually. There is a requirement on all 3 partners to put in place arrangements to achieve a balanced budget each year. The Good Practice Note on Directions advices that the formal written notification be given to the Health Board and the Council to carry out the actions and services as specified in the Strategic Commissioning Plan.
6.5 Finance:	The partners face a significant challenge associated with the need to address the funding gap on NHS Shetland funded services. The estimated gap between the cost of the current service delivery models and the amount of funding made available by the funding partners in 2017-18 is £2.5m. The gap relates only to NHS Shetland funded services delegated to the IJB. A separate report on today's agenda addresses the detailed budget proposals for 2017-18 and the arrangements to be put in place to bridge the funding gap.
6.6 Assets and Property:	At this stage, there are no implications for Assets and Property. However, any significant changes to existing service models and

	methods of delivery may, in time, affect the overall estate in order that service costs can be accommodated within the total budget allocation.
6.7 ICT and new technologies:	The Plan outlines the need to continue to modernise our working practices – both internally and with our patients / service users / customers – by maximising eHealth, Telehealthcare and Telecare opportunities.
6.8 Environmental:	At this stage, there are no specific environmental implications. Any changes to services models which result in changes to access points and transport arrangements may, in time, result in environmental considerations.
6.9 Risk Management:	The Plan includes a section on risk factors and has identified a range of governance, financial, partnership and capacity issues. If approved, the IJB's Risk Register will be updated and will then form part of the ongoing risk mitigation and management arrangements reported regularly to the IJB. The consequence of not approving the refreshed Strategic Commissioning Plan would be that the existing Plan remains in force, that the Strategic Programmes for developing sustainable models of service would not be endorsed and the funding gap would therefore continue to grow month on month.
6.10 Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB assumed responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting in November 2015. The delegated functions are set out in the Integration Scheme. <u>SIC Policy and Resources Committee</u> Shetland Islands Council delegated functions, including the planning arrangements, to the IJB. The Policy and Resources Committee is responsible for receiving reports on any matters relating to functions delegated to the IJB that require to be reported to the Council. Approval of strategic policies, including the Strategic Commissioning Plan, falls within this remit. <u>NHS Shetland Board</u> NHS Shetland delegated functions, including planning for acute and hospital services, to the IJB. The NHS Board retains the overall authority for consideration and approval of strategic planning, taking guidance from its Standing Committees, in particular the Strategy and Redesign and Staff Governance Committees. Approval of the Strategic Commissioning Plan

	therefore rests with the NHS Shetland Board. IJB The Integration Scheme states that, "The IJB has responsibility for the planning of the Integrated Services. This will be achieved through the Strategic Plan....The IJB will be responsible for the planning of Acute Hospital Services delegated to it....". Consideration and approval of the annual update of the Strategic Commissioning Plan is therefore within and the authority delegated to the IJB. The Integration Scheme also states that, 'the detailed commissioning and operational delivery arrangements will be set out in the Strategic Plan'.	
6.11 Previously considered by:	Strategic Planning Group	6 March 2017

Contact Details:

Hazel Sutherland
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27 February 2017

Appendices:
Appendix 1 - Shetland Islands Health and Social Care Partnership Strategic Commissioning Plan 2017-2020 This Appendix is available electronically only - http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=20744

Background Documents:

Shetland Islands Health and Social Care Partnership Integration Scheme
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/SHSCPartnershipIntegrationScheme15May2015.pdf

Scottish Government: Good Practice Note Directions from Integration Authorities to Health Boards and Local Authorities
http://www.gov.scot/resource/0049/00498164.pdf

Shetland Islands Health and Social Care Partnership

Strategic Commissioning Plan

2017- 2020

Contents:

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Foreword

"We are the community, and they are us[1]"

Shetland, in keeping with other areas in the UK, is facing a period of unprecedented change in its public services. Investment in health and care services has been hugely successful, with people living longer and being able to live longer even though they may have more complicated health and care needs. Shetland has an excellent reputation for delivering high quality, safe and effective services. However, the pressures before us continue to grow and we will have less money year on year to be able to stay the same, never mind dealing with increasing demand. In line with the Scottish Government's policies we need to turn our attention to significantly change how we design and deliver services. It goes without saying that individuals, families, unpaid carers, volunteers, staff and communities will be at the heart of the changes – after all that is why we are all in the business of public service. Our challenge is to find a way to genuinely streamline all that we do and make sure that services are integrated around the needs of individuals, their families and unpaid carers and are not built around the convenience of organisations. It is a hugely exciting challenge to be at the forefront of modernising public sector service in Shetland and to help individuals enjoy a good quality of life. We want to grow a system where skilled staff and volunteers are trusted to do the best they can for the individuals that we serve within a safe and open learning environment and we look forward to working with the Shetland community to make that happen.

Cecil Smith
Chair of Shetland Islands Health and Social Care Partnership Integration Joint Board

Ian Kinniburgh
Chair
Shetland Health Board

Gary Robinson
Leader
Shetland Islands Council

[1] Feedback from member of staff 2015

Introduction

This is a plan for the whole of the health and care system in Shetland. It covers services provided in each community, those provided in Lerwick at the Gilbert Bain Hospital and at other Shetland-wide facilities as well as services which are provided by our partner health and care services in Aberdeen, and further afield. The plan covers:

- Hospital, Acute and Specialist Services;
- Emergency Services, including Out of Hours arrangements;
- Public Health and Health Improvement;
- Primary Care;
- Social Care; and
- Support Services

The partners are:

- Shetland Islands Health and Social Care Partnership, through the formal arrangements of the Integration Joint Board (IJB);
- NHS Shetland, Shetland's local Health Board; and
- Shetland Islands Council, the local authority.

The Plan also has a specific function as the Shetland Islands Health and Social Care Partnership's Joint Strategic Commissioning Plan. It describes the services which will be delivered to meet the health and social care needs of adults, through the Integration Joint Board. The Public Bodies (Joint Working) (Scotland) Act 2014 placed a duty on NHS Shetland and Shetland Islands Council to work together to integrate services around the needs of individuals, their unpaid carers and their families to get the right care, in the right place and at the right time. A range of national and local statutory, private sector and voluntary organisations deliver the actual services required to the community.

Specifically, the Act put in place:

(A) nationally agreed outcomes, which will apply across health and social care, and for which NHS Boards and Local Authorities will be held jointly accountable;
(B) a requirement on NHS Boards and Local Authorities to integrate health and social care budgets; and
(C) a requirement on Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

The Shetland Island's Health and Social Care Partnership Strategic Commissioning Plan should:

- identify the total resources available across health and social care for each care group and for unpaid carers and relate this information to the needs of local populations as determined by the needs assessment;
- agree desired outcomes and link investment to them;
- assure sound clinical and care governance is embedded;
- use a coherent approach to selecting and prioritising investment and disinvement decisions; and
- reflect closely the needs and plans articulated at locality level.

Executive Summary

Audit Scotland, in their report on 'Changing Models of Health and Social Care' stated that,

> *"the growing number of people with complex health and social care needs, particularly frail older people, together with continuing tight finances, means that current models of care are unsustainable. New models of care are needed."*

The Scottish Government recently announced their plans for re-shaping the Health Service in Scotland to respond to increasing demand. Shetland is not immune from these challenges and the Government's Delivery Plan makes reference for the need for changes to be made "at pace".

Alongside increasing demand, health and care services will continue to face an unprecedented restriction in resources over the next three years. Within this, while the NHS continues to see "real term" growth this is at historically low levels. Social care in Shetland will see further budget reductions, all be it from a comparatively high level of spend per head of population. It should also be noted that the extra costs associated with Shetland operating services in a remote and rural setting are already recognised in the funding settlements to NHS Shetland and Shetland Islands Council. We are also fortunate to receive ongoing funding from Shetland Charitable Trust to support our care services. It is therefore important to recognise that any significant increases to the budgets projected in this plan are unrealistic and we need to find a way, collectively, to develop the mix of hospital, primary and community care services that best meet the needs of our population.

The Shetland Islands Health and Social Care Partnership Plan sets out the arrangements which we intend to put in place to reconsider the level and type of service that we can sustain. This reflects the funding available and recognises some specific issues around the recruitment and retention of staff to various specialist posts. These projects will look at:

- the hospital model, to determine what services need to be provided locally and which are best provided by our partner health boards, such as NHS Grampian in Aberdeen, and the associated staffing levels required to maintain a safe, high quality and effective service;
- the primary care model, to determine an equitable distribution of primary care resources across Shetland, recognising the particular recruitment challenges in this area; and
- developing an affordable and sustainable social care model for Shetland, which builds on the network of care centres and Shetland-wide services, and responds to the need to promote self care and multi-disciplinary teams working to support individuals and families to live well for longer in their own home, or a homely setting.

Services have become accustomed to making savings and efficiencies over the years. Our performance is measured in a range of quality indicators and service outcomes. On the whole, Shetland's health and care system performs well. However, given the extent of the savings and efficiencies which still need to be found, Health and Social Care services cannot continue to be provided in the same way as at present, if we are to provide the best possible services for the local population. Our ability to make the books balance through one-off initiatives is diminishing; we therefore need to think differently about how our services are configured to deliver safe, quality and effective services in a sustainable way.

There are some lifestyle choices and behaviours which persist within society that may impact negatively on people's ability to look after their own well-being and live in good health for longer. The Scottish Government's Health and Social Care Delivery Plan 2016 states that, "we need to move away from doing things to people to working with them on all aspects of their care and support.....to one based on anticipation, prevention and self management". With our partners, we have identified several strands of work where we consider that Shetland could do better. We have put in place programmes of work to:

- reduce the percentage of adults who smoke
- reduce premature mortality from Coronary Heart Disease among under 75s
- increase physical activity levels
- reduce obesity levels
- address issues associated with mental health, wellbeing and resilience
- promote suicide prevention
- recognise and respond to public protection issues e.g. domestic violence
- reduce harm caused by alcohol; and
- address issues caused by substance misuse

The scale of the challenge before the Shetland Islands Health and Social Care Partnership is significant. This Plan will only work if we focus on creating sustainable models for the future. That means looking forward to an uncharted future; not backwards to where we have been. It will only work if we do it together, respecting the views of all stakeholders to find acceptable solutions for each community.

Vision and Objectives

Our Vision is that by 2020 everyone in Shetland is able to live longer healthier lives, at home or in a homely setting. We will have an integrated health and care system focused on prevention, supported self management and reducing health inequalities. We will focus on supporting people to be at home or in their community with as much specialist care provided in Shetland and as close to home as possible. Care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.

Our work is to improve the wellbeing of service-users, as described in the nine national health and wellbeing outcomes[2] below:

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

The following integration planning principles[3] will underpin how we shape our services and find innovative solutions to meet our communities' needs and improve the wellbeing of service-users so that our services:

- are integrated from the point of view of service-users
- take account of the particular needs of different service-users
- take account of the particular needs of service-users in different parts of Shetland
- take account of the particular characteristics and circumstances of different service-users
- respect the rights of service users, whilst ensuring they understand and respect their responsibilities
- take account of the dignity of service-users

[2] Public Bodies (Joint Working) National Health and Wellbeing Outcomes (Scotland) Regulations 2014
[3] Section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014

- take account of the participation by service-users in the community in which service-users live
- protect and improve the safety of service-users
- improve the quality of the service
- are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- best anticipate needs and prevent them arising
- make the best use of the available facilities, people and other resources

and are designed so that:

- emergency care is maintained in Shetland, including medicine, surgery and maternity services
- care is only provided in a hospital setting if it cannot be provided safely and effectively in the community
- patients are only sent outwith Shetland for healthcare if it cannot be provided safely and effectively locally
- attendance at hospital for diagnostic tests and investigations, outpatient consultations and minor procedures is kept to a minimum
- healthcare is provided by multi-professional teams, with reliance on single handed practitioners kept to a minimum
- increased use of technology is helping us provide care for the most vulnerable and elderly in our community
- older people and people who are living with long-term conditions will be getting the services they need to help them live as independently as possible
- people will be supported to look after and improve their own health and well-being, helping them to live in good health for longer

Context

Strategies and Policies

This Plan both informs, and is informed by, a number of strategic and service specific strategies and plans. The diagram below sets the strategic and policy context within which NHS Shetland, Shetland Islands Council and the Integration Joint Board is operating.

<table>
<tr><td colspan="8">Integration Joint Board</td></tr>
<tr><td rowspan="3">Values / Quality Ambitions

Person Centred
Safe
Effective
Efficient
Equitable
Timely
Sustainable
Ambitious</td><td colspan="6">NHS Scotland 2020 Vision
The Scottish Government's 2020 Vision for health and social care is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:
- whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions;
- we have integrated health and social care;
- there is a focus on prevention, anticipation and supported self-management;
- where hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm;
There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk or re-admission.</td><td rowspan="3">In partnership with

Patients
Service Users
Unpaid Carers
Families
Staff
Professionals
Partners
Communities
Public</td></tr>
<tr><td colspan="6">Delivering Health and Wellbeing Outcomes</td></tr>
<tr><td colspan="6">Using Integration Principles</td></tr>
<tr><td>Resources</td><td>Staff</td><td>Bought in Services</td><td>Money for Resources</td><td>Assets and Equipment</td><td>E'Health, Records and Information</td><td>Resources</td></tr>
<tr><td>Strategic Direction</td><td colspan="6">Joint Strategic Commissioning Plan
- Needs Assessment – Resources – Performance - Risk</td><td>Strategic Direction</td></tr>
<tr><td>Strategies</td><td>Primary Care Strategy</td><td>Shetland Mental Health Strategy</td><td>NHS Shetland Public Health</td><td>Changing Lives: Report of the 21st Century Social Work Review</td><td>Shetland Clinical Strategy</td><td>Older People's Strategy</td><td>Property and Asset Management Strategy</td></tr>
<tr><td>Government's Health and Social Care Delivery Plan</td><td>Autism Spectrum Disorder Strategy</td><td>Carers' Strategy</td><td>Reshaping Care for Older People: A Programme for Change</td><td>Domestic Abuse Strategy</td><td>Prescription for Excellence</td><td>Oral Health Strategy</td><td>Children and Young Peoples Integrated Strategic Plan</td></tr>
<tr><td>Keys for Life</td><td>Alcohol and Drug Strategy</td><td>National Dementia Strategy</td><td>Adult Rehabilitation</td><td>Realising Potential</td><td>Realistic Medicine</td><td>See Hear Strategy</td><td>Shetland Partnership Local Outcome Improvement Plan</td></tr>
<tr><td>National and Local Strategy for Autism</td><td>Allied Health Professionals National Delivery Plan</td><td>Intermediate Care Operational Plan</td><td>Prevention and Management of Falls</td><td>Integration Fund Plan</td><td>Unscheduled Care plan</td><td>Winter Plan</td><td>"On Da Level", Achieving a Fairer Shetland</td></tr>
<tr><td rowspan="4">Service Delivery Plans:</td><td colspan="6">Joint Strategic (Commissioning) Plan</td><td rowspan="4">Service Delivery Plans:</td></tr>
<tr><td colspan="6">Service Plans</td></tr>
<tr><td colspan="6">Financial Plan / Budgets</td></tr>
<tr><td colspan="6">Resources and Support Services
Change Management Projects</td></tr>
<tr><td>Measured By (for assurance / improvement):</td><td colspan="2">Performance Measures</td><td>Chief Social Work Officer Annual Report</td><td>Audits</td><td colspan="2">Quality Reports</td><td>Measured By (for assurance / improvement):</td></tr>
</table>

Current Performance on Health and Wellbeing Outcomes

There are in place a range of service and quality indicators which are used to measure Shetland's health and care performance against national targets and outcomes. Shetland, on the whole, performs well and delivers high quality, safe and effective services.

A recent publication from the Scottish Government, the Health and Social Care Delivery Plan 2016, reflected on the success of the health service in general, when it stated that, "there have also been significant improvements in treatment times, reductions in mortality rates, ... reduction in healthcare associated infections...and patient satisfaction has also increased to record highs".

There are specific measures for the Health and Social Care Partnership, known as Health and Wellbeing Outcomes. Shetland's performance, against peer group comparators and the Scottish average, is outlined in the table below. Some areas worth highlighting are:

- Percentage of the last six months of life spent at home or in a community setting in 2014/15, Shetland achieved 92.3% (compared to the Scotland average of 86.3%). For this outcome, Shetland is the best in Scotland.
- Percentage of carers who feel supported to continue in their caring role (at 54% compared to a national average of 41%); although 54% may still be considered to be a lower than acceptable level.
- Percentage of adults with intensive needs receiving care at home (69% compared to a national position of 61%); while starting to fall slightly, the rate has historically been very high for Shetland compared with the peer group average and well above the Scotland level.
- The emergency admission to hospital rate is lower than the Scottish average and the peer group (and the trend has remained fairly static in Shetland compared to a general increase for Scotland as a whole).
- The rate of emergency bed days is also low with Shetland at the lowest end of the peer group range indicating fewer days are spent in hospital after an emergency admission.
- The readmission rates to hospital within 28 days of discharge is low, indicating that services are working at discharging people when they are ready and then keeping them in the community thereafter.
- The falls rates per 1,000 of population in the over 65s has been mostly above peer group and Scotland average, although it has dropped in the last year.

The Scottish Government has asked the Shetland Islands Health and Social Care Partnership, along with all other partnerships, to pay particular attention to the following indicators:

- Unplanned admissions
- Occupied bed days for unscheduled care
- A&E performance
- Delayed discharges
- End of life care and
- The balance of spend across institutional and community services.

The good performance shown in 2014-15 has been sustained into 2015-16 and Shetland continued to perform well across all categories. It is the intention that the changes outlined in this Plan will seek to maintain the good performance in these areas, so far as it is reasonably possible to do so within the funding available, as described below.

Indicator	Current Performance	Target
Unplanned admissions	2015-16 unplanned admission rates 75+ all specialities: best in Scotland	Maintain current performance.
Occupied bed days for unscheduled care	2015-16 unplanned bed day rates 75+ all specialities: second best in Scotland.	Maintain current performance
A&E performance	A&E Attendance rate per 1,000 population 2015-16: 12th in Scotland (out of 32). A&E % seen within 4 hours, November 2016: 5th in Scotland (our of 32).	Maintain current performance
Delayed discharges	Delayed Discharge Census November 2016 Standard Delays over 3 days, by type of delay: best in Scotland	Maintain current performance
End of life care	Proportion of the last six months of life spent at home or in a community setting for people who died in 2015-16: best in Scotland. 2015-16 Bed Days in the last six months of life by partnership: lowest (best) in Scotland.	Maintain current performance.
The balance of spend across institutional and community services	2014-15 Balance of Care 75+ by Intensive Care at Home; Care Home and Hospital: 11th in Scotland (out of 31).	Continue to shift the balance of care from hospital to the community by investing in a community based Intermediate Care Team for Rehabilitation and Reablement.

Table 1: Performance against National Health and Wellbeing Outcomes

Indicator	Shetland	*Peer Group Average*	*Scotland*
1. Percentage of adults able to look after their health very well or quite well	95%	*95%*	*94%*
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.	78%	*86%*	*84%*
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	81%	*80%*	*79%*
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	60%	*77%*	*75%*
5. Percentage of adults receiving any care or support who rate it as excellent or good	79%	*83%*	*81%*
6. Percentage of people with positive experience of care at their GP practice.	89%	*90%*	*87%*
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	84%	*87%*	*84%*
8. Percentage of carers who feel supported to continue in their caring role.	54%	*45%*	*41%*
9. Percentage of adults supported at home who agree they felt safe.	79%	*86%*	*84%*
10. Percentage of staff who say they would recommend their workplace as a good place to work.*		*Not yet available.*	
11. Premature mortality rate (per 100,000 population)	443.90	371.58	423.20
12. Rate of emergency admissions for adults.* - data shown for all ages per 100,000 total population	9,143.35	9,595.47	10,435.95
13. Rate of emergency bed days for adults.* - data shown for all ages per 100,000 total population	65,617.74	73,144.10	73,597.30
14. Readmissions to hospital within 28 days of discharge.*	5.40	6.53	7.80
15. Proportion of last 6 months of life spent at home or in community setting.	92.32	88.55	86.29
16. Falls rate per 1,000 population in over 65s.*	20.32	18.69	20.48
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	80.0%	77.1%	81.2%
18. Percentage of adults with intensive needs receiving care at home.	69.3%	64.4%	61.1%
19. Number of days people spend in hospital when they are ready to be discharged. (per 1,000 pop)	1661.20	1143.51	1043.99
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.	14.9%	21.3%	23.1%
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*		*Not yet available.*	
22. Percentage of people who are discharged from hospital within 72 hours of being ready.*		*Not yet available.*	
23. Expenditure on end of life care.*		*Not yet available.*	

Strategic Needs Assessment

The Shetland Partnership's Local Outcome Improvement Plan highlighted a number of priority services where focused partnership working is required:

> **Priority Outcome: We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age**
>
> Priority Actions:
> - Reduce percentage of adults who smoke
> - Reduce premature mortality from Coronary Heart Disease among under 75s
> - Increase Physical Activity Levels
> - Reduce obesity levels
> - Address issues arising from mental health
> - Promote Suicide Prevention
>
> **Priority Outcome: Shetland is a safe place to live for all our people, and we have strong, resilient and supportive communities**
>
> Priority Actions:
> - Address issues arising from domestic violence
> - Reduce the harm caused by alcohol

The Plan needs to address some growing pressures on health and care services as a recent Report from the Accounts Commission on Health and Social Care Integration in December 2015 stated that,

> *"If current rates of activity continue, it is unlikely that health and social care services will be able to cope with the effects of the changing population unless they make major changes to the way they deliver services."*

At a national level, if the current rates of activity and growth in demand continue, the movement from 2013 to 2030 could be:

- The number of people in the age group 75-84 could increase by 44% and those over 85 could rise by 68%;
- The number of GP consultations is projected to rise by 12%;
- The number of homecare clients is forecast to rise by 33%;
- The number of homecare clients receiving 10+ hours per week of care is predicted to rise by 31%;
- The number of practice nurse consultations could rise by 18%;
- The number of long-stay care home residents could rise by 35%:
- Acute emergency bed days from patients with 3+ admissions could increase by 26%;
- Similarly emergency bed days are forecast to rise by 28%;
- The number of acute emergency admissions is predicted to increase by 16%;
- Acute day cases could rise by 14%; and
- New outpatient appointments could increase by 9%.

Shetland is already responding to these demographic and social changes. There is evidence of:

- A growing demand for services (an increasing number of people being referred or assessed for services).
- A growing demand for services from an increasingly elderly population, living well longer but often with complex and multiple conditions. Health Centres are responding to an increased number of residents with long term conditions (asthma, diabetes, high blood pressure). There is an increased number of frail elderly in the community requiring additional support to remain at home. Analysis of Lerwick Health Centre appointments, for example, has shown that the number of GP and Additional Nurse Practitioner appointments increased by 26% from 23,773 in 2014-15 to 29,933 in 2015-16.
- An increase in referrals to mental health services for assessment of anxiety and depression.
- Demographic change placing demands on centres of population, leaving remote and rural services more difficult to sustain.
- Significant financial savings and efficiencies to be realised.
- More people living alone.
- The need to tackle health inequality barriers.
- Lifestyle choices, eg alcohol consumption and the impact on personal health and population health.
- Workforce challenges – recruitment and retention; integrated working and professional support; pension age changing; generic and specialist skills mix; single handed practitioners; expectation that staff will deliver the 'transformational change'; technological advances; ability to 'compete' with other employers.
- The changing nature of availability of unpaid carers and informal support networks putting pressure on statutory services.
- Rising expectations of services – a more demanding public and expectation of more engagement about individual health and care options.
- Medical advances, changing the nature of treatment for diseases.
- The potential for home or community based technology to transform interactions between professionals and patients / service users, including living safely at home and managing long term conditions.
- The use of video conferencing facilities, social media and smart phone applications to transform our relationship with patients / services users and help them to look after and improve their own health and wellbeing.

- An increase in focus on community based provision and primary and social care - working in partnership with local communities, enhancing roles in primary care, and helping people to help themselves.

- A persistent, and perhaps widening, inequality gap.

  "The Commission on Tackling Inequalities in Shetland[4] heard evidence relating to socio-economic equalities and geography in Shetland. The Foreword states that,

  "Shetland doesn't exhibit the extreme disparities in wealth, health and other indicators that characterise some communities. Nevertheless, the evidence gathered by the Commission confirms that, in 2016, inequality is an inescapable feature of Shetland life. Some of our fellow citizens are struggling. Their circumstances differ, but lack of sufficient money to live a decent life is a common factor. The causes of their difficulties are not simple but it's clear that a variety of influences, including changes in welfare policies, are making their position steadily more precarious.

  Inequality can take many forms. It is frequently thought of as economic and characterised in terms of wealth and poverty. However, there are also manifestations of inequality in education, environmental quality, ethnicity, gender, geography, health, social status and in power and influence.

  Inequalities in Shetland are more keenly felt, where the differences between those with resources and without are well defined; the relatively prosperous community and cost of housing adds to the pressures faced by those who are struggling to make ends meet. In summary, those individuals and families in Shetland who are particularly vulnerable are those:

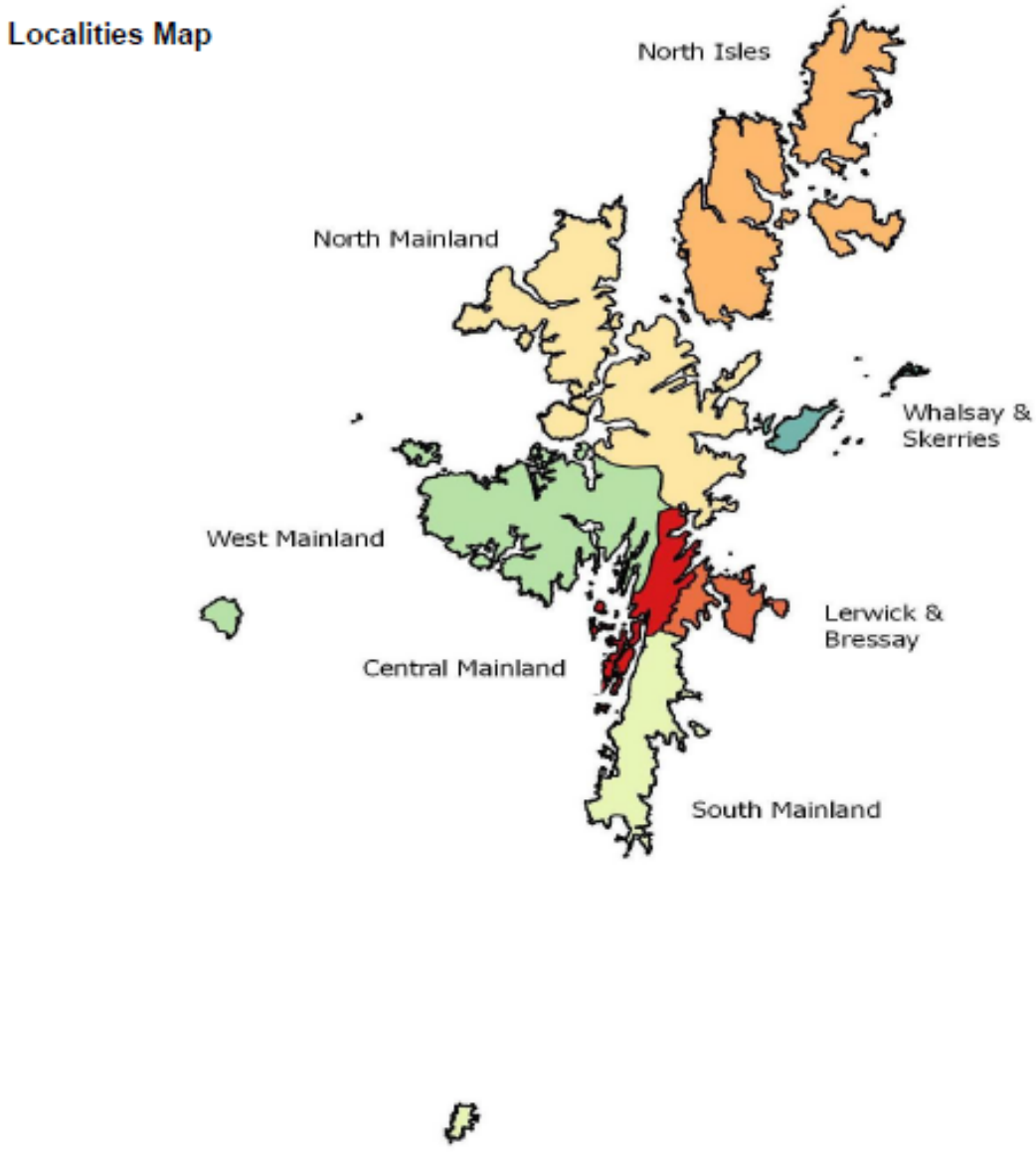
  - *with poor educational experiences: engagement is difficult, attainment may be low;*
  - *unable to achieve or maintain employment;*
  - *at risk of homelessness;*
  - *with poor mental health;*
  - *with chronic illness;*
  - *with experience of substance misuse;*
  - *not involved in their local community (this may include not attending pre-school);*
  - *living in remote areas, where employment opportunities are limited and the cost of transport or running a private vehicle can be prohibitive.*

  And:
  - *Looked After Children;*
  - *workless or low income households; and*
  - *young.*

[4] On Da Level, Achieving a Fairer Shetland, Report and Recommendations from Shetland's Commission on Tackling Inequalities, March 2016

Planning in Localities

The Strategic Plan is formed around seven localities based on geography and ward boundaries; also used for locality planning purposes and for community planning. The views and priorities of localities must be taken into account in the development of the Strategic Plan.

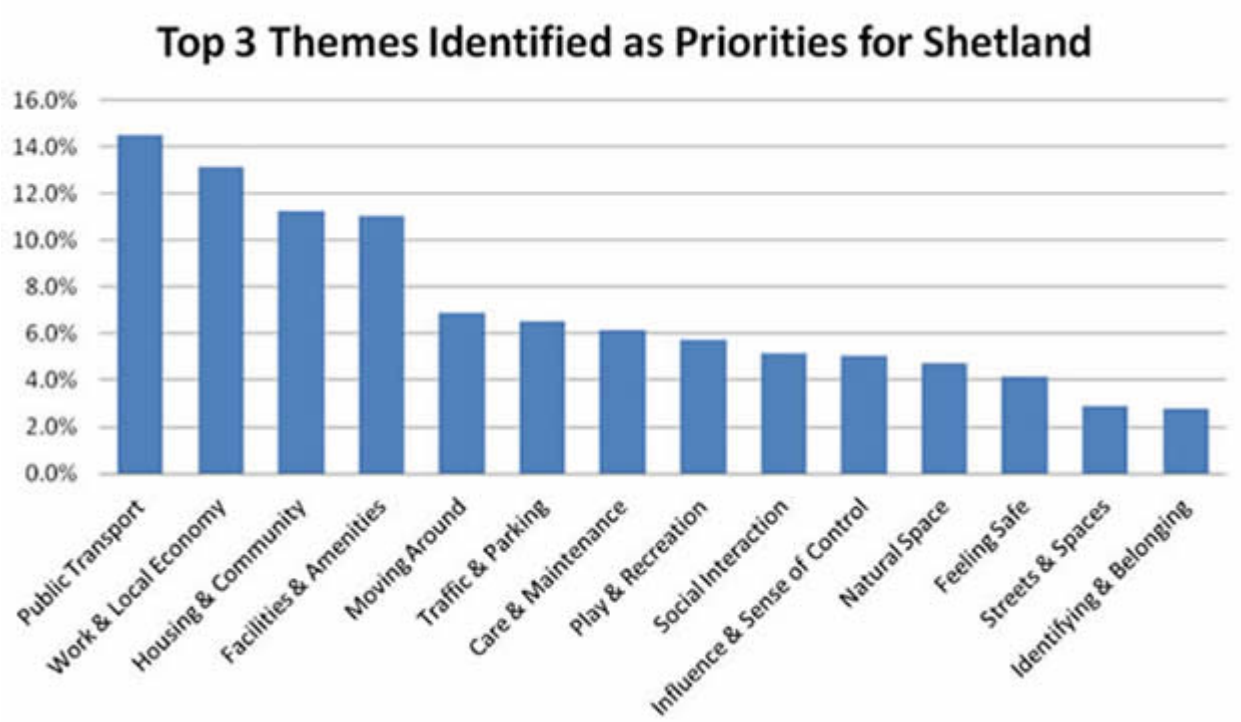


The Shetland Place Standards[5] is a consultation exercise undertaken to find out what people feel is most important to where they live. The survey took place in July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments. This helps to build the evidence for what makes communities good places to live in and highlights issues which

[5] A community consultation exercise run by Shetland Partnership Board in July 2016

might need to be resolved. In time, it will provide good evidence to help public sector agencies to have open discussions with communities about any potential changes to service delivery models.

The bar chart below also shows the data for the fourteen themes that respondents feel should be prioritised for improvement for Shetland as a whole. The top four themes identified, across all areas, were: public transport; work and local economy; housing and community; and facilities and amenities.



While each area may have similar health and care needs overall, there will be very specific differences as to how we can respond to meeting those needs, perhaps around transport, population demographics, distances from specialist services, etc.

The Shetland Partnership, the group which overseas strategic planning on a Shetland-wide level and across all service sectors, have set three high level priorities in the Local Outcome Improvement Plan. The Partners have agreed to work together to improve the lives of the people of Shetland through:

- making the best use of existing assets, infrastructure and human capital for sustainable socio-economic development;
- ensuring the needs of our most vulnerable children and young people are met; and
- supporting the development of a digital, diverse and innovative business base (which will include comprehensive and resilient broadband coverage).

The key issues with regard to delivering health and care services are outlined at Appendix 1 and summarised below.

North Isles

Primary Care – current GP Recruitment and Retention issues, sustainable Primary Care Provision, Dental Provision, Out of Hours services, Community Nursing on Non Doctor islands

Using technology to ensure that access to specialist services (e.g. in a hospital setting) is equitable and achievable

Sustainable care models and, in particular, the building issues for Isleshavn Care Centre

Whalsay and Skerries

Primary Care – Sustainable Primary Care arrangements, Out of Hours services, Community Nursing on Non Doctor islands

Using technology to ensure that access to specialist services (e.g. in a hospital setting) is equitable and achievable

North Mainland

Primary Care - Sustainable primary care arrangements

Using technology to ensure that access to specialist services (e.g. in a hospital setting) is equitable and achievable

West Mainland

Primary Care - Sustainable primary care arrangements, Community Nursing on Non Doctor islands

Using technology to ensure that access to specialist services (e.g. in a hospital setting) is equitable and achievable

Lerwick and Bressay (including services provided on a Shetland-wide basis)

Ensuring that we deliver the best and most appropriate balance of specialist services in Shetland (e.g. models for hospital and specialist services in Shetland versus mainland service provision)

Primary Care – Lerwick Health Centre demand and capacity management

Community Nursing on non doctor islands, intermediate care team

South Mainland

Primary Care – community nursing on Non Doctor Islands

Using technology to ensure that access to specialist services (e.g. in a hospital setting) is equitable and achievable

Local Delivery Arrangements and Strategic Priorities

Shetland's local priorities for the period 2017-2020 will be built on:

- Keeping people safe from harm, protecting vulnerable people
- Delivering integrated health and care pathways and single point of entry to services by continuing to shift resources to primary and community care
- Strengthening and working in partnership with individuals, their families and communities
- Reducing avoidable admission to and inappropriate use of hospital services
- Developing primary care and community responses through multi-disciplinary teams
- Supporting unpaid carers
- Tackling inequalities, with a focus on health inequality
- Prevention and early intervention
- Promoting health lifestyles
- Improving mental health and wellbeing
- Promoting self management and independence

The service delivery arrangements are set out in Appendix 2, the detailed Service Plans (to follow).

The service arrangements, for the integrated services, are summarised in Appendix 3 which includes:

- a description of the services and their purpose;
- the number of service users and emerging trends which have been identified;
- the resources (assets, staff and budget) needed to delivery services;
- the current performance measures and actual performance; and
- a note of the links to the strategic programmes and projects, where applicable.

The specific links to other infrastructure and services are set out at Page 27, with the Housing Contribution Statement included at Appendix 4.

The things which might go wrong and mean that we are unable to, or are less successful in being able to, deliver what we are trying to achieve are included in the Risk Assessment section on Page 28.

The Integrated Impact Assessment is included at Appendix 5.

This work to develop a sustainable health and care model will be done through ten strategic work programmes under three strategic themes:

- Whole population
- Sustainable models
- Organisational issues

The projects which will be developed under each of the strategic themes are summarised and then expanded on below.

(A) Whole Population:

- Implementing an asset based approach to health care prevention
- Effective Prescribing – working with patients and prescribers to ensure that evidenced, best value, medicines are started and stopped appropriately

(B) Sustainable Models:

- Developing a safe and effective model of unscheduled care
- Developing a sustainable hospital, acute and specialist services model for Shetland
- Developing a sustainable primary care model for Shetland
- Developing a sustainable model of social care resources
- Development a sustainable model for mental health services, including appropriate crisis and emergency arrangements
- Developing a sustainable model for adults affected by learning disabilities and autistic spectrum disorders

(C) Organisational Issues

- Improving business performance and efficiency
- Improving the Quality and Safety of our services

The background and intended outcomes for each of the projects are set out below. Appendix 6 maps the projects to each of the nine health and wellbeing outcomes and includes a timeline for the projects to be undertaken.

(A) Whole Population Health

Implementing an asset based approach to health care prevention

NHS Shetland's Public Health and Health Improvement Team's work cover the three strands of: prevention; protection; and cessation. The focus of the team's work will be: weight management; physical activity; substance misuse; mental health and inequality. There is a key link with the priority outcomes as described in the Local Outcome Improvement Plan (the LOIP). The team will have a significant influence in leading and developing the project to implement an asset based approach to health care prevention. This will promote an approach that is 'person centred'.[6] This means working with people as active participants rather than passive recipients of health or social care programmes, in ways which are empowering, and could ultimately lead to less reliance on public services. Indeed many of the solutions which individuals will be able to draw on may be from community based or private sector providers. The project is multi-dimensional and cross cutting and will include:

- understanding patients
- health information and self directed care
- health literacy
- behaviour change and skills development

[6] Healthcare Quality Strategy for NHS Scotland

- reducing health inequalities
- anticipatory care
- self management / long term conditions support group
- involving carers
- realistic medicine

When analysing service trends and demand, some services have highlighted an issue around repeat attenders to services. In some cases there is a link between repeat or frequent attenders and high costs, referred to as High Resource Individuals. These are often appropriate and reflective of complex, long term and multiple needs. However, there may be underlying social or mental health needs which result in unnecessary attendances or repeat referrals which are of no benefit to the service user / patient and therefore cause waste within the system. One of the first priorities for this project will therefore be to look into the causes of and effect on people who are high users of services. This work may identify unmet needs or gaps in service at the lower level social intervention stage to see if other service models might help to avoid some folk feeling the need to access statutory services, for no long term benefit.

The work to reduce the barriers causing health inequalities is set out in the Report 'On Da Level'. Services will consider how best to respond to help families who are struggling to thrive and work with local communities and voluntary services to ensure that no one is lonely or stigmatised. The report indicated that approximately 5% of people in Shetland, at any life stage, are not able to have the same positive experiences and opportunities as the majority of people living in Shetland. Over the last 15 or so years, it has become more common to see these poor experiences being passed down the generations. Shifting money and staff to better target support, and at an earlier stage, is known to help these families and also save money. There are many local examples of the impact of stigma, isolation and loneliness on people and families and there is an increasing body of research showing the negative impacts on physical and mental health. Services will be encouraged to target resources to break negative cycles for individuals and within families.

Effective Prescribing- working with patients and prescribers to ensure that evidenced, best value, medicines are started and stopped appropriately

The recent Annual Report from the Chief Medical Officer, entitled Realistic Medicine, challenged current health care by stating that,

> *"Doctors generally choose less treatment for themselves than they provide for their patients. In striving to provide relief from disability, illness and death, modern medicine may have overreached itself and is now causing hidden harm – or at best providing some care that is of lesser value.... Waste in healthcare should be assessed not in terms of what might be thrown away, but in interventions that don't add value for patients....We need to change the outdated 'doctor knows best' culture to one where both parties can combine their expertise and be more comfortable in sharing the power and responsibility of decision-making. It requires system and organisational change to promote the required attitudes, roles and skills".*

This needs to become an underpinning philosophy in all the service redesign models and will be a specific theme in the Effective Prescribing project.

(B) Sustainable Service Models

Developing a safe and effective model of unscheduled care

The Scottish Government recognises the importance of primary care as the first point of contact to health care for most people and that this should also be the case during the out of hours period when people need urgent (unscheduled) care. A recent national review of Primary Care out of hours[7] services recommended that services:

- are person-centred, sustainable, high quality, safe and effective;
- provide access to relevant urgent care when needed; and
- deliver the right skill mix of professional support for patients during the out-of-hours period.

The national review recommended a model for out of hours and urgent care in the community that is clinician-led and delivered by a multi-disciplinary team (referred to as an "unscheduled care hub") enabling patients to be seen by the most appropriate professional to meet their individual needs.

Shetland already has a number of challenges in sustaining "out of hours" services, whether these are in the community or in secondary care with the issues highlighted in the national review exacerbated as a result of remoteness, economies of scale and existing recruitment and retention issues.

The ability to safely deliver services at all times of the day (24/7) is also a key determinant of the staffing required for a particular community or service and it is therefore important Shetland develops resilient out of hours unscheduled care services. This project will therefore explore how Shetland can implement the recommendations in the national report and create a sustainable 24/7 unscheduled care service.

Developing a sustainable hospital, acute and specialist services model for Shetland

NHS Shetland's long established policy is that the Gilbert Bain Hospital is a Rural District General Hospital, with a consultant led model of care. This is based predominantly on safety, quality and logistical reasons but has also been considered to be the most cost effective model for Shetland. However, with current recruitment issues there are concerns that this model is no longer sustainable. A project will be undertaken to review the options available to develop models for a sustainable hospital, acute and specialist service model for Shetland that is built around sustainable care pathways. This work will include a costing exercise to understand the fixed and variable costs associated with running the Gilbert Bain Hospital in its current form and the extent to which services, bed numbers, staffing and support services need to change to become sustainable in the medium term (3-5 years). This will explore a number of scenarios for the provision of acute hospital services for the local population including comparing the current consultant led rural general hospital with other models. It is intended to progress this work in partnership with other island Health Boards to inform the drafting of the North of Scotland Regional Clinical Strategy so that a clear Island General hospital model is developed.

[7] National Review of Primary Care Out of Hours Services

A complimentary project will continue to develop the extent to which some services might be repatriated from mainland hospitals and provided locally. The focus on this work is on avoiding unnecessary travel (for patients and for staff) and unnecessary appointments by maximising the opportunities for services to be provided locally and extending the use of tele-health and other technological solutions as well as streamlining pathways, to reduce where possible unnecessary steps in patient journeys.

Alongside this, the project to rebalance care from hospital to the community will continue. The Scottish Government's Health and Social Care Local Delivery Plan 2016 states that, "too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and for help for their carers – could better serve their needs". This philosophy is well-established and community care has successfully responded to the reduction in long stay hospital beds over the years. The Government policy is clear about the reasons for the shift in the location of care; minimising time in hospital and maximising opportunities for rehabilitation in the community provides the best possible outcome for the patient / service user. This work will be continued locally, with the ongoing development of the intermediate care team, the extension of community rehabilitation and the resultant optimisation of bed use within the Gilbert Bain hospital.

Developing a sustainable primary care model for Shetland

The approval of the Primary Care Strategy together with the recent requests for two practices within Shetland to become employees of the NHS (and not remain independent) provides a foundation upon which to build sustainable models of primary care within each locality. Primary Care services are predominantly the first point of contact for our service users and include GP practices, dentistry, pharmacy, nurses working in the community and allied health professionals. In many cases, primary care practitioners co-ordinate access to specialist services (in Shetland and mainland Scotland) and bring together complex care planning across health and social care services based in the community. Due to the fragility of the current arrangements, the remodelling of options for Primary Care will start with the north isles and be under-pinned by some fundamental principles including: quality; effectiveness; safety; accessibility; equality; integrated teams; and sustainability and be built in partnership with each local community.

The intention, as the project develops, is for the vision within the Primary care strategy to be fully implemented and a clear and sustainable Primary care model for Shetland to be created.

Developing a sustainable model of social care resources

The current model of care centres is not sustainable in the long term. The policy focus is to find ways to enable folk to stay safely and independently in their own home for as long as possible; moving away from hospital and residential models of care. The balance of permanent and respite care beds is regularly reviewed. In September 2016, the overall occupancy of beds was 91%. The funding from Shetland Charitable Trust towards the care home model is due to reduce by £100,000 per annum for the next 3 years, while the cost structure will increase due to wage increases and inflation. There is therefore a need to look again at sustainable models of community care

resources, including the development of integrated, multi-purpose care 'hubs' within each community identifying, where possible, opportunities for the co-location of services within one physical space and sharing back office support functions. The complexity, and cost, of enabling people to stay in their own home, including end of life care, is challenging and work will need to be done to further explore options for 24 hour care in localities. The value of unpaid carers and local and national third sector organisations in building sustainable service models is acknowledged and will be an integral part of the review process.

Developing a sustainable model for mental health services, including appropriate crisis and emergency arrangements

Mental illness is one of the major public health challenges in Scotland. Around one in three people are estimated to be affected by mental illness in any one year. Improving wellbeing, resilience and mental health is therefore a priority for Shetland Islands Health and Social Care Partnership. Work to promote mental wellbeing and improve mental health services is set out in the Mental Health Strategy and mirrors the importance of this area as a national priority. There are also specific work programmes to reduce suicide and self harm.

We will therefore continue to focus on delivering these strategies in 2017-18 including the development of a sustainable model for mental health services with appropriate crisis and emergency arrangements in place. This will need to look across all service areas, from specialist and acute services in Aberdeen and elsewhere, through local primary care support and into community based programmes supported by local and national voluntary organisations. The project aims to build capacity through the redesign and integration of health and social care elements of mental health.

Services for people living with dementia, their families and carers are set out in the Dementia Strategy, which is a key element of mental health services. There will be a specific focus on how we develop Old Age Psychiatric Services in the refreshed strategy and action plan for 2017-18 and beyond.

Developing a sustainable model for adults affected by learning disabilities and autistic spectrum disorders

A Scottish Government report in 2013, called The Keys to Life, set out recommendations for improving the quality of life for people with learning disabilities. The report acknowledged the stark fact that people with learning disabilities still die 20 years earlier than the general population. The report set out to ensure that all those who work in health care understand the health needs of people with learning disabilities, how these can differ from the general population and to respond appropriately and positively to support individuals to lead healthier and happier lives. People with learning disabilities should be supported to live independently in the community wherever possible. Shetland has a good range of services to support individuals and their families and unpaid carers – through housing, day care, short breaks and respite, and employment and training opportunities. The demand for services is growing and a new resource centre to support adults with learning disabilities is due to completion in the summer of 2017. However, with a projected reduction in funding overall, there is a need to look afresh at sustainable models of service to respond to the changing demands.

(C) Organisational Issues

Improving business performance and efficiency

Staff are at the heart of all the service delivery models. It is therefore intended, as part of all our projects, to put in place the right staffing numbers, ratios and skills mix for each service area. Within this we will respect professional boundaries while also supporting multi-disciplinary team working. The Health and Social Care Partnership needs to support staff to be the best they can be through positive leadership and creating a culture of openness and trust which allows staff to grow, learn and develop in a safe environment in a rapidly changing service. We expect our staff to be the champions of the transformational change that this plan advocates. There will therefore be specific support arrangements to build organisational capacity and resilience to focus on staff health and well-being, including aspects of leadership, values and behaviours and clear communication.

Alongside the support to staff, there will be a programme to redesign business and organisational systems, integrated insofar as they possibly can be, so that our staff can focus on tasks which support front line service delivery and are not wasteful. This might also involve working locally with partners in Shetland to make the best use of systems and resources, where it might be possible to develop a common approach. An example of this might be shared transport and distribution arrangements. The programme will cover:

- Maximising eHealth, Telehealthcare and Telecare opportunities
- Building staff organisational resilience and capacity
- Maximising local opportunities from national shared services programmes
- Review of decision making arrangements
- Procurement and commissioning
- Working out ways to do things 'once for Shetland', by sharing common systems and resources with local partners.

Within this we recognise the inherent tension between working out how best to do things for Shetland's Health and Care Partnership at a local level whilst also responding to the challenges for the NHS of working better at a regional and national level.

Improving the Quality and Safety of our services

(To be completed once the Local Delivery Plan Guidance is issued).

A summary of the programme of work is set out in the Table below.

Table 2: Overview of Strategic Programmes

(A) Whole Population	
Implementing an asset based approach to health care prevention	Effective Prescribing- working with patients and prescribers to ensure that evidenced, best value, medicines are started and stopped appropriately
(B) Sustainable Service Models	
Developing a safe and effective model of unscheduled care	Developing a sustainable hospital, acute and specialist services model for Shetland
Developing a sustainable primary care model for Shetland, with clear links to the 7 locality areas and the Gilbert Bain Hospital	Developing a sustainable model of social care resources
Developing a sustainable model for mental health services, including appropriate crisis and emergency arrangements	Developing a sustainable model for adults affected by learning disabilities and autism spectrum disorders
(C) Organisational Issues	
Improving Business Performance and Efficiency	Improving the Quality and Safety of our services
Achieving Financial Balance	

Resources Section / Financial Plan (TO FOLLOW)

Reliance on Other Services

The community focused nature of the Plan means that it cannot be delivered without relying on the support and services provided by others, including housing, leisure, learning and transport arrangement.

Housing

The Health and Wellbeing Outcomes provide a focus for enabling people to live safely and independently in their own homes and this is for all housing tenures, including private homes, rented homes, social housing and extra care housing. The Vision for the Housing Service is:

> "to work in partnership to enable everyone in Shetland to have access to a choice of affordable housing options across all tenures that are warm and safe, energy efficient and in keeping with the Shetland environment, of good quality and in good repair, able to meet demand and the particular needs of households in inclusive and vibrant communities."

The Housing Contribution Statement is included at Appendix 6.

Third Sector, Communities and Volunteering

The third sector provides an invaluable tool in helping to shape services. They play a significant role in identifying and finding ways to address unmet need. Their approach of helping individuals and communities to help themselves lies at the heart of how public sector services need to be reformed. Their overall objective is to improve people's lives and their approach to ensuring that community views are heard and understood is one of the under-pinning principles of the Plan. Harnessing the skills, knowledge and ability of communities to find solutions for themselves is essential to the Plan's success.

Transport

Reliance on safe and regular public transport is fundamental to supporting people to access health and care services. It also allows our staff to get to any area of Shetland to visit people in their own homes, during the day and at night time for planned visits and at any time to respond to emergency incidents. ZetTrans is a statutory body responsible for the provision and maintenance of public transport services in the Shetland Islands. Working in cooperation with a number of stakeholders and interested bodies, including bus operators, airlines and ferry companies, ZetTrans is geared towards the development of a sustainable transport network to meet the needs of the present while also looking towards the future.

Roads

The care at home service relies on unpaid carers and staff having safe access to people's own homes all over Shetland. The Council's approved Winter Maintenance Policy identifies the level of service that is provided in order to "ensure an efficient, effective and proportionate response to winter conditions within an environment of reducing resources."

Leisure

Supporting people to lead an active lifestyle through regular exercise is a key element of helping people to live to stay healthy for longer.

Infrastructure – Broadband

The existing and emerging technological solutions to support digital working and Telehealth and Telecare services relies on full coverage of effective and resilient broadband services.

Risk Assessment

The things which might go wrong and mean that we are unable to, or are less successful in being able to, deliver what we are trying to achieve include:

- the governance arrangements detracting from rather than supporting a journey towards 'single system' working across health and care services;

- the scale of the financial challenges and extent of the Government's ambition to modernise public services not being well understood when decisions about changes to specific service areas are required;

- the individual needs of each of the partner organisations being greater than the partnership agreement in influencing how services are designed and delivered;

- this Strategic Commissioning Plan not adequately reflecting the transformational change required to build sustainable and affordable health and care services for Shetland;

- the need for transformational change not being effectively understood or communicated to all stakeholders;

- the pressure to address short term needs is greater than planning what needs to change to create a sustainable future;

- spending decisions being based solely on historical service models rather than those we need to develop for now and into the future;

- insufficient staff, or ability to recruit and retain staff with the necessary skills;

- lack of leadership in the transformational change agenda, including insufficient clarity of purpose;

- cultural differences around extent to which staff on the ground are able to make decisions and choices around flexible, integrated and person-centred health and care services without recourse to management;

- when the fixed costs of maintaining the current model of service is factored into the financial planning process, the savings may have to fall disproportionately on community health and social care and health improvement services, which is contrary to the Government guidance on where investment should be targeted to achieve the best outcomes for individuals;

- legal impediments around records management which may limit the extent to which each partner organisation can pro-actively support data sharing arrangements for front line staff;

- the Strategic Commissioning Plan may be seen as a stand-alone document which does not get converted in achievable delivery plans;

- there may be insufficient staff time to undertake all the strategic projects in the timeframe suggested as staff have to balance their time between operational matters and development work and day to day service delivery matters will always take priority;
- the underpinning requirement for resilient and complete broadband coverage to take advantage of technological solutions might not be secured within the timescale of this Plan.

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http://www.shetland.gov.uk/equal-shetland/documents/OnDaLevel_Full_Version_13_April_16.pdf

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http://www.gov.scot/Resource/0049/00492520.pdf

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http://www.gov.scot/Resource/0051/00511950.pdf

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http://www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151203_health_socialcare.pdf

Accounts Commission: Changing Models of Health and Social Care, March 2016
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National Review of Primary Care Out-of-Hours Services
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ENDS

Appendix 1, Locality Profiles

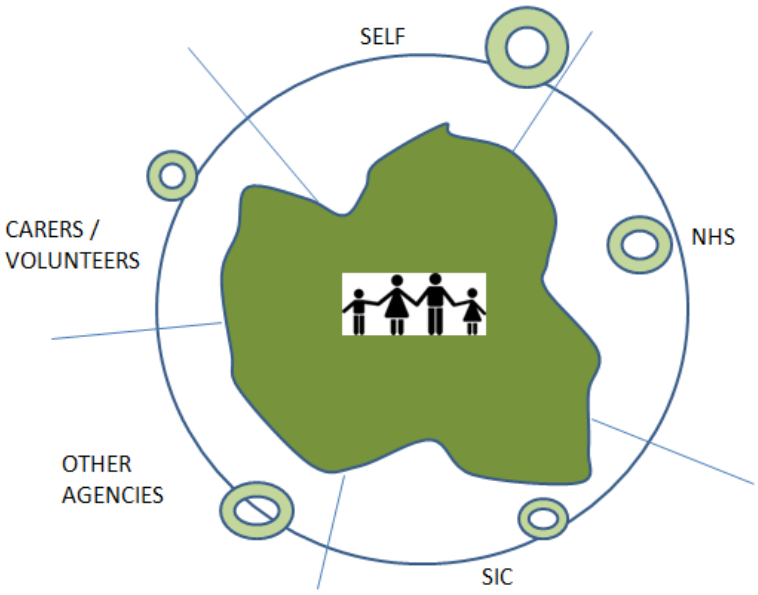
Introduction

The Plan is considered across seven localities based on geography and ward boundaries. The same arrangements are in place for all Shetland's strategic plans, including the Shetland Partnership's Local Outcome Improvement Plan.

A good strategic commissioning process will take account of the differing needs of each locality. Over time, and aligned to modernising ways of work supported by the community planning philosophy, the Strategic Commissioning Plan will evolve into a plan which clearly links needs to resources in each locality area.

This way of working moves from a paternalistic approach (doing things to people / communities) to actively working with local communities to share problems, identify solutions and make the best possible use of all resources available.

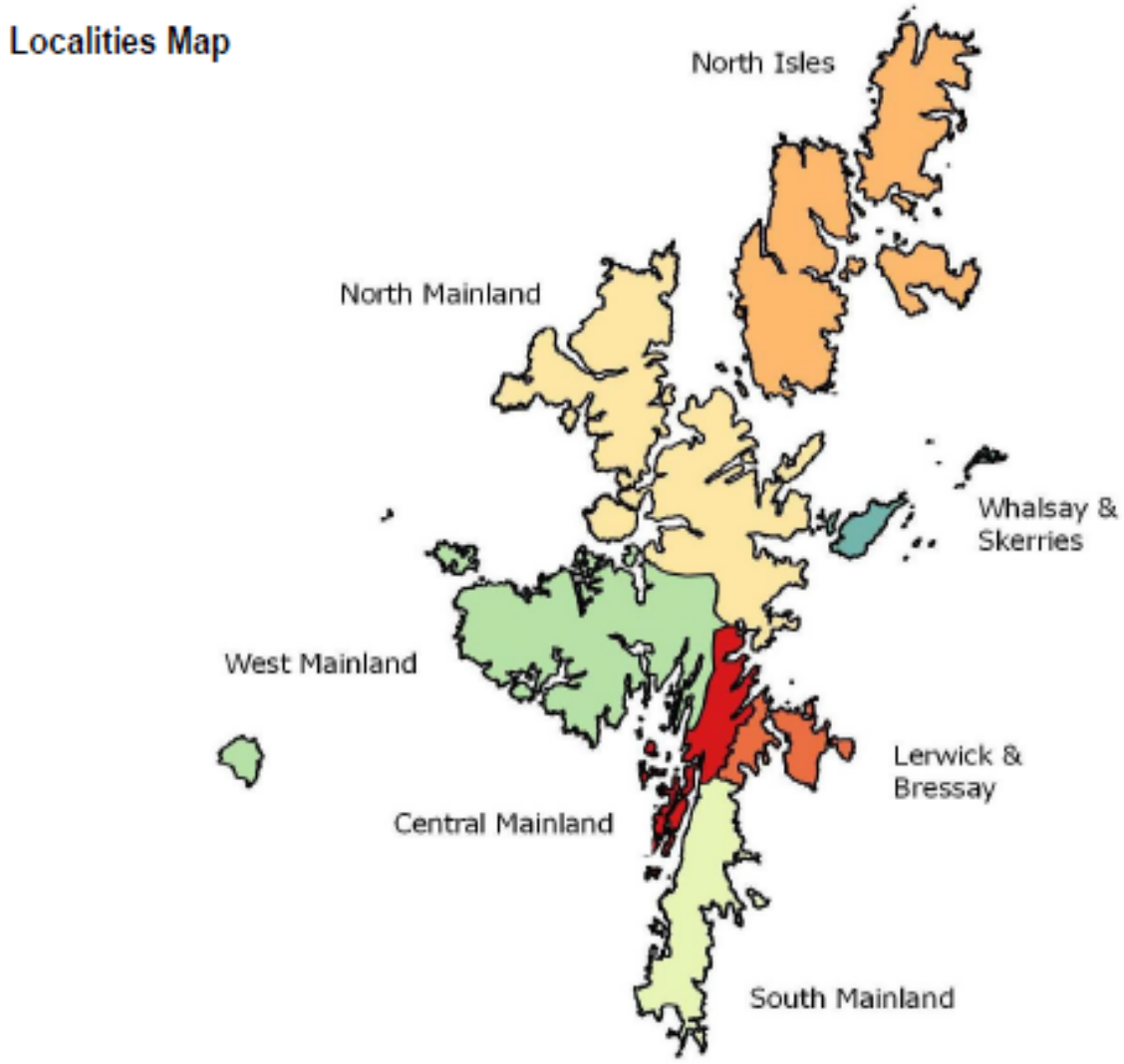
The Plan will be developed and 'owned' by each locality; it is then the responsibility of the commissioning body (the IJB) to turn that into service delivery on the grounds through its service delivery arrangements with public, community, voluntary and private sector partners. It places individuals, families, their carers and communities at the heart of the planning process, as shown diagrammatically below.



The seven localities in Shetland are:

- North Isles
- North Mainland
- West Mainland
- Whalsay and Skerries
- Central Mainland
- Lerwick and Bressay
- South Mainland

These are shown on the map below.



Each area currently has a set of services delivered within the locality:

- primary care;
- community nursing;
- care at home; and
- care home resources

alongside a broad range of voluntary activity to support individual and community wellbeing.

The Occupational Therapy and Health Improvement teams have practitioners allocated to deliver services and work with partner services within the locality. The Adult Social Work team has identified link professionals for each locality and the Pharmacy and Prescribing service are developing their community based support to GP practices.

There is in place a considerable range of voluntary and community provision in each area to support well being. Examples of this will include: support for individuals with dementia; befriending; lunch clubs; craft circles; leisure and learning opportunities. These deliver invaluable social benefits to those attending and form an intrinsic part of the network of provision to support individual health and wellbeing and community resilience.

Many services, although located in Lerwick, will provide outreach services throughout the islands to wherever the patients and service users live. An example of this way of working is the podiatry service.

During 2015/16 a series of locality planning meetings were held across localities to engage local staff and key other stakeholders (third sector, user and carer representatives, and community leaders - Community Council and SIC councillors), and feedback of the issues identified were passed to services to inform the development of the Joint Strategic Commissioning Plan.

The next section sets out some key health and social care indicators by locality. This is a summary of the published locality data held at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/Localities.asp

The source (and year to which the data refers) is included in the main analysis on the web-site.

The overall practice patient registrations (as at July 2016) is shown below.

Some of the datasets are currently incomplete and work is in hand to make sure that the analysis included comparable data across all seven localities.

Not all GP practices provide an Out of Hours service. Only those who do provide out of hours have a satisfaction score for the statement 'Overall, how would you rate the care you experienced out of hours?'

Shetland Practice's Patient Registrations

	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Bixter	90	140	132	278	309	131	70	17	1167
Brae	146	252	318	627	751	273	96	29	2492
Hillswick	59	77	86	198	212	95	32	19	778
Lerwick	436	962	1078	2263	2495	944	538	178	8894
Levenwick	128	323	286	592	815	321	164	48	2677
Scalloway	248	456	346	993	949	338	156	72	3558
Unst	28	70	37	100	178	118	49	18	598
Walls	46	94	85	160	199	86	52	24	746
Whalsay	59	132	122	251	274	139	97	32	1106
Yell	43	116	93	192	347	149	94	26	1060
Total	1283	2622	2583	5654	6529	2594	1348	463	23076

North Isles

Main Report

The full analysis can be found at:
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/HealthandSocialCareIntegration-NorthIslesMASTERV4.pdf

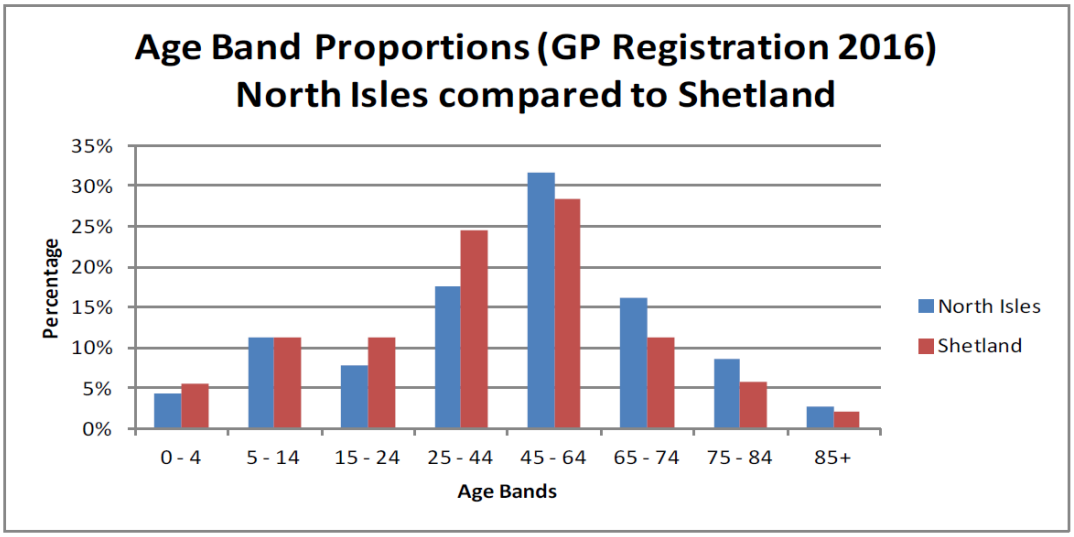
Age Profile of the North Isles Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Unst and Yell practices within a number of different age groups.

North Isles Practice's Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
North Isles	71	186	130	292	525	267	143	44	1658

The graph below shows that the age profile of the patients registered with the Unst and Yell in 2016 is slightly different to the rest of Shetland with fewer young people and adults in the 15-44 age group and then more in all the older age groups, compared to Shetland as a whole. There are some differences between the age profiles in the Unst and Yell population, but the actual numbers are small. Having a slightly larger population of older people and a slightly smaller population of working age people could mean that the implications of an aging population for the provision of health and care services in the North Isles could be even more marked in this area compared to the rest of Shetland. The data is from 1st July 2016.



Service Points

The key assets for accessing health and social care services in the north isles are:

- Unst Health Centre
- Yell Health Centre
- Nordalea Care Home
- Isleshavn Care Home

The Scottish Government arranges an annual survey of patient experience in attending GP practices. The most recent scores are shown below (http://www.hace15.quality-health.co.uk/index.php/reports/gp-practice-reports).

Unst Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	100%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	100%
I am treated with compassion and understanding	98%
Overall, how would you rate the care provided by your GP practice?	98%

Yell Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	87%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	92%
I am treated with compassion and understanding	95%
Overall, how would you rate the care provided by your GP practice?	91%
Overall, how would you rate the care you experienced out of hours?	67%

Care services are subject to regular inspection through the Care Inspectorate. The most recent scores are set out below (http://www.careinspectorate.com/).

Nordalea Care Centre

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
Nordalea, Unst	6	67	1	250	7	95	8

* The Director can adjust the use of beds between 'residential' and 'respite' to suit need.

Nordalea Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
29 June 2016	4- Good	No grade available	No grade available	4-Good
15 Oct 2015	5 – Very Good	5 – Very Good	4 – Good	4 - Good

Nordalea Quality Grades: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
6 Feb 2015	5 – Very Good	5 – Very Good	5 – Very Good	5 – Very Good
30 Jan 2012	5 – Very Good	5 – Very Good	Not assessed	Not assessed

Isleshavn Care Centre

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
Isleshavn, Mid Yell	9	22	1	677	10	92	4

Isleshavn Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
10 Aug 2015	3 – Adequate	4- Good	4- Good	4-Good
15 Oct 2016	4- Good	4- Good	4 – Good	4 - Good

Isleshavn Quality Grades: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
29 June 2016	4- Good	No grade available	No grade available	4- Good
30 Jan 2012	4- Good	4- Good	4 – Good	4 - Good

Health Risk Factors

The next section assesses the prevalence of various conditions by GP practice area.

A higher recording for a practice may reflect differences in recording methods or projects to target specific conditions; it is not necessarily an accurate reflection of a 'better' or 'worse' health profile without further investigation.

The small numbers involved also make it difficult to draw specific conclusions.

Category	Unst Health Centre		Yell Health Centre	
	Number of Patients (and where given % of total registered) Comment on data where pattern is not similar to other practices			
Smoking	155 patients (combined total), which is 9.3%			
Obesity	97	17%	205	19%, Highest
Hypertension	161	second highest	311	Highest
Asthma	51		91	
COPD[1]	8		13	
CHD[2]	20		73	Significantly higher
Heart Failure	4		26	Second highest
Diabetes	42		76	Significantly higher
Stroke TIA[3]	17	higher than average	30	Higher
Chronic Kidney or Renal Disease	32	high	72	Highest
Cancer	22		36	
Mental Health	7		6	
Depression	24		67	
Dementia	16 patients (combined total)			

[1] Chronic Obstructive Pulminory Disorder

[2] Coronery Heart Disease

[3] Transient Ischaemic Attacks

Community Consultations

The Shetland Place Standard Consultation took place between14th June to 10th July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments.

The results of the consultation are presented below, outlining respondents' views on how they feel about where they live. The results are presented as 'spider' diagrams, showing the average rating for each of the 14 questions in the Place Standard survey for each of the seven localities.

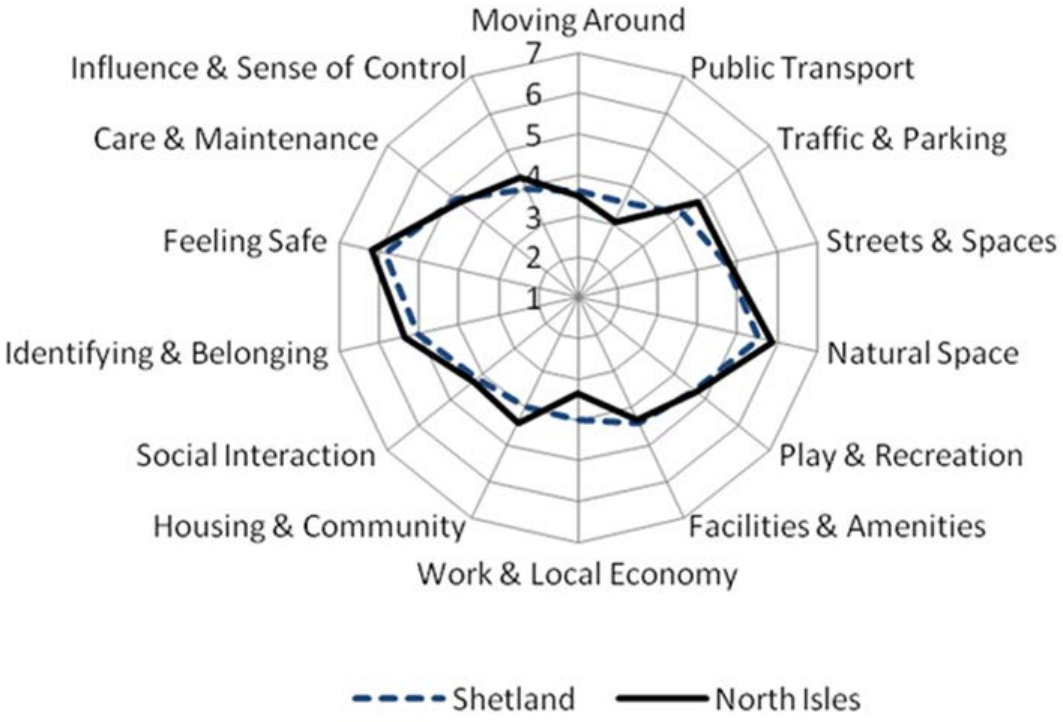
http://www.shetland.gov.uk/placestandard.asp

The top 3 considerations for the north isles were:

- Public transport
- Work and Local Economy
- Facilities and Amenities

Average Rating North Isles

1: A lot of room for improvement
7: No improvement required



North Mainland

Main Report

The full analysis can be found at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/HealthandSocialCareIntegration-NorthMainlandMASTERV4.pdf

Age Profile of the North Mainland Population

North Mainland Practices Patient Registrations North Mainland overall has roughly the same age distribution as Shetland, with slight differences – slightly more 15-64 year olds and slightly fewer 75 year olds and older. However, the differences are small scale (1 or 2%).

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
North Mainland	205	329	404	825	963	368	128	48	3270

Service Points

The key assets for accessing health and social care services in the north mainland are:

- Hillswick Health Centre
- Brae Health Centre
- North Haven Care Home

The Scottish Government arranges an annual survey of patient experience in attending GP practices. The most recent scores are shown below (http://www.hace15.quality-health.co.uk/index.php/reports/gp-practice-reports).

Hillswick Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	99%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	98%
I am treated with compassion and understanding	98%
Overall, how would you rate the care provided by your GP practice?	99%

Brae Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	90%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	97%
I am treated with compassion and understanding	84%
Overall, how would you rate the care provided by your GP practice?	91%

Overall, how would you rate the care you experienced out of hours?	80%

Care services are subject to regular inspection through the Care Inspectorate. The most recent scores are set out below (http://www.careinspectorate.com/).

North Haven Care Centre

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
North Haven	13	54	2	312	15	93	12

* The Director can adjust the use of beds between 'residential' and 'respite' to suit need.

North Haven Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
22 Jul 2016	4- Good	No grade available	No grade available	4-Good
17 Aug 2015	3 – Adequate	4 – Good	3- Adequate	3 - Adequate

North Haven Quality Grades: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
2 May 2016	4- Good	No grade available	No grade available	4- Good
6 May 2015	4- Good	4- Good	4- Good	3 - Adequate

Health Risk Factors

The next section assesses the prevalence of various conditions by GP practice area.

A higher recording for a practice may reflect differences in recording methods or projects to target specific conditions; it is not necessarily an accurate reflection of a 'better' or 'worse' health profile without further investigation.

The small numbers involved also make it difficult to draw specific conclusions.

Further work done in Hillswick as part of a needs assessment project has shown a higher number of people with chronic conditions and higher rates of smoking in patients with chronic diseases, but not in the population as a whole. This project found that there are a group of people in that area with a number of related chronic conditions, where a focus on prevention and dealing with risk factors could make a big difference to their health.

Category	Hillswick Health Centre		Brae Health Centre	
	Number of Patients (and where given % of total registered) Comment on data where pattern is not similar to other practices			
Smoking				
Obesity		Higher		High
Hypertension				
Asthma		Highest		
COPD[1]		Highest		
CHD[2]		High		
Heart Failure		High		
Diabetes	207	Highest		
Stroke TIA[3]				
Chronic Kidney or Renal Disease				
Cancer				
Mental Health				
Depression		Higher		Higher
Dementia				

[1] Chronic Obstructive Pulminory Disorder

[2] Coronery Heart Disease

[3] Transient Ischaemic Attacks

Community Consultations

The Shetland Place Standard Consultation took place between14th June to 10th July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments.

The results of the consultation are presented below, outlining respondents' views on how they feel about where they live. The results are presented as 'spider' diagrams, showing the average rating for each of the 14 questions in the Place Standard survey for each of the seven localities.

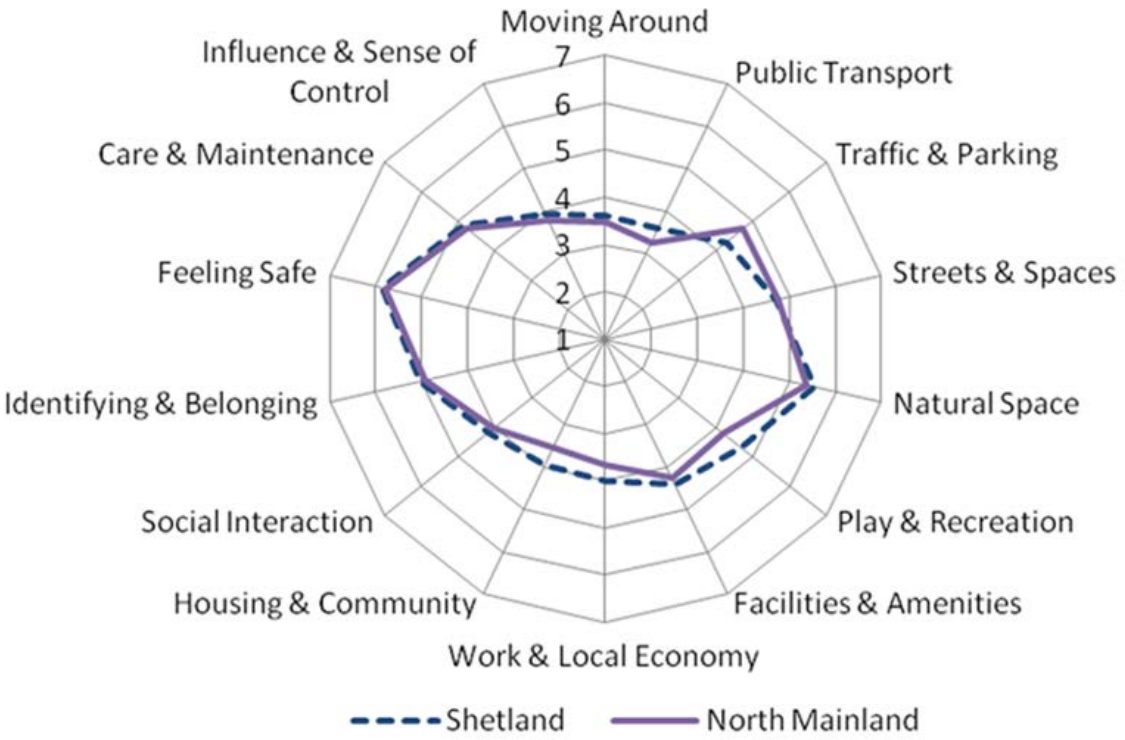
http://www.shetland.gov.uk/placestandard.asp

The top 3 considerations for the north mainland were:

- Public transport
- Housing and Community
- Work and Local Economy

Average Rating North Mainland

1: A lot of room for improvement
7: No improvement required



West Mainland

Main Report

The full analysis can be found at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/HealthandSocialCareIntegration-WestMainlandMASTERV4.pdf

Age Profile of the West Mainland Population

The information below is based on GP practice registrations: it shows the number of people registered with the Walls and Bixter practices within a number of different age groups.

The chart shows that the age profile of the patients registered with the West Mainland practices is similar to the rest of Shetland with slightly fewer adults in the 25-44 and 45-64 age groups.

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
West Mainland	136	234	217	438	508	217	122	41	1913

Bixter has a similar rate, or less, in the older age groups compared to the rest of Shetland, and more in the youngest age groups. Walls has a higher rate of people in the older age groups, and more in the very youngest age groups.

Service Points

The key assets for accessing health and social care services in the north isles are:

- Walls Health Centre
- Bixter Health Centre
- Wastview Care Home

The Scottish Government arranges an annual survey of patient experience in attending GP practices. The most recent scores are shown below (http://www.hace15.quality-health.co.uk/index.php/reports/gp-practice-reports).

Walls Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	97%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	97%
I am treated with compassion and understanding	96%
Overall, how would you rate the care provided by your GP practice?	94%
Overall, how would you rate the care you experienced out of hours?	76%

Bixter Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	99%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	100%
I am treated with compassion and understanding	95%
Overall, how would you rate the care provided by your GP practice?	95%

Care services are subject to regular inspection through the Care Inspectorate. The most recent scores are set out below (http://www.careinspectorate.com/).

Wastview Care Centre

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
Wastview	13	96	2	88	15	88	12

* The Director can adjust the use of beds between 'residential' and 'respite' to suit need.

Wastview Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
2 May 2016	4- Good	No grade available	No grade available	4-Good
4 June 2015	4- Good	4- Good	4 – Good	3 - Adequate

Wastview Quality Grades: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
4 Feb 2016	5 – Very Good	5 – Very Good	4 – Good	4 – Good
21 Feb 2013	5 – Very Good	5 – Very Good	5 – Very Good	4 – Good

Health Risk Factors

The next section assesses the prevalence of various conditions by GP practice area.

A higher recording for a practice may reflect differences in recording methods or projects to target specific conditions; it is not necessarily an accurate reflection of a 'better' or 'worse' health profile without further investigation.

The small numbers involved also make it difficult to draw specific conclusions.

Category	Bixter Health Centre		Walls Health Centre	
	Number of Patients (and where given % of total registered) Comment on data where pattern is not similar to other practices			
Smoking	195 patients (combined total)			
Obesity	158	17% , High	49	8%
Hypertension	212		127	
Asthma	103		60	
COPD[1]	21		8	
CHD[2]	37		16	
Heart Failure	10		12	
Diabetes	50		22	Lowest
Stroke TIA[3]	22		28	Highest
Chronic Kidney or Renal Disease	81	Lower	12	Lower
Cancer	40		17	
Mental Health	7		10	
Depression	89	higher	22	Lower
Dementia	3	Lowest	15	Highest

[1] Chronic Obstructive Pulminory Disorder

[2] Coronery Heart Disease

[3] Transient Ischaemic Attacks

Community Consultations

The Shetland Place Standard Consultation took place between14th June to 10th July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments.

The results of the consultation are presented below, outlining respondents' views on how they feel about where they live. The results are presented as 'spider' diagrams, showing the average rating for each of the 14 questions in the Place Standard survey for each of the seven localities.

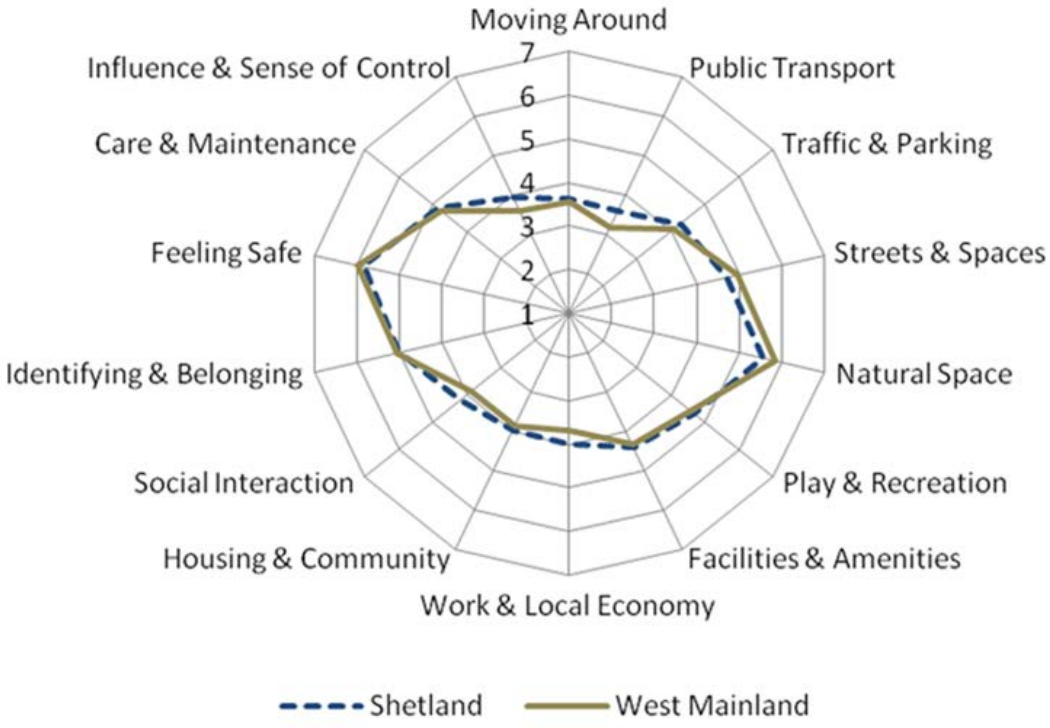
http://www.shetland.gov.uk/placestandard.asp

The top 3 considerations for the West Mainland were:

- Public transport
- Facilities and Amenities
- Work and Local Economy

Average Rating West Mainland

1: A lot of room for improvement
7: No improvement required



Whalsay and Skerries

Main Report

The full analysis can be found at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/HealthandSocialCareIntegration-WhalsaySkerriesMASTERV4.pdf

Age Profile of the Whalsay and Skerries Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Whalsay practice within a number of different age groups.

Whalsay Practice Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Whalsay & Skerries	59	132	122	251	274	139	97	32	1106

Whalsay and Skerries have slightly fewer adults in the 25-64 age group – although this equates to around 30 individuals – not a huge figure. They also have slightly more older adults in the 65-85+ age groups, compared to Shetland as a whole – these are only 1 or 2 %. We see an aging population which is slightly higher than the Shetland average, with fewer (than the Shetland average) middle aged working adults.

Service Points

The key assets for accessing health and social care services in Whalsay and Skerries are:

- Whalsay Health Centre
- Fernlea Care Home

The Scottish Government arranges an annual survey of patient experience in attending GP practices. The most recent scores are shown below (http://www.hace15.quality-health.co.uk/index.php/reports/gp-practice-reports).

Whalsay Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	94%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	96%
I am treated with compassion and understanding	94%
Overall, how would you rate the care provided by your GP practice?	95%
Overall, how would you rate the care you experienced out of hours?	95%

Care services are subject to regular inspection through the Care Inspectorate. The most recent scores are set out below (http://www.careinspectorate.com/).

Fernlea Care Centre

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
Fernlea	8	88	2	77	10	88	8

* The Director can adjust the use of beds between 'residential' and 'respite' to suit need.

Fernlea Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
11 Dec 2015	4- Good	5 – Very Good	4 – Good	4-Good
23 Jan 2015	4- Good	5 – Very Good	4 – Good	4 - Good

Fernlea Quality Grades: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
23 Jan 2015	5 – Very Good	5 – Very Good	4 – Good	4-Good
2 Feb 2012	5 – Very Good	Not assessed	Not assessed	4-Good

Health Risk Factors

The next section assesses the prevalence of various conditions by GP practice area.

A higher recording for a practice may reflect differences in recording methods or projects to target specific conditions; it is not necessarily an accurate reflection of a 'better' or 'worse' health profile without further investigation.

The small numbers involved also make it difficult to draw specific conclusions.

Category	Whalsay and Skerries Health Centre	
	Number of Patients (and where given % of total registered) Comment on data where pattern is not similar to other practices	
Smoking		
Obesity		High
Hypertension		Higher
Asthma		
COPD[1]		
CHD[2]		
Heart Failure		
Diabetes		
Stroke TIA[3]		
Chronic Kidney or Renal Disease		Higher
Cancer		
Mental Health		Below Average
Depression		

[1] Chronic Obstructive Pulminory Disorder

[2] Coronery Heart Disease

[3] Transient Ischaemic Attacks

Community Consultations

The Shetland Place Standard Consultation took place between14th June to 10th July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments.

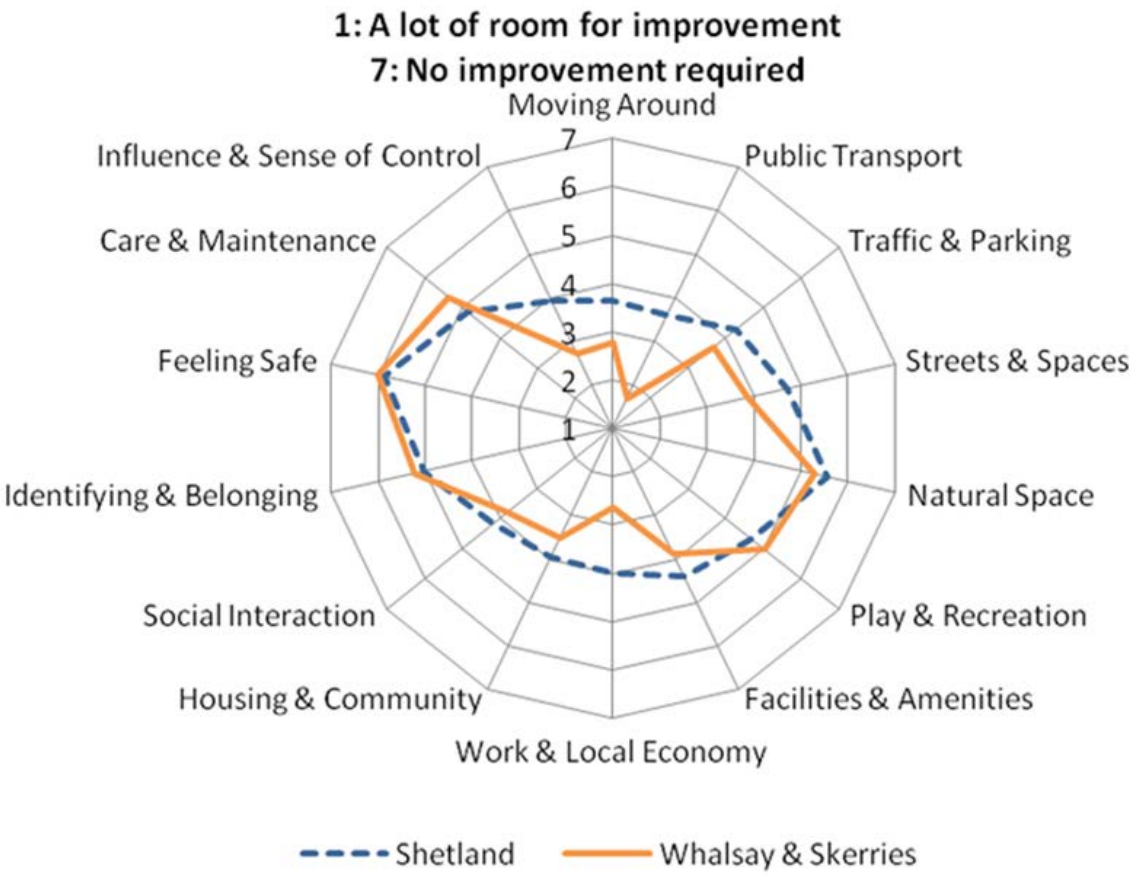
The results of the consultation are presented below, outlining respondents' views on how they feel about where they live. The results are presented as 'spider' diagrams, showing the average rating for each of the 14 questions in the Place Standard survey for each of the seven localities.

http://www.shetland.gov.uk/placestandard.asp

The top 3 considerations for Whalsay and Skerries were:

- Public transport
- Facilities and Amenities
- Work and Local Economy

Average Rating Whalsay & Skerries



Central Mainland

Main Report

The full analysis can be found at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/HealthandSocialCareIntegration-CentralMainlandMASTERV4.pdf

Age Profile of the Central Mainland Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Scalloway practice within a number of different age groups.

Central Mainland Practices Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Central Mainland	248	456	346	993	949	338	156	72	3558

Central mainland has an age distribution roughly similar to the whole of Shetland. The 15-24 and 65-74 age groups are very slightly smaller in central mainland, whereas the 25-44 age group is larger, but the differences are small.

Service Points

The key assets for accessing health and social care services in the Central Mainland are:

- Scalloway Health Centre
- Walter and Joan Gray Care Home

The Scottish Government arranges an annual survey of patient experience in attending GP practices. The most recent scores are shown below (http://www.hace15.quality-health.co.uk/index.php/reports/gp-practice-reports).

Scalloway Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	89%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	92%
I am treated with compassion and understanding	98%
Overall, how would you rate the care provided by your GP practice?	100%
Overall, how would you rate the care you experienced out of hours?	58%

Care services are subject to regular inspection through the Care Inspectorate. The most recent scores are set out below (http://www.careinspectorate.com/).

Walter and Joan Gray Care Home

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
Walter and Joan Gray Home	15	56	1	743	16	99	10

* The Director can adjust the use of beds between 'residential' and 'respite' to suit need.

Walter and Joan Gray Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
14 Oct 2015	4- Good	4- Good	4 – Good	4- Good
29 Aug 2014	4- Good	4- Good	4 – Good	4- Good

Walter and Joan Gray Quality Grades: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
30 Jan 2015	4- Good	4- Good	4 – Good	4- Good
3 Feb 2012	5 – Very Good	4- Good	Not assessed	Not assessed

Health Risk Factors

The next section assesses the prevalence of various conditions by GP practice area.

A higher recording for a practice may reflect differences in recording methods or projects to target specific conditions; it is not necessarily an accurate reflection of a 'better' or 'worse' health profile without further investigation.

The small numbers involved also make it difficult to draw specific conclusions.

Category	Scalloway Health Centre	
	Number of Patients (and where given % of total registered) Comment on data where pattern is not similar to other practices	
Smoking		
Obesity		Lower
Hypertension		Low
Asthma		Above average
COPD[1]		Lower
CHD[2]		
Heart Failure		
Diabetes	130	Below average
Stroke TIA[3]		Lower
Chronic Kidney or Renal Disease		Lower
Cancer		
Mental Health		Higher
Depression		Higher

[1] Chronic Obstructive Pulminory Disorder

[2] Coronery Heart Disease

[3] Transient Ischaemic Attacks

Community Consultations

The Shetland Place Standard Consultation took place between14th June to 10th July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments.

The results of the consultation are presented below, outlining respondents' views on how they feel about where they live. The results are presented as 'spider' diagrams, showing the average rating for each of the 14 questions in the Place Standard survey for each of the seven localities.

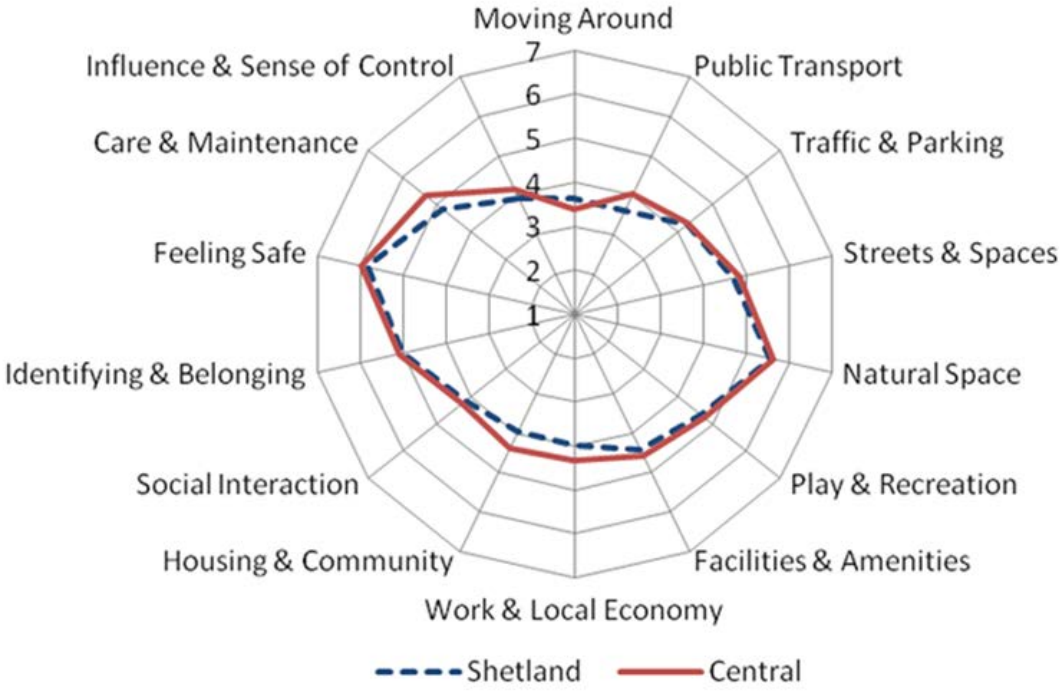
http://www.shetland.gov.uk/placestandard.asp

The top 3 considerations for Central Mainland were:

- Public transport
- Facilities and Amenities
- Housing and Community

Average Rating Central Mainland

1: A lot of room for improvement
7: No improvement required



Lerwick and Bressay

Main Report

The full analysis can be found at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/HealthandSocialCareIntegration-LerwickandBressayMASTERV4.pdf

Age Profile of the Lerwick and Bressay Population

The information below is based on GP practice registrations for 2016. It shows the number of people registered with the Lerwick practice within a number of different age groups.

Lerwick Practice's Patients Registrations

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
Lerwick & Bressay	436	962	1078	2263	2495	944	538	178	8894

Lerwick and Bressay have an age distribution very similar to the whole of Shetland. The 15-44 age group is fractionally larger in Lerwick and Bressay.

Service Points

The key assets for accessing health and social care services in Lerwick and Bressay are:

- Lerwick Health Centre
- Gilbert Bain Hospital
- Ewarard Thomason and Taing House Care Home
- Montfield Support Services
- Independent Living Resource Centre

The Scottish Government arranges an annual survey of patient experience in attending GP practices. The most recent scores are shown below (http://www.hace15.quality-health.co.uk/index.php/reports/gp-practice-reports).

Lerwick Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	34%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	87%
I am treated with compassion and understanding	84%
Overall, how would you rate the care provided by your GP practice?	79%
Overall, how would you rate the care you experienced out of hours?	83%

Care services are subject to regular inspection through the Care Inspectorate. The most recent scores are set out below (http://www.careinspectorate.com/).

Edward Thomason and Taing House and Montfield Support Services

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
Edward Thomason and Taing House, Lerwick	38	97	3	38	41	93	12
Montfield, Lerwick	2	100	15	81	17	83	

* The Director can adjust the use of beds between 'residential' and 'respite' to suit need.

Edward Thomason and Taing House Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
27 Sept 2016	5 – Very Good	Not assessed	Not assessed	5 – Very Good
1 Dec 2015	4- Good	5 – Very Good	4- Good	4- Good

Edward Thomason and Taing House: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
27 Sept 2016	5 – Very Good	Not assessed	Not assessed	5 – Very Good
1 Dec 2015	4- Good	5 – Very Good	4- Good	4- Good

Montfield: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
27 May 2016	5 – Very Good	No grade available	No grade available	5 – Very Good
2 July 2015	4- Good	4 - Good	4- Good	4- Good

Health Risk Factors

The next section assesses the prevalence of various conditions by GP practice area.

A higher recording for a practice may reflect differences in recording methods or projects to target specific conditions; it is not necessarily an accurate reflection of a 'better' or 'worse' health profile without further investigation.

The small numbers involved also make it difficult to draw specific conclusions.

Category	Lerwick Health Centre	
	Number of Patients (and where given % of total registered) Comment on data where pattern is not similar to other practices	
Smoking		
Obesity		Fewer
Hypertension		
Asthma		Below average
COPD[1]		
CHD[2]		
Heart Failure		Lower
Diabetes	328	Lower
Stroke TIA[3]		
Chronic Kidney or Renal Disease		
Cancer		
Mental Health		Above Average
Depression		Higher

[1] Chronic Obstructive Pulminory Disorder

[2] Coronery Heart Disease

[3] Transient Ischaemic Attacks

Community Consultations

The Shetland Place Standard Consultation took place between14th June to 10th July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments.

The results of the consultation are presented below, outlining respondents' views on how they feel about where they live. The results are presented as 'spider' diagrams, showing the average rating for each of the 14 questions in the Place Standard survey for each of the seven localities.

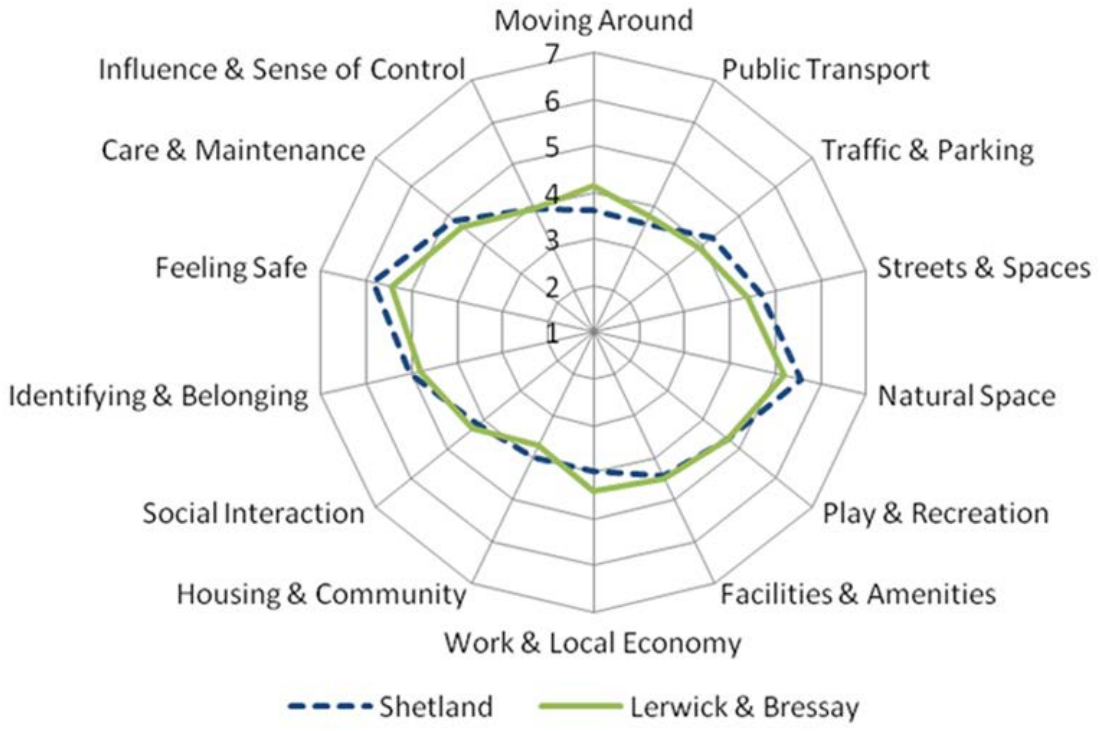
http://www.shetland.gov.uk/placestandard.asp

The top 3 considerations for Lerwick and Bressay were:

- Housing and Community
- Work and Local Economy
- Public Transport

Average Rating Lerwick & Bressay

1: A lot of room for improvement
7: No improvement required



South Mainland

Main Report

The full analysis can be found at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/HealthandSocialCareIntegration-SouthMainlandMASTERV4.pdf

Age Profile of South Mainland Population

South Mainland has slightly more people in the 45-64 age group, and slightly fewer in the 25-44 age group, compared to Shetland as a whole, but overall the age distribution is similar to Shetland.

Age Group	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
South Mainland	128	323	286	592	815	321	164	48	2677

Service Points

The key assets for accessing health and social care services in the South Mainland are:

- Levenwick Health Centre
- Overtonlea Care Home

The Scottish Government arranges an annual survey of patient experience in attending GP practices. The most recent scores are shown below (http://www.hace15.quality-health.co.uk/index.php/reports/gp-practice-reports).

Levenwick Health Centre

Statement	Result 2015-16
Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?	75%
Overall, how would you rate the arrangements for getting to see a nurse in your GP practice?	94%
I am treated with compassion and understanding	92%
Overall, how would you rate the care provided by your GP practice?	93%
Overall, how would you rate the care you experienced out of hours?	65%

Care services are subject to regular inspection through the Care Inspectorate. The most recent scores are set out below (http://www.careinspectorate.com/).

Overtonlea Care Home

Establishment	Permanent Residential Places (No)	Permanent Residential Places (% Occupancy, Sept 2016)	Respite / Short Stay Places (No)	Respite Residential Places (% Occupancy, Sept 2016)*	Total Places (No)	Occupancy at September 2016 (%)	Day Care Places (No)
Overtonlea	13	62	2	287	15	85	12

* The Director can adjust the use of beds between 'residential' and 'respite' to suit need.

Overtonlea Quality Grades: Care Home

Date	Care and Support	Environment	Staffing	Management and Leadership
18 Nov 2016	4- Good	Not assessed	Not assessed	4- Good
10 Dec 2015	4- Good	4- Good	4- Good	4- Good

Overtonlea Quality Grades: Support Services

Date	Care and Support	Environment	Staffing	Management and Leadership
4 Feb 2015	5 – Very Good	4- Good	4- Good	4- Good
27 Jan 2012	5 – Very Good	Not assessed	Not assessed	4- Good

Health Risk Factors

The next section assesses the prevalence of various conditions by GP practice area.

A higher recording for a practice may reflect differences in recording methods or projects to target specific conditions; it is not necessarily an accurate reflection of a 'better' or 'worse' health profile without further investigation.

The small numbers involved also make it difficult to draw specific conclusions.

Category	Levenwick Health Centre	
	Number of Patients (and where given % of total registered) Comment on data where pattern is not similar to other practices	
Smoking		
Obesity		Lower
Hypertension		Low
Asthma		
COPD[1]		Below average
CHD[2]		Below average
Heart Failure		Very Low
Diabetes		Below average
Stroke TIA[3]		Lower
Chronic Kidney or Renal Disease		
Cancer		Below average
Mental Health		Below average
Depression		Below average

[1] Chronic Obstructive Pulminory Disorder

[2] Coronery Heart Disease

[3] Transient Ischaemic Attacks

Community Consultations

The Shetland Place Standard Consultation took place between14th June to 10th July 2016. A total of 939 people responded to this public consultation, and there were 4,840 individual comments.

The results of the consultation are presented below, outlining respondents' views on how they feel about where they live. The results are presented as 'spider' diagrams, showing the average rating for each of the 14 questions in the Place Standard survey for each of the seven localities.

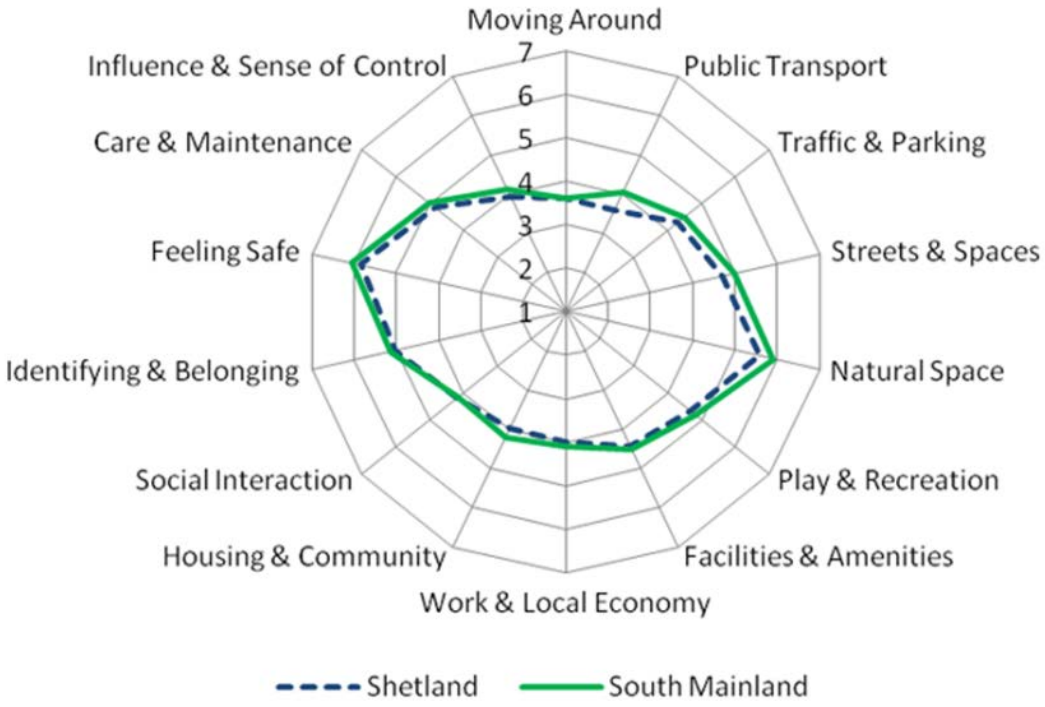
http://www.shetland.gov.uk/placestandard.asp

The top 3 considerations for the South Mainland were:

- Public Transport
- Facilities and Amenities
- Work and Local Economy

Average Rating South Mainland

1: A lot of room for improvement
7: No improvement required



Appendix 2, Service Plans

Roles and Responsibilities

The Partners are:

IJB	the Integration Joint Board, which is the formal arrangements for Shetland Islands Health and Social Care Partnership
NHS Board	Shetland Health Board
SIC	Shetland Islands Council

Delegation

The extent to which each organisation can approve the Strategic Commissioning Plan and direct activity, through the Service Plans, is determined by the Shetland Islands Health and Social Care Partnership Integration Scheme 2015.

http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/SHSCPartnershipIntegrationScheme15May2015.pdf

Service Plans

Detailed Service Plans are included as an integral part of Strategic Commissioning Plan. These are the means by which services will respond to the needs assessment.

The Integration Scheme is mainly for adults aged over 18. However, some services are not easily delineated between children and young people and adult services, and transition into adulthood is an intrinsic part of some service offerings (eg for adults with learning disabilities). The Service Plans have been built around natural groupings of services and those which may include children services are highlighted in the schedule below.

Each service falls within a Category as described below.

- **Category A** services - the community health and social care services which are wholly integrated and wholly delegated to the Integration Joint Board within the managerial responsibility of the Chief Officer;
- **Category B** services – certain acute and hospital based services which support integration, referred to as 'set aside' services and managed outwith the IJB;
- **Category C** services – other local health services which are included in the Plan in the interest of having a holistic oversight of all health and care services. These are also managed outwith the IJB.

Schedule

Service Area	Category A	Category B	Category C	Children and Young People
Adult Services	√			Transition
Adult Social Work	√			
Allied Health Professionals	√			Yes
Carers	√			Yes
Community Care Resources	√			
Community Nursing	√			
Criminal Justice	√			
Domestic Abuse	√			Yes
Intermediate Care	√			
Mental Health	√			
Oral Health	√			Yes
Pharmacy and Prescribing	√	√		Yes
Primary Care	√			Yes
Substance Misuse	√			Yes
Suicide Prevention	√			Yes
Set Aside Services		√		Yes
Public Health and Health Improvement		√	√	Yes
Human Resources and Support Services			√	
Finance			√	
Estates, Facilities and Medical Physics			√	

Purpose of Direction

The detailed Service Plans which will form the basis of the 'direction' from the Integration Joint Board to NHS Shetland and Shetland Islands Council.

The 'Direction' is defined in the Integrated Resource Advisory Group Finance Guidance as a, 'written instruction from the integrated authority that an integrated function must be carried out by a particular person, eg the Local Authority or Health Board which is binding on the recipient'.

The 'Direction' is the specific instruction from the Integration Joint Board which requires NHS Shetland and Shetland Islands Council to:

- Deliver the Strategic Commissioning Plan by providing the services as set out in the Service Plans;
- Delivers the services within the budget and resources described in the Strategic Commissioning Plan;
- Delivers the services within the overall strategic and policy framework which supports both service delivery and back office support functions;
- Undertakes to implement to the agreed timescale all the service change, savings or efficiency projects ;
- Puts in place the necessary performance monitoring arrangements to reassure the IJB that:

    - services within the Strategic Commissioning Plan are being delivered;
    - that service standards and performance targets are being met;
    - that the services are provided within budget;
    - the projects are being implemented on time; and
    - remedial action is being taken as necessary if expected performance is not achievable.
- Regularly review the strategic and operational risks of delivering the plan and puts in place arrangements to reassure the IJB that the risks are well managed and appropriate mitigation is in place.

Service Plan – Adult Services
Learning Disability and Autism Spectrum Disorder Services

Joint Strategic Commissioning Plan 2017 – 2020

Policy context

There are a wide range of legislative provisions which impose powers and duties on public bodies with regard to the care and support of people with learning disabilities and autism spectrum disorder. The main statutory duties are contained in the Social Work (Scotland) Act 1968, which establishes an overall duty to 'promote social welfare' by providing advice, guidance and assistance; the National Health Service and Community Care Act 1990 which requires the local authority to assess the individual care needs of people, including people who have care needs as a consequence of disability, mental health problems or increasing age; and in Sections 25 and 26 of the Mental Health Care and Treatment (Scotland) Act 2003. The 2003 Act applies to people who have a mental disorder, and 'mental disorder' is defined as including mental illness, learning disability, autism spectrum disorder and personality disorder.

Section 25 of the 2003 Act requires the local authority to provide or arrange the provision of care and support to people who have or have had a mental disorder and are in need of services and to give people the opportunity to lead lives which are as normal as possible. This can include accommodation and care at home to support both quality of life and safety. Section 26 requires the local authority to provide or arrange provision of service which promote the social development and well being of persons with a mental disorder. This includes social and recreational activities; training for people over school age; and assistance in obtaining and undertaking employment. The Act also requires public bodies to provide support including through independent advocacy and local authority services.

In addition, all health and social care organisations and staff are under a general duty to carry out their work in a way that promotes equality of opportunity and seeks to counter or eliminate discrimination.

Other legislation which shapes service delivery for people with learning disability and autistic spectrum disorder includes; Adults with Incapacity (Scotland) Act 2000; Regulation of Care (Scotland) Act 2001; Adult Support & Protection (Scotland) Act 2007; Social Care (Self-directed Support) (Scotland) Act 2013; Public Bodies (Joint Working) (Scotland) Act 2014; Carers (Scotland) Act 2016.

Health and Wellbeing

There are many different social, economic, environmental and cultural factors which affect and influence a person's health and wellbeing. People living in the same community, or people of the same age, can have vastly different chances of good health, with many of the determinants of health and wellbeing out of our own personal control.

Some of the main ‘determinants of health’ include**:**

- Where you live: Is housing safe and not overcrowded? How safe are roads? Are there jobs with decent working conditions?
- Genetics: have you inherited greater likelihood of certain illnesses? How do you cope with stress?
- Income: unsurprisingly, higher income is linked with better health.
- Nutrition: can you regularly eat enough healthy food?
- Education: going to school can improve many other determinants of health.
- Relationships with friends and family: better support networks are linked with better health.
- Gender: men and women face different diseases at different ages..
- Culture: customs, traditions and beliefs can all affect health for better or worse.
- Social status and social exclusion: people who are excluded, or on the margins of society have worse health chances.
- Access to and use of health services:
- Personal behaviours: What do you eat? How much exercise do you do? Do you smoke or drink?
- All these health determinants interact to create a complex set of health and wellbeing dynamics.
- Reducing inequalities; poverty, providing livelihoods, increasing access to education and promoting equality are key parts of the solution.

Two principle Scottish Government strategies which set out plans to improve the quality of life for people with learning disabilities and autistic spectrum disorders in Scotland are The Keys to Life (2013) and The Scottish Strategy for Autism (2011).

The Keys to Life makes 52 specific recommendations for action across Scottish Government, the NHS, local authorities and the voluntary sector.

The strategy presents a major focus on health promotion and prevention of ill health amongst people with learning disabilities.

The other major shift in the Keys to Life is a renewed focus on adopting a human rights based approach to supporting and empowering individuals to live healthy and happy lives.

Other recommendations within the Keys to Life focus on:

- Day Services
- Housing
- Local Area Co-ordination
- Advocacy
- Befriending
- Family carers
- Parents with learning disability
- Transitions, FE and Employment
- Volunteering
- Profound and Multiple Learning Disabilities

- Criminal Justice
- Complex Care

The Scottish Strategy for Autism is based on the vision that individuals on the autism spectrum are respected, accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives. The strategy is underpinned by 6 key principles of;

- Dignity: people should be given the care and support they need in a way which promotes their independence and emotional well-being and respects their dignity;
- Privacy: people should be supported to have choice and control over their lives so that they are able to have the same chosen level of privacy as other citizens;
- Choice: care and support should be personalised and based on the identified needs and wishes of the individual;
- Safety: people should be supported to feel safe and secure without being over-protected;
- Realising potential: people should have the opportunity to achieve all they can;
- Equality and diversity: people should have equal access to information assessment and services; health and social care

The Strategy contains 26 key recommendations key to achieving the vision; improving services and access to services for people on the autistic spectrum disorder.

Shetland's Autism Spectrum Disorder Strategy 2016-21 was approved by the Council and IJB in 2016. The Strategy takes a whole life approach in recognition that autism is a life long condition and that people can need through different stages. Production of the Shetland strategy identified 6 local priority areas for development, which are;

- Awareness Raising and Workforce Development;
- Assessment and Diagnosis;
- Active Citizenship;
- Transition;
- Support for Families and Carers;
- Employment

An action plan is in progress to deliver on these key themes.

Current Services

In recent years there has been a growing commitment across the health and social care to focus on the outcomes important to the person and to support families and carers maintain their caring role and have a life outside of caring. This attention to individual outcomes puts the person at the centre of support and ensures that organisations are focussed on the positive difference their involvement makes to people's lives.

Supported Living Service (SL) works in close association with SIC Housing and Hjaltland Housing Association using the existing housing application process to provide supported tenancies for adults with learning disability, autistic spectrum disorder and complex needs. Outreach support for people living in their own or family home may also be available.

Following assessment and allocation, each person is supported to develop a person centred plan that assists them to achieve goals and outcomes, and manages welfare and financial risks.

Supported Vocational Activity Service, the Eric Gray Resource Centre (EGRC), provides a needs led, day support service to adults with learning disabilities and autistic spectrum disorder that recognises the rights of the individual to participate as meaningfully and as independently as possible in everyday life. Assessed needs are met through a range of vocational, learning and recreational opportunities and experiences to promote inclusion, choice and independence and encourage each person to fulfil their personal goals and aspirations.

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

Short Break and Respite Service, Newcraigielea. Shetland Community Health and Social Care is committed to supporting unpaid carers manage their caring role and be enabled to have a life outside of caring. Good quality and flexible support to meet the assessed needs of adults with a learning disability, autistic spectrum disorder and complex needs and those of the unpaid carer is provided through our short break and respite service at Newcraigielea. Newcraigielea also offers a day care service through the GOLD Group for older people with learning disability to meet the level of assessed need in line with eligibility criteria.

Learning Disability Nurse is a single handed, community nursing service offered throughout Shetland for people aged 5 - 75 with a learning disability in addition to a health need. The nurse works with a range of services such as Education, Social Work, Supported Employment, Day and Voluntary Sector Services. There is a consultative and liaison service with Secondary Health Care, Adult Mental Health, CAMHS, Community and Children's Nursing.
Specialist Psychiatry and Clinical Psychology are provided by a visiting Consultant Psychiatrist and a visiting Clinical Psychologist offer outpatient appointments or home visits as appropriate.

Allied Health Professionals (AHPs) in Shetland work through partnerships across health, social care, education, voluntary and independent sectors with adults and children of all ages. This group of professionals includes a range of practitioners in Dietetics; Occupational Therapy; Orthotics; Physiotherapy; Podiatry; Speech and Language Therapy who work with a range of technical and support staff to deliver direct care and provide rehabilitation, self-management, "enabling" and health improvement interventions.

AHPs work concentrates on the provision of “enabling” services, shifting the focus away from professional dependency and towards supported self-management and resilience, which will be central to achieving better outcomes for people who use services, their families and carers.

Shetland Community Health and Social Care (CH&SC) is committed to providing good quality and flexible support for unpaid carers to enable them to continue in their caring role for as long as they are able to do so and be enabled to have a life outside of caring. A review of the carer strategy is underway and the final Shetland Carer Information Strategy 2016 – 20 to be published soon. This high level document strengthens the recognition of carers as equal partners in the support of the cared for person.

Shetland has recently reviewed it’s With You For You (Single Shared Assessment) Procedures which has reinforced statutory service’s ability to identify carers at an early stage either in their own right or through identification during a cared for persons assessment of need. Our new assessment and care management model is based on people’s assets and carers’ views are central to this. Carers are identified in this process and offered their own assessment and support plan.

Contribution to Local Delivery Plan Priorities

Adult Services, Learning Disability and Autism Spectrum Disorder Services contribute through the services it provides and described within this Plan to the deliver on local priorities that support our community to have improved health and well being, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way.

The relevant corporate priorities include:

Our Plan 2016 – 2020, Shetland’s Corporate Plan:
‘The needs of the most vulnerable and hard-to-reach groups will be identified and met, and services will be targeted at those that need them most’.
‘People who are living with disabilities, including learning disabilities and long-term conditions, will be getting the services they need to help them live as independently as possible’.
‘People are supported to help them be active and independent throughout adulthood and in older age’.
‘People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer’.
‘Increased use of technology will be helping us provide care for the most vulnerable and elderly in our community.
‘People, particularly those from vulnerable backgrounds, will be getting access to the learning and development opportunities that allow them to best fulfil their potential’.

Joint Strategic Commissioning Plan:
Key integration delivery principles are:
That the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users,

That, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:

- is integrated from the point of view of service-users
- takes account of the particular needs of different service-users
- respects the rights of service-users
- protects and improves the safety of service-users
- improves the quality of the service

NHS Shetland's 2020 Vision is:
"to deliver sustainable high quality, local health and care services, that are suited to the needs of the population; to make best use of our community strength, community spirit and involvement; for people to make healthy lifestyle choices, and use their knowledge and own capacity to look after themselves and each other."

Contribution to Strategic/Cross Cutting Themes

The key actions identified under "Policy Context" support the achievement of the National Health and Wellbeing Outcomes in addition to the 23 Integration indicators described in the Strategic Plan. The services support the cross cutting themes of support to people with learning disability and/or autism spectrum disorder and carers and delivering on Integrated Care Fund aims by enabling individuals to live as independently as possible, provision of self care advice, health improvement advice, technological support and locality working where applicable. Adult Services works closely with a wide range of statutory partners including Social Work, Children Services, Housing, Community Planning, Allied Health Professions, Community Nursing; independent providers (Hjaltland Housing Association); social enterprise and 3rd sector partners to ensure service delivery is robust, effective and person centred.

With less public funding available due to a reduced settlement for local authorities, Adult Services undertook a whole model audit in financial year 2016/17. Delivery on findings from this work will in 2017/18 and onwards will help ensure that any change delivers a sustainable and affordable service that meets the needs of people with learning disabilities, autism spectrum disorders, their families and carers into the future.

Needs/Unmet needs/Drivers for change

Any individual (18+) with an assessment of need linked to their learning disability, autistic spectrum condition or complex need will be supported to develop a plan to meet those needs.

Young people age 16 – 18 can be at risk of falling between services for children and adults. The Children and Young People Act (Scotland) 2014 is clear that all young people up to the age of 18 should have a Named Person in place that can be a first point of contact if the young person requires advice and assistance. For some young people between the ages of 16 and 18, Shetland Inter- Agency Adult Support and Protection Procedures may apply wherever concerns are raised. Where the

young person is 'Looked After' at the age of 18 the local authority has a responsibility for their care and welfare up to the age of 26.

The most recent information [1] identifies that there are 155 adults with a learning disability or ASD in Shetland, 98 male 57 female. 8.2 adults known per 1,000 population (national average 6.1), 42 of the 155 have an ASD diagnosis, 77 not known and 36 without ASD. A further 51 children under 16 years old in Shetland with either an LD or ASD.

As the population of people with a learning disability and autism spectrum disorder grows larger and are reaching older age, experiencing the issues associated with older age such as arthritis, the menopause and dementia, it is increasingly important to consider what enables people to remain in their own homes and have meaningful lives in their communities. With rising demand, the main challenge for the foreseeable future will be the provision of flexible, creative and responsive services to appropriately meet the statutory duties of the local authority and the personal outcomes of individuals we support within the available resources.

The Scottish Government, COSLA and ADSW have been working in partnership to review services for people with learning disability. The strategy entitled, *'The Keys to Life*' covers the period 2013 to 2023 and aims to build on themes of independence and joint working approaches from the first strategy '*The Same as You?*' (SAY), which ran from 2000 to 2010.

'The Keys to Life' aims to progress priority topics which include improved health outcomes, equality and the personalisation agenda. It also focuses on the potential of Self Directed Support; addresses challenges around the affordability and outcomes for people with high cost support needs and aims to advance the adult protection agenda.

Addressing need in relation to autistic spectrum disorder is recognized as a national priority and in 2011, the Scottish Government and COSLA launched the Scottish Strategy for Autism. The vision of this policy is to ensure progress across Scotland in delivering quality services to people with autism and their families, underpinned by values that have been recognised as important, namely; being respected, accepted, treated fairly, valued by the community and being able to have satisfying and meaningful lives.

Plans for change

Description	Lead Officer	Start date/ target end	Expected Outcome(s) (link to National Outcomes)
Progression of the Replacement	Clare Scott	Started July 2014. Target	• Health and social care services are centred on helping to maintain or improve the quality

[1] http://www.scld.org.uk/wp-content/uploads/2016/08/2015-Learning-Disability-Statistics-Scotland-report-1.pdf

Description	Lead Officer	Start date/ target end	Expected Outcome(s) (link to National Outcomes)
Vocational Activities Build (EGRC)		date for completion August 2018	of life of people who use those services. • People who use health and social care services have a positive experience of those services, and have their dignity respected.
Delivery of findings from the Adult Services Audit.	Clare Scott	Start Date April 2017	• People with LD/ASD are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. • Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. • People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being. • Ensuring that resources are used effectively and efficiently in the provision of health and social care services and that the services provided are able to operate within the available resources.
Delivery of Shetland Autism Spectrum Disorder Strategy 6 local priority areas, through the action plan.	Clare Scott	Commenced 2015. Ongoing to 2021	• People are able to look after and improve their own wellbeing and live in good health for longer • People with ASD are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. • People who use health and social care services have positive experiences of those services, and have their dignity respected • Public services, particularly health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Remodelling of commissioned clinical services for adults with learning disabilities.	Clare Scott & Edna Mary Watson	2017	• People are able to look after and improve their own wellbeing and live in good health for longer • People with ASD are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Description	Lead Officer	Start date/ target end	Expected Outcome(s) (link to National Outcomes)
			• Ensuring that resources are used effectively and efficiently in the provision of health and social care services and that the services provided are able to operate within the available resources.
Monitor progress of the Scottish Government's commitment to review the place of learning disability and autism within the Mental Health (Care and Treatment) (Scotland) Act 2003.	Clare Scott	2017 onwards	• At present the review has no specific remit except that it will consider views and other evidence for removing learning disability and autism from the definition of 'mental disorder' under the 2003 Act, and all options are possible. The purpose of monitoring is to ensure involvement where appropriate and understanding as the review progresses. • People who use health and social care services have a positive experience of those services, and have their dignity respected. • Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Key Risks to Delivery

Increasing prevalence of learning disability and autism spectrum disorder, complex needs and co morbidity in individuals is placing increased pressure on staff, teams and resources.

The service relies on recruiting and retaining sufficient staff with the appropriate skills and knowledge, or ability to achieve these, for effective and efficient delivery of safe services and Social Services Scotland registration where the register is open.

The vulnerability of reliance on single handed post holders and key post holders remains a risk area for the service.

Reductions in public funding will impact on the way we deliver services if the status quo continues.

Lack of capacity within the management and support areas of the service is affecting the services ability to move forward with actions.

Performance Targets with links to National Outcomes

Measure	Aim	National Outcome
Number of adults with LD/ASD obtaining a recognised	Adults with learning disability, autistic spectrum disorder and/or	Outcome 4 - Health and social care services are centred on

qualification in lifelong learning; personal development; maintaining skills	complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted	helping to maintain or improve the quality of life of service users
Number of emergency respite nights provided for adults with LD/ASD. *An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays.*	Advance Care Plans will be developed with people, those close to them and service providers to make decisions with respect to their future health, personal and practical aspects of care and support. The risk of unscheduled care will be reduced.	Outcome 6 - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing
Number of Social Care staff trained to implement Positive Behaviour Support.	Staff will have the knowledge and theory of Positive Behaviour Support and be able to put into practice in the support they provide.	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

Contact Details

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Further Reading;

Keys to Life. Improving quality of life for people with learning disabilities.
http://www.gov.scot/resource/0042/00424389.pdf

Shetland Autism Spectrum Disorder Strategy 2016 – 21.
http://www.autismstrategyscotland.org.uk/news/local-autism-action-plans.html

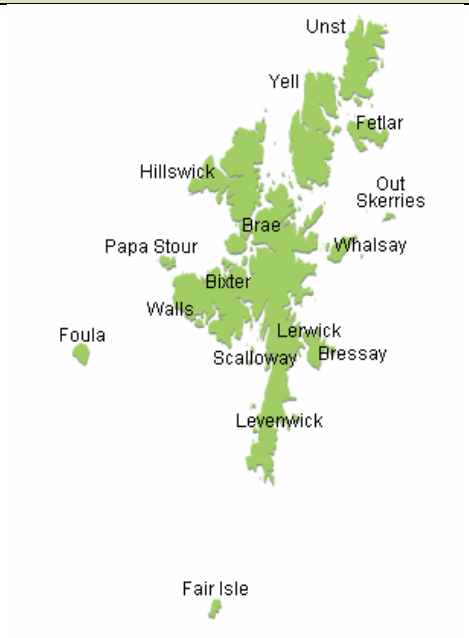
Scottish Government's Scottish Strategy for Autism Website. This website will keep you informed about current developments, news and events and progress relating to the strategy.
http://www.autismstrategyscotland.org.uk/strategy/linking-goals-aims-and-recommendations.html

Mental Health Care and Treatment (Scotland) Act 2003
http://www.scotland.gov.uk/Publications/2005/08/29100428/04330

Comprehensive information on the provisions of the relevant legislation is available from the Scottish Government website http://www.gov.scot/Home

Safeguarding Children, Young People and Adults in Shetland
http://www.safershetland.com/

Adult Social Work Service
2017/18 Service Plan



Supporting Community Health and Social Care Departments vision:

"To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community"

Introduction

Every year, each Service within the Council is required to produce a Service Plan for the following year. This Service Plan provides an overview of the Adult Social Work Service for 2017/18, the Adult Social Work Service is in the Community Health and Social Care Directorate. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Adult Social Work Service is committed to supporting the Community Health and Social Care Directorate's Vision which is "To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community".

Drivers for Change

The drivers for change for Adult Social Work are:

1) Increasing older population, with people living longer often with multiple long term conditions.
2) Supporting people to live independently at home.
3) Emerging trend of people to make their own arrangements through self-directed support.
4) Working with families with complex, inter-generational needs.
5) Focus on anticipatory care planning and actively managing risk.
6) Building the capacity of individuals, families and communities to support them to help themselves.
7) Supporting preventative initiatives and self care management.
8) Supporting young adults with complex needs through transition.

About Us

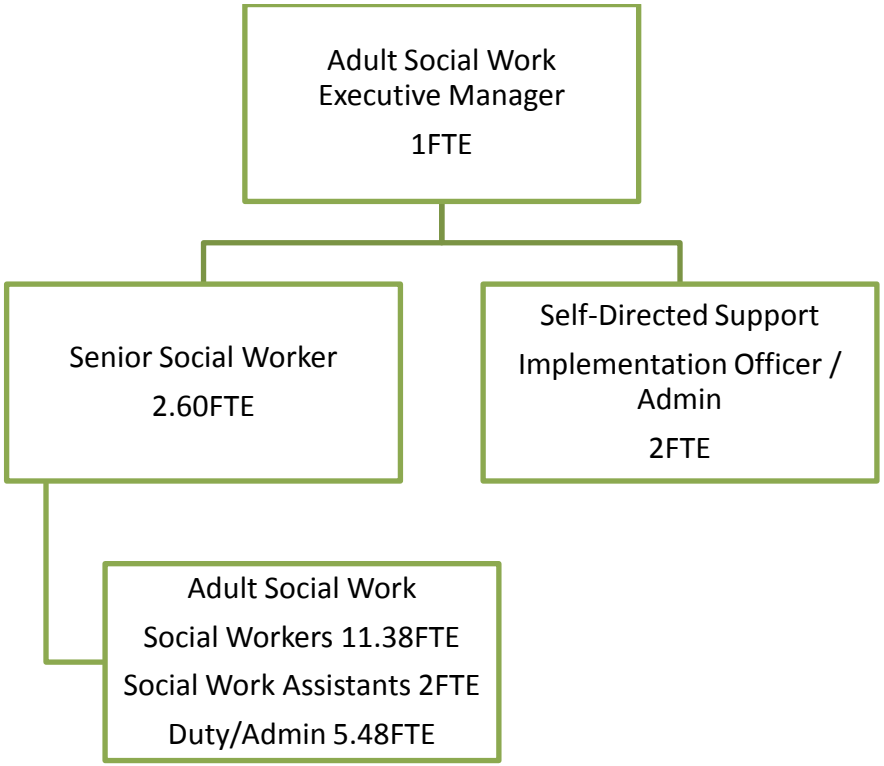
In 2015, the Adult Social Work Team was formally established in the Council structure with the appointment of an Executive Manager. This strengthened the prior interim arrangements that were in place.

The Service comprises a team of professionally qualified social workers, support workers and administration support staff who undertake a range of statutory social work functions, primarily in three areas: Community Care Assessments and Care Management, Adult Support and Protection, and Mental Health Officer functions.

Who We Are

This Service sits within the Community Health and Social Care Department is lead by the Director of Community Health and Social Care (Simon Bokor-Ingram) the following Services are also in the Community Health and Social Care Department: (Adult Services, Criminal Justice, Mental Health, Occupational Therapy & Community Care – Resources)

Organisational Chart



Locations

The Adult Social Work Service is located at the Grantfield Office and provides a service to the whole of Shetland by allocating social workers to the seven locality planning areas and also oversees a number of specialist off-island placements.

Governance

The Adult Social Work Service is part of the Community Health and Social Care Directorate and reports to the Integrated Joint Board. The Service's performance is reported to the Directorate Management Team monthly and 4 performance indicators are reported to the Integrated Joint Board 4 times per year as part of the Department's quarterly performance report.

Regulation and Compliance

Social workers are required to be registered with the Scottish Social Services Council in order to practice. They also have to abide by the Scottish Social Service Code of Practice.

Mental Health Officers require an additional post qualifying award and express permission from the Chief Social Work Officer in order to practice.

Social Workers who act as a "Council Officer" for Adult Protection assessments and investigations require specific training and express permission from the Chief Social Work Officer in order to fulfil this function.

Regulation of performance is carried out by the Care Inspectorate in the form of inspections. The frequency of inspection is based on an "intelligence model" and reflects how well the service currently operates. The Care Inspectorate inspected this service as part of a multi agency inspection of services to older people in January, February and March 2015.

The function of this service is broadly governed by the following legislation: Social Work (Scotland) Act 1968, NHS and Community Care Act 1990, Mental Health (Care and Treatment) (Scotland) Act 2003, Adults with Incapacity (Scotland) Act 2000, Adult Support and Protection (Scotland) Act 2007, Social Care (Self-directed Support)(Scotland) Act 2013.

What We Do

The Adult Social Work Team, responsible for:

Screening referrals to establish whether or not a social work response is required. This area of work may result in no further action, offer of advice, signposting or referral to other service areas, referral to social work assessment.

Assessment of social need and care management – assess whether or not an adult (aged 18 or over) requires support. For complex cases the team will manage the case, this is called care management.

Mental Health assessment, support and intervention – assess whether or not an individual requires support due to a mental health disorder. There are a number of specific functions only a Mental Health Officer can perform.

Adult Support and Protection – receive and assess adult protection referrals which involves working with police and health services, investigate whether or not an adult is in need of protection from abuse. If this is the case a protection plan will be put in place to support the individual. This will be care managed by a social worker. Additionally working with adults who are subject to protection plans to reduce risk of abuse and to provide them with support.

Our Customers

The Adult Social Work Team provides a service to any adult who requests or requires an assessment under the legislation listed above. Customers include adults with dementia, mental health difficulties, brain injuries, lifelong conditions, learning disabilities, physical disabilities, older and frail people, carers and those at risk of abuse.

Those who have a social worker as a care manger have complex and changing needs. As well as themselves, their family and community support, they usually have several services or agencies supporting them. Supporting people in such circumstances is a time consuming and challenging task. It requires a range of skills and abilities. The social work function is protected in law due to the nature of the work we do.

The amount of people supported by this service through care management is currently around 280. The number of people supported on a short term basis, either through screening or assessment will be higher than this and can fluctuate.

The number of people supported by this service has increased significantly in recent years. In 2012/13 a total of 367 people were supported by the service, this increased to 393 in 2013/2014 and to 428 in 2015/16.

Population projections for our customer base show the following:

Adults

The population of adults (18-64) is predicted to decrease by 6.6% (13,691 to 12,791) between 2013 and 2023 and by 15% by 2033 (to 11,641).

Over 65's

The population of over 65's is predicted to increase by 32% (4,200 to 5,544) between 2013 and 2023 and by 65% by 2033 (to 6,924).

Over 85's

The population of over 85's is predicted to increase by 44% (533 to 769) between 2013 and 2023 and by 143% by 2033 (to 1,294).

Funding and resources

Funding predominantly covers staff costs and provision of funding for those who choose to purchase their own support under Self-directed Support. There has been no directive to reduce staff numbers in this area.

Aims and Objectives

Directorate Plan Aims	Action
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish. There will be ease of access to services, with clear understanding within the community of who to contact and where to go Information will be available to each household in Shetland which explains how to access services, what service standards they can expect and how each organisation is performing through an effective public performance reporting regime
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so
3. People who use health and social care services have	There will be more flexible services and more choice for our customers, within

positive experiences of those services, and have their dignity respected.	available resources Systems, procedures and information will be shared between organisations wherever possible and there will be clarity in the decision-making process, thereby reducing bureaucracy and delays in decisions about service delivery.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Customer's needs will be assessed for eligibility for services using a person centred approach. Where possible, a customer will have allocated to them a named individual who looks after their needs and care services.
5. Health and social care services contribute to reducing health inequalities.	There will be equity in access to services through better information, more locally based services and better transport arrangements where provision needs to be centralised. Everyone will be able to access services to meet their needs irrespective of their race, religion/faith, sexual orientation, age, disability, gender or socio-economic background.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	We will improve our identification of people who are carers and offer a carer's assessment so that the appropriate support can be put in place. We will continue to work with the Third Sector to develop strategies to support carers and to continue with training programmes and carer's events.
7. People using health and social care services are safe from harm.	We will build on our governance and quality assurance systems. Early reporting of incidents and near misses will help us to put in place actions that will improve procedures and processes. Effective responses to concerns that adults may be being harmed sexually, financially, physically or by being neglected or emotionally abused will be built into staff training.
8. People who work in health and social care services	There will be in place a system of team working which recognises and values

feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	individuals' skills and knowledge, provides good professional supervision and encourages joint training and secondment opportunities and works to meet the needs of our customers. There will be in place a seamless method of service delivery, not restricted by organisational or professional boundaries – modelled on a "one-stop-shop" methodology There will be an individual within Shetland who is publicly recognised as being the manager of each service area
9. Resources are used effectively and efficiently in the provision of health and social care services.	Financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions. Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system Resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need. Services are delivered to the best possible standard and quality, at the best possible price. The Directorate will have a single planning and design process with clarity in what they are trying to achieve in the short, medium and longer term. Services will be planned and designed in partnership with customers and the general public.

Service Aims/Priorities	**Objectives/Actions (Details below)**

To enable older people to remain at home	We will provide good quality and timely asset based assessments to help people get the correct support to improve their outcomes. We will work with multi agency partners to assist people to get the best possible support to improve their outcomes, including consideration of the 4 options of Self-directed Support.
To maintain or increase levels of independence	We will provide good quality and timely asset based assessments to help people get the correct support to improve their outcomes. We will work with multi agency partners to assist people to get the best possible support to improve their outcomes, including reablement, enablement and consideration of the 4 options of Self-directed Support.
To reduce unplanned, emergency and inappropriate admissions to hospital	We will provide good quality and timely asset based assessments to help people get the correct support to improve their outcomes. We will work with multi agency partners to assist people to get the best possible support to improve their outcomes, including reablement, enablement and consideration of the 4 options of Self-directed Support. We will work with individuals, their families, carers and partners to increase the number of people who have an anticipatory care plan for people with complex social and health problems including long term conditions.
To facilitate discharge from hospital appropriately	We will work with multi agency partners to coordinate discharge from hospital, including timely comprehensive assessments.
To protect adults from abuse	We will investigate all cases where an adult might be in need of support and protection. Where it is the case an adult is in need of support and protection we will lead in the preparation and implementation of protection plans, including appropriate legal interventions.

Risks to Delivery

Demographic change: the demographics detailed earlier show an increasing older population which is likely to have an impact on the number of people requiring assessment and case management. We have seen a steady increase in the number of cases held by the team over the past three years and this will continue. We have streamlined the way we work by introducing a duty and intake system which combines the hospital liaison function. This has enabled us to manage the increase in cases held by the team to date. We will closely monitor this using a workload management system to ensure that we have sufficient capacity in the team. It is possible that additional resource will be required in the future in order that the service can fulfil its statutory duties.

Contact Details

Stephen Morgan – Executive Manager of Adult Social Work
Grantfield Offices
Lerwick

Service Plan – Allied Health Professions

Joint Strategic Commissioning Plan 2017 – 2020

- **Policy context**

There are many polices and strategies covering AHP services. The main strategic direction currently is the Scottish Government's Active and Independent Living Improvement Plan which is aimed specifically at Allied Health Professionals in Scotland. The plan has 34 separate actions with outcomes to be achieved shorter term (by 2017), and longer term (2020 and beyond). Some of the key actions are described below:

Well Being
•Promote a Personal Outcomes approach across all AHP services
•Enhance the role of good nutrition to support well being
•Enhance the communication environment to support wellbeing
•Promote physical activity to support well being
•Promote screening for early diagnosis and intervention

Children & Young People (CYP)
•Deliver on Ready to Act ambitions
•Undertake tests of change relating to the 5 ambitions in Ready to Act

Vocational rehabilitation
Enhance approached to Vocational Rehabilitation in AHP services

Musculoskeletal Programme (MSK)
•Utilising technology to support access and care allocation
•Enhance approaches to self management and well being
•Create efficient pathways across acute, community and 3rd sector

Falls and Frailty
•Support full implementation of the Framework for Action 2016-20
•Enhance approaches to falls prevention and frailty
•Partner with HSCP to drive falls/frailty ambulance pathways

Dementia
•Deliver on AHP Connecting People Connecting Support Policy
•Increase awareness of contribution to living well with dementia
•Influence and integrate AHP contribution with national transformational changes

- **Current Services**

Team	Role
Dietetics	Dieticians assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. They use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. Dieticians treat complex clinical conditions such as diabetes, food allergy and intolerance, IBS syndrome, eating disorders, chronic fatigue, malnutrition, kidney failure and bowel disorders. They provide advice to caterers to ensure the

	nutritional care of all clients in NHS and other care settings such as care homes, they also plan and implement public health programmes to promote health and prevent nutrition related diseases. A key role of a dietician is to train and educate other health and social care workers. Dieticians also advise on diet to avoid the side effects and interactions between medications.
Occupational Therapy	Occupational therapy takes a whole-person approach to both mental and physical health and wellbeing, enabling individuals to achieve their full potential. It provides practical support to enable people to facilitate recovery and to overcome any barriers that prevent them from doing the activities (occupations) that matter to them. This helps to increase people's independence and satisfaction in all aspects of life. Occupational therapists work with adults and children of all ages with a wide range of conditions; most commonly those who have difficulties due to a mental health illness, physical or learning disabilities. They can work in a variety of settings including health organizations, social care services, housing, education and voluntary organisations. In Shetland the Occupational Therapy Team provides Occupational Therapy Assessments at home, in the Gilbert Bain Hospital or as outpatient appointments, a rehabilitation and reablement service, advice, assessment and provision of Equipment and Adaptations; a Sensory Impairment Service, Telecare and Telehealth provision and advice, Wheelchair Assessments and Blue Badge Assessments
Orthotics	Orthotists provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. They are able to design and provide orthoses that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They treat patients with a wide range of conditions including Diabetes, Arthritis, Cerebral Palsy, Stroke, Spina Bifida,Scoliosis, MSK, sports injuries and trauma.
Physiotherapy	Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible. Physios use their knowledge and skills to improve a range of conditions associated with different systems of the body, including neurological, musculoskeletal and respiratory
Podiatry	Podiatrists triage, assess, diagnose and treat the full range of podiatric conditions of the foot and lower limb. We provide treatment for nail management, wound management, vascular and neurological assessment, advise on foot health and footwear, provide advise and practical solutions for personal footcare, work with the multidisciplinary "high risk limb" team, musculoskeletal clinics, manufacture and prescription of orthoses, nail surgery, undertake diabetic foot screening and assessment, assist patients in preventing trips and falls, work towards prevention of foot problems therefore reducing non-planned hospital admissions, provide treatment for patients with long term conditions (LTC), work jointly with other health care professionals, provide training to care workers, hold joint assessments with Physiotherapy and work closely with the Shetland Voluntary Nail Cutting Service (SVNCS)
Speech and	Speech and language therapists (SLTs) provide life-improving treatment, support

Language Therapy	and care for children and adults who have difficulties with communication, eating, drinking or swallowing. SLTs assess and treat speech, language and communication problems in people of all ages to help them communicate better. They also assess, treat and develop plans to support people who have eating and swallowing problems. Using specialist skills, SLTs work directly with clients and their carers and provide them with tailored support. They work closely with teachers and other health professionals such as nurses, doctors and other AHPs and psychologists to help develop programmes.

- **Contribution to Local Delivery Plan priorities (as required)**
  Allied Health Professions work across child and adult services so deliver on priorities such as contributing to GIRFEC, Early Years Collaborative, Bridging the Gap Attainment project, developing Universal as well as targeted aspects of service delivery. They also deliver on a number of scheduled care, mainly outpatient based initiatives such as MSK and orthopaedic consultations, healthy weight and diabetes interventions. They contribute to unscheduled care in areas such as falls prevention, rehabilitation and reablement.

- **Contribution to Strategic / Cross Cutting Themes (as required)**
  The key actions identified under "Policy Context" support the achievement of the National Health and Wellbeing Outcomes as well as the 23 Integration indicators described in the Strategic Plan. The services support the cross cutting themes of support to carers, rehabilitation and delivering on Integrated Care Fund aims by enabling individuals to live as independently as possible, provision of self care advice, health improvement advice, technological support and locality working where applicable. AHPs work with a very wide range of care groups including frail elderly, physically disability, mental health, dementia, learning disability and autism, and children

- **Needs/Unmet needs/Drivers for change**

The main considerations are:

- Government policies such as 4 Week waiting time for MSK services, and the expectation that self referral will be the primary route of access to AHP services. This has led to a steep increase in referrals.
- Emerging role for AHPs e.g. SLT input into dementia care with regard to swallowing assessments, and a high demand for input into Autism Spectrum Disorder diagnosis and training, OT input into Vocational Rehabilitation
- Increase in emphasis on health improvement interventions in conjunction with health improvement services
- Demographics e.g. improved survival rate of premature babies and earlier diagnosis of children leading to increased need for Physio and OT intervention at an early stage of life.
- Increase in complexity of referrals and co-morbidities means that patients stay longer on caseloads.
- Increasing elderly population and incidence of dementia, along with the expectation that aging, and disabled people will remain at home whenever possible

- The increasing role that carers of all ages will play in supporting aging and disabled people to remain at home and the need for their support.
- The increase in mental ill health - the World Health Organisation has identified mental illness as a growing cause of disability worldwide and predicts that in the future, mental illness—specifically depression—will be the top cause of disability.

- **Plans for change**

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Implement rolling programme of ASD parent training sessions including introduction to ASD, Social Stories, Sensory Issues, Use of Visuals.	Clare Burke	January 2017, ongoing	Scottish Strategy for Autism; support for families and carers
Improving the Universal level of the SLT service through joint working with other services.	Clare Burke	April 2017, ongoing	Prevention and Early Intervention. Ready to Act
Implement actions relating to Augmentative and Alternative Communication	Clare Burke	April 2017, ongoing	Health (Tobacco, Nicotine and Care)(Scotland) Act 2016
Undertake Orthotic work in other health board areas in order to release savings to NHS Shetland	Laurence Hughes	Ongoing	NHWO 9 More efficient use of resources.
Reduce DNA rate to 5% by implementing Patient Focus Booking	Laurence Hughes	Jan 2017 Complete by Mar August 2017	NHWO 9 Reduce DNA rate making the clinic more efficient
Ensure Brief Interventions are embedded in practice	Laurence Hughes	April 2017 ongoing	NHWO 1 – improve health and wellbeing
Implement relevant actions from Falls Action plan	Jo Robinson/Jane Pembroke/Fiona Smith/ Chris Hamer	January 2017 Complete by Mar 2018	NHWO 1, 2 & 4. improve health and well being, support to live at home, quality of life
Maximise contribution to support people with dementia and their families, partners and carers to live	Jane Pembroke	January 2017 ongoing	NHWO 1, 2, 4 & 6. Improve their health and well being, enable living

positive fulfilling and independent lives			at home, improved quality of life and support for unpaid carers
Develop a mental health OT service underpinned by the Scottish Government's priorities and commitments to improve mental health services and to promote mental wellbeing and prevent mental illness	Jane Pembroke	March 2017 Complete by March 2018	NHWO 1, 4, 5 & 6. Improve health and well being, quality of life, reducing health inequalities and support for unpaid carers
Review vocational rehabilitation provision to explore options for continuing provision post-EU funding	Jane Pembroke	March 2017 Complete by March 2018	NHWO 1, 4, 5 & 9. Improve health and well being, quality of life, reducing health inequalities and effective and efficient practice
Investigate options for locations of service delivery and implement findings	Chris Hamer	Nov 2016, complete by March 2017	Increase in actual clinical time. NHWO 9
Reinstate joint paediatric MSK clinics with Physiotherapy.	Chris Hamer	Dec 2016, complete by March 2017	Reduce patient journey. NHWO 3, 6 + 7.
Recommence Orthopaedic triage.	Chris Hamer	Dec 2016, complete by March 2017	Ensure referrals are directed to the appropriate clinical service. NHWO 2,3,4,5, 7 + 9.
Devise and implement Tier 3 weight management pathways	Stefanie Jarzemski	Complete by March 2018	NHWO 1 & 2 Improve their health and well being, enable living at home
Complete review of NHS Shetland/ SIC Nutrition Policy	Stefanie Jarzemski	Complete by March 2018	NHWO 1, 2 & 7 Improve their health and well being, enable living at home, safe from harm
Implement recommendations from Physiotherapy Workforce Plan	Fiona Smith	As per timescales in plan	NHWO 1 - 9
Investigate options for increasing occupancy, accessibility and use of	Jo Robinson/ Jane Pembroke/	Ongoing	NHWO 9

Independent Living Centre	Jonathan Molloy		

- **Key Risks to Delivery**

Risk	Mitigation strategies
Lack of capacity to undertake emerging roles and increase in referral numbers/ caseload complexity	Continued redesign of services to ensure most effective and efficient use of resources
Small staff teams with some single handed practitioners mean services are vulnerable	Ensure retention strategies are adhered to, succession planning, business continuity plans are up to date
Holding of vacant posts/ delayed recruitment increases workload and strain on remaining staff/ increased stress levels/ has a negative impact on service delivery	Continue to advise management of risks to service of delayed recruitment
Lack of availability of clinical facilities	Continue to raise risk where appropriate
Potential conflict between needs of health board and statutory responsibilities of local authority within limited resources	Continued redesign of services to ensure most effective and efficient use of resources
Continuing downward pressure on equipment and housing adaptation budgets	Continue rationalisation of access criteria and funding requests
Large geographical area and increasing need to provide wider range of services, to respond to a wide variety of government and professional initiatives	Rationalise current service delivery models Improve sign posting
Recruitment challenges – shortage of relevant skills across the UK means it can be hard to fill vacancies.	Foster retention of skilled staff Succession planning
Lack of management capacity to implement volume of government strategies, due to very small staff groups and longstanding vacancies.	Continue to feed into formation of government strategies where appropriate

- **Performance Targets with links to National Outcomes**

  4 week referral to treatment for MSK conditions
  18 week referral to treatment for other NHS services
  National Eligibility Criteria timescales (Local authority standards)
  Increasing number of people are supported by technology enabled care

- **Contact Details**

  Allied Health Professionals
  Upper Floor Montfield

Burgh Road
Lerwick ZE1 0LA
community.care@shetland.gov.uk

01595 744308

- **Further Reading**

  Active and Independent Living Improvement Programme
  http://www.knowledge.scot.nhs.uk/ahpcommunity/active-and-independent-living-improvement-programme.aspx

  The Prevention and Management of Falls in the Community - Framework for action
  http://www.gov.scot/Resource/0045/00459959.pdf
  Exploring the system wide cost of falls
  https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/exploring-system-wide-costs-of-falls-in-torbay-kingsfund-aug13.pdf

  Ready to Act- A transformational plan for children and young people, their parents, carers and families who require support from allied health professionals (AHPs), available at **www.gov.scot**

  AHP Connecting People Connecting Support - Policy on Dementia due to be published late 2016 https://letstalkaboutdementia.wordpress.com/

Carers Service Plan

A carer is generally defined as a person of any age who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live without the carer's help due to frailty, illness, disability or addiction.

The support a carer provides may include moving and assisting (manual handling); help with feeding, personal hygiene and administering medication; as well as providing emotional support, acting as an advocate or guardian for the cared-for person and enabling the person with support needs to access leisure and recreation.

There are approximately 660,000 unpaid carers in Scotland. This figure is growing. Local research shows that by 2020 we can expect to see a 3-fold increase in the number of people with disabilities who will need health and social care services from the numbers in 2000. Population projections for the next 15 years predict an increase in the numbers of older people of approximately 40% and simultaneously a 15% decrease in the adult working population.

Consequently the need for unpaid and family carers is going to grow for the foreseeable future. Carers are key partners in care provision alongside the statutory agencies and organisations in the voluntary and independent sector.

Policy Context

The Carer's Strategy was approved by the IJB in January 2017. The strategy follows the Epic (Equal Partners in Care) principles which are based on six outcomes for carers. These are:

- carers are identified
- carers are supported and empowered to manage their caring role
- carers are enabled to have a life outside of caring
- carers are free from disadvantage and discrimination related to their caring role
- carers are fully engaged in the planning and shaping of services
- carers are recognised and valued as equal partners in care.

This strategy outlines how Shetland will continue to support positive outcomes for carers using these outcomes.

Legislation is due to come into force in April 2018. which is designed to support unpaid carers' health and wellbeing. This includes:-

- a duty on local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria;
- a specific Adult Carer Support Plan and Young Carer Statement to identify carers' needs and personal outcomes; and

- a requirement for each local authority to have its own information and advice service for carers which must provide information and advice on, amongst other things, emergency and future care planning, advocacy, income maximisation and carers' rights.
- To remove the "substantial and regular" test so that all carers will be eligible for a Carer's Support Plan. Under current legislation, local authorities only have to offer the assessment to carers who care on a regular and substantial basis. Currently there is no set definition for what is considered regular and substantial, and those carers providing low levels of support (no matter what the impact this has on them) are not eligible. This means that it can be more difficult to provide preventative support and carers may feel unable to access support until a crisis point is reached.
- To build in support for carers to ensure that there is a plan in place for emergencies.

Assessments for carers are integral to the With You, For You process. A commitment of this process is that all carers in Shetland will be offered an assessment of their needs, in their own right. Consideration is given to each carer's individual circumstances including their age; the carer's own health and well-being; the potential impact on other family members; the caring tasks and amount of time and effort required; the carer's other responsibilities and any employment. A key consideration is the importance of their caring role within the agreed care plan.

Using "Getting it Right for Every Child" (GIRFEC) concepts and tools, practitioners will have an holistic approach that will enable the needs of children and young people to be identified. This will include the recognition of children and young people as "Young Carers". Using this approach should result in better meeting the needs of young carers. Equally it is a pathway for Young Carers to access any services that will assist them.

A support package/access to resources will be offered according to local eligibility criteria but will use the EPiC principles. This could include advice and information, training opportunities, advocacy, peer support, health and well being checks and short breaks.

Other services provided for vulnerable people in the community also help their carers by providing relief from caring tasks or by increasing the independence of the person for whom they provide care. These include:

- care services delivered at home – such as personal care, community nursing, help with domestic tasks and meal preparation;
- occupational therapy;
- physiotherapy;
- speech and language therapy;
- psychological therapies;
- specialist equipment;
- adaptations to property;
- community alarms & Telecare.

The investment in Telecare promotes independence and provides reassurance to carers by enabling flexible response to problems and reducing the need for someone to be with the cared for person 24/7.

Providing carers with the right support helps to prevent them reaching crisis. To put it simply the cost of small and inexpensive interventions at the right time is far less costly than providing full time replacement care when a carer becomes ill or the caring relationship breaks down due to carer strain. A preventative agenda is the main focus for the future.

Performance Measures / Targets

The Scottish Government have developed a data set for carers which is to be collected during 17/18 and this will also be used to monitor the Carers Act once this is implemented in 2018. We have adopted this locally as part of our strategy and this will provide more a meaningful picture regarding carers in Shetland over the next few years.

This will measure:-

- No of carers completed assessment
- No of carers declined assessment
- No of carers eligible for support?
- No of young carers statements completed
- With the following data we will be able measure the impending risks for Shetland:-
- Age of carers
- No of care hours they are providing?
- Length of time they have been providing care
- Willingness to provide care
- Type of support provided?
- The impact on the carer of providing care

We currently have the following data:
From the SWIFT system the number of people currently recorded with an active category of 'Carer' is 175. On the SEEMIS system there are 2 young carers. On the VAS database we have 262 carers registered. All of these figures will overlap and work over the summer of 2017 will enable us to provide much more accurate data in future years.

Currently we do not have an easy way of collating this data, however once this has been collected it will enable us to set useful targets, instead of using generalised population predictions.

Unmet Needs / Emerging Trends / Service Issues

In Shetland we have recognised an ongoing issue in identifying and recording carers appropriately. There is a large difference between the identified carers on the shared database (260) and the numbers for the census information (2034). We have identified some solutions for this and these will start to be addressed within the action plan. There continues to be other challenges for carers which includes

- Identifying carers from (all disadvantaged groups: ethnic minorities / gender /etc),
- Demographic changes in Shetland, will mean increasing demand for all existing service provision and this trend is expected to continue for the foreseeable future.
- Improved recording of carers and their support needs will place us in a stronger position to identify unmet needs in the future.

We are currently aware of the following trends in relation to carers:

- Greater uptake of direct payments since the introduction of the Social Care (Self-directed Support)(Scotland) Act 2013.
- Increased number of cared for people accessing residential respite care to support carers.

Plans for Change

This Carers Strategy Implementation Plan looks at the outcomes for Carers in the Carer Support Plan, and links these with the Carers Strategy proposals, to outline a programme of action. This plan will be monitored by the Shetland Carers Strategy Group.

Action	Lead	Date	Progress
EPIC Principle 1: Identify Carers			
Continue to celebrate Carers Week and use to help identify carers at an earlier opportunity.	VAS	Annual event	
Raise awareness by attending events for example flu fairs with leaflets and information for carers.	VAS	Continuous	
Offer carer awareness training to all organisations with representatives on the Carers Strategy Group.	VAS	September 2017	
Reissue the information pack for young carers, to all schools and present at a Head Teachers meeting.	VAS & Young Carer Lead	June 2017	

Action	Lead	Date	Progress
Embed the protocol for GP surgeries to encourage staff to take a proactive role identifying carers.	VAS & NHS Primary Care Developm ent Officer	June 2017	
Ensure process for hospitals to encourage staff to take a proactive role identifying carers is included in Admissions and Discharge protocol.	Executive Manager Adult Social Work	June 2017	
Ensure there are regular displays and poster campaigns in a variety of establishments including local shops, ferries, halls, ARI, GBH, Forrester Hill and all hospitals that Shetland residents use.	VAS	Quarterly from 2017	
Deliver carer awareness training to Community Health and Social Care Directorate Team Meeting for dissemination to all staff.	VAS, Executive Manager Adult Social Work	September 2017	
EPiC Principle2: To be supported and empowered to manage my caring role			
Training for staff to carry out carer support plans (including Young Carer statements)including menu of info so all carers are aware of support available.	VAS & Claire Derwin	April 2018	
Ensure that information about carer support plans are cascaded to their respective organisations.	Carers Strategy Group	April 2018	
Work with employers to raise awareness of carers, identify flexible opportunities for carers in employment and promote carer friendly workplace policies.			
Promote the use of emergency cards for carers to carers	Carers Strategy Group	Continuous	
Promote income maximisation through referral to CAB for benefits checks at every opportunity.	Carers Strategy Group	Continuous	

Action	Lead	Date	Progress
EPiC Principle 3 – To be enabled to have a life outside caring			
Third sector to continue applying for external funding for example the Shortbreaks Fund.	Third Sector	Continuous	
Ensure carers are aware of the range of support services such as day care, respite Alzheimer Scotland activities, befriending and Shetland Care Attendant Scheme.	Strategy Group	Continuous	
Through support planning ensure carers who wish to access learning, volunteer and employment opportunities can do so by promoting in newsletter, and through website.	Assessors / Care Managers	Continuous	
EPiC Principle 4: To be fully engaged in the planning and shaping of local services.			
Seek views of carers and cared for people at their review and use this information in service planning.	Care Manager	Continuous	
Increase carer representation on the Strategy Group.	Strategy Group	Continuous	
Ensure consultation of carers for any change in services which affect them.	All services	Continuous	
EPiC Principle 5: To be free from disadvantage or discrimination related to their caring role			
This Strategy and good carer support planning will assist in carers being free from disadvantage or discrimination.	N/A	N/A	
EPiC Principle 6: To be recognised and valued as equal partners in care			
Explore the use of the principles of the "Triangle of Care" for all carers.	Strategy Group	Continuous	
Publicise and promote Carers Advocacy service to carers and professionals/other services.	Strategy Group	Continuous	

Key Risks to Delivery

It is unclear at this stage the extent to which the draft legislation might change local arrangements but it is suffice to say that there is a significant reliance on unpaid carers throughout the sector.

The Carers Act is due into legislation in April 2018 and currently no money has been identified to support the work that will be produced from this. There continue to be challenges within the funding of social and health care which will impact on the health and well being of carers.

The Support Worker for carer projects currently sits within Voluntary Action Shetland and will play a key role in delivering the action plan for this service plan. This post is temporary and seeks funding on a year to year basis. Carer Information Strategy money currently funds 1/3 of this post and this funding may finish at the end of 17/18.

Contact Details:

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Further Reading

- Carers' Strategy 1 April 2010
- Carer Information Strategy 2016
- NHS Shetland 2020 Vision of Shetland's Healthcare
- Caring Together, the Carers Strategy for Scotland (2010-2015)
- Caring Together – The Carers Strategy for Scotland 2010-2015
- Getting it Right for Young Carers – The Young Carers Strategy for Scotland 2010-2015.
- The Care 21 Report – The Future of Unpaid Care in Scotland.
- UN Convention on the Rights of the Child
- Work and Families Act 2006
- Changing Lives: 21st Century Social Work Review (2006)
- Delivering for Health (2005)
- Community Care and Health (Scotland) Act 2002
- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Children (Scotland) Act 1995
- Equality Act 2010
- Carers (Waiving of Charges for Support) (Scotland) Regulations 2014
- Getting it Right for Young Carer's, The Young Carer's Strategy for Scotland 2010-2015
- The Education (Additional Support for Learning) (Scotland) Act 2004, 2009
- The Children and Young People (Scotland) Act 2014
- GIRFEC - http://www.shetland.gov.uk/children_and_families/GIRFEC.asp
- WYFY documentation

Service Plan – Community Care Resources

Joint Strategic Commissioning Plan 2017 – 2020

Policy context

Shetland's Older People's Strategy evidences the demographic changes that Shetland is facing with an ageing population, increasing prevalence of long term conditions and increasing multiple morbidity. It is suggested that the number of people aged 65 or over is 38% greater than in 2006 and will be 92% greater by 2031. This is higher than the national average and the fourth highest rate of change across Scotland's 32 local authorities.

The challenges facing community care resources is recognised nationally within the 2010 Reshaping Care for Older People and new legislation in the form of the Public Bodies (Joint Working)(Scotland) Act 2014. These are significant drivers in setting out a vision for joint working across Health and Social Care Services and a vision for reshaping the care and support of older people in Scotland by 2021. The aim is to improve the quality and outcomes of current models of care, whilst developing services in a sustainable way that address current demographic and funding pressures.

Current Services

Community Care Resources provides services to adults in need across Shetland. Our purpose is to enable people to remain within their own homes and communities by providing person centred care to increase or maintain levels of independence, self-care and self-managed care. The service works in partnership to reduce unplanned, emergency and inappropriate admissions to hospital and facilitate early discharge from hospital wherever possible. The service has the following elements, delivered from a number of localities around Shetland:

- Residential care used for long term care or short breaks (respite)
- Day services
- Care at home
- Domestic
- Meals on Wheels

In addition, services are commissioned from Crossreach which provides 16 residential placements and 10 day care places in Scalloway.

In a typical week, the services deliver approximately 2200 hours of personal and domestic care in peoples own homes to approximately 350 clients. There are 149 residential beds providing long stay care, respite care and short term re-ablement placements.

We have two extra supported housing complexes in Lerwick and Unst which provides access to 24 hour care to 30 individuals living in their own home.

Contribution to Local Delivery Plan priorities

Shetland Corporate Plan:

Older people and people who are living with disabilities (including learning disabilities) or long-term conditions will be getting the services they need to help them live as independently as possible.

People will be supported to look after and improve their own health and well-being, helping them to live in good health for longer.

Our Integrated Health and Social Care services will be providing the services people need in a more efficient way, improving standards of care and keeping people healthier for longer.

Increased use of technology will be helping us provide care for the most vulnerable and elderly in our community.

Contribution to Strategic / Cross Cutting Themes

Community Care Resources is one of the main services enabling individuals to reside in their own home for as long as possible, it is linked closely with the older people's strategy and dementia care strategy. The service works closely with all partners in the Community Health and Social Care Directorate, Housing and Third Sector to ensure service delivery in localities is robust, effective and person centred.

Staffing

All care staff working within residential and day care services are registered with the Scottish Social Services Council. Registration is being extended to community based care workers in 2017. The team leader in each locality is also registered with the Care Inspectorate as a Registered Manager. The service is seeing a significant pressure placed on senior social care workers both in residential care and the community due to increased workloads and conflicting priorities.

Needs/Unmet needs/Drivers for change

Increased demand on services and reducing finances are main drivers for change and it is acknowledged that the service needs to review the way it works in order to create sustainable services for the future.

The service is seeing an increase in requests for carer support, particularly respite care and day care. The service is seeing unmet need in day care provision and its ability to respond to immediate unscheduled care.

Plans for change

The service continues to develop its thematic self evaluation and highlight areas for continuous improvement. The drivers from Government and individual outcomes for flexible care delivered in people's own homes remains a priority. The service will work closely with colleagues and agencies to take an integrated approach to service review and development.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Review current models of care in Shetland to ensure sustainability of service	Director of CH&SC	January 2017	Resources are used effectively and efficiently in the provision of high quality health and social care services. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. 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
Thematic Self Evaluation in the area of Day Care Services	TLs	November 2017	Resources are used effectively and efficiently in the provision of high quality health and social care services. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
Develop Performance Management Framework	Executive Manager	April 2017	Resources are used effectively and efficiently in the provision of high quality health and social care services

Key Risks to Delivery

The service relies on recruiting and retaining well trained and well supported staff. Difficulty with recruitment remains a risk area for the service in certain localities.

Increasing prevalence of long term conditions and multiple morbidity in individuals living in residential care is placing increased pressure on staff teams.

Lack of capacity within the management and support areas of the service is affecting the services ability to move forward with actions.

Reductions in public funding and Shetland Charitable Trust funding will impact on the way we deliver services if the status quo continues. The way care is delivered in Shetland and the sustainability of services needs to be addressed in order to ensure that the model of care delivered is fit for purpose and sustainable.

Performance Targets with links to National Outcomes

This needs populating from covalent.

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Further Reading

Social Work Services, Care Homes, Respite Providers and Care At Home Services are subject to inspection by the Care Inspectorate www.careinspectorate.com

All social care staff must be registered with Scottish Social Services Council in order to practice and must abide by the Codes of Practice.
www.sssc.uk.com

Community Nursing

Policy context

The Scottish Government's vision for primary care and general practice is that

- General Practice and primary care are at the heart of the healthcare system;
- People who need care are more informed and empowered than ever, with access to the right person at the right time, and remaining at or near home wherever possible; and
- Multi-disciplinary teams in every locality, both in and out of hours, involved in the strategic planning and delivery of services (Scottish Government, Nov 2016).

The Scottish Government's Primary Care vision puts general practice and primary care at the centre of a community based health service, improving outcomes for local communities.

Working within the context of Health and Social Care integration, Health and Social Care Partnerships are responsible for the commissioning, planning and delivery of all community and primary care services in their localities. Focusing on delivery of the 9 Health and Wellbeing outcomes, there are 6 Primary care outcomes where primary care has a specific contribution. These are:

1 – We are more informed and empowered when using primary care

2 – Our primary care services better contribute to improving population health

3 – Our experience as patients in primary care is enhanced

4 – Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care

5 – Our primary care infrastructure – physical and digital – is improved

6 – Primary care better addresses health inequalities.

Within this context, the Community Nursing service has an integral role to play in achieving the delivery of the 6 Primary Care Outcomes.

Work of the national Transforming Nursing Roles groups aims to support the development of the nursing workforce for the future with new and enhanced roles appearing across the District Nursing and Practice Nursing workforce with consideration given to role development across the workforce from support worker to nurses working at an Advanced Practice level. The implementation of the new GP contract in October 2017 will also play a key role in influencing the shape and delivery of nursing services in the community setting for the future.

Current Services

The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting.

The District Nursing service is the largest part of Community Nursing services, which provides a nursing service to individuals within their own home, or a care home, on a 24 hours a day, seven days a week, 365 days a year basis.

The District Nursing service provides

- Acute care at home;
- Complex care at home;
- End of life care at home.

The following groups of staff who provide care in a community setting are also provided, and managed, via the Community Nursing service:

- Practice Nurses – the Practice Nursing service for all of the NHS Board provided general practices, namely Lerwick, Unst, Yell, Brae and Whalsay;
- Advanced Nurse Practitioners – the Advanced Nurse Practitioner posts based at the Lerwick Health Centre;
- Specialist Nurses, eg Continence Nurse Advisor;
- Non-Doctor Island/Out of Hours Nursing – there are resident nurses on the non-doctor islands of Fair Isle, Foula, Fetlar, Skerries and Bressay. and
- Intermediate Care Team – this multi-disciplinary, partnership team provide additional support at home for individuals to prevent unnecessary admission to hospital or provide additional support to increase independence on discharge home from hospital. This additional support is provided on a time limited basis of up to 6 weeks. The team are based at the Independent Living Centre, Gremista, Lerwick.

Whilst the Community Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16years and are housebound, the services will endeavour to meet the needs of any individual across the lifespan from birth to death, within the community setting who have a nursing and/or health need. Community Nursing staff also provide support and teaching to informal and /or family carers to enable them to care effectively for their relative, whilst also addressing any care and support needs the individual carer might have themselves.

All of the component services within Community Nursing services work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.

Funding and Resources

The overall Community Nursing Services has approx 47.45 full time equivalent staff and an annual revenue expenditure of £2.3 million. The staffing establishment is as detailed below:

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Community Nursing services	47.45	2,312,966	0	2,312,966	240,000

Needs/Unmet needs/Drivers for change

The service priorities have been informed by both national and local drivers for change and are aimed at enhancing service delivery at locality level. The actions outlined should respond to the issues of importance to local communities, which have been identified through Locality Planning meetings. Consideration has also been given to additional service specific information which has been gained by engagement with various groups eg patient satisfaction survey for ANP service at Lerwick Health Centre, General Satisfaction survey across all of District Nursing and Continence Service, discussions with Community Councils regarding sustainability of provision of health services.

Service Aims/Priorities	Objectives/Actions
There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish.	All community based nurses will promote healthy lifestyles to all individuals on the caseload. Anticipatory care plans will be developed with individuals in order to support them manage their own condition as well as to remain in their own homes for as long as possible.
The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so	District Nurses/Community Nursing service will work as part of a locality service delivery model, influencing and leading care for individuals with a health need.
Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to "tell their story once".	District Nurses will actively adopt the case manager role for individuals with complex health needs, where appropriate.

Plans for change

New Planned Actions Due to Start in 2017/18					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Implement sustainable extended Intermediate Care Team with integral overnight nursing/care service	Chief Nurse (Community)/ Intermediate Care Team	April 2017	July 2017	Sustainable service in place	Provides a 24hour nursing and care service at home thus supporting early supported discharge from hospital as well as avoiding unnecessary admissions
Source Emis Web as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care	Chief Nurse (Community)	March 2017	March 2018	Electronic record keeping/management system in place	Enhance communication across multidisciplinary, interagency teams thus supporting improved seamless care for individuals
Further develop model of case management	Chief Nurse (Community) / Clinical	Ongoing		District Nurses undertake case	Better co-ordinated care for individuals with

New Planned Actions Due to Start in 2017/18					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
within Community Nursing services	Team Leaders			management role	complex health needs
Continue to support implementation of eKIS Anticipatory Care Planning across the services	Chief Nurse (Community)/ Clinical Team Leaders	Ongoing		Increase in eKIS plans in place across all General Practices in Shetland	Enhance anticipatory approach to care for individuals with complex health needs.
Continue to progress review of local District Nursing services in line with national "Transforming Nursing Roles" project – implementing new service	Chief Nurse (Community)	April 2016	September 2017	Ensure that District Nursing workforce locally continues to develop in line with national direction	District Nursing workforce is fit for purpose for 21st century Role of District Nurse in Locality based teams is confirmed
Review of skill set across Nursing and Care staff	Chief Nurse (Community) / Exec Manager Community Care Resources	Ongoing	September 2017	Agreed roles / skill sets across nursing and care staff	Better utilisation of staff within integrated team
Develop Advanced Nurse Practice Structure / Capacity & Capability	Chief Nurse (Community)	September 2017	March 2018	Ability to develop ANPs locally and succession plan to support roll out of ANP led services	Increase multi-professional approach to care delivery in primary care Supporting delivery of 6 Primary Care outcomes

New Planned Actions Due to Start in 2017/18					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Develop Nursing in Community Strategy	Chief Nurse (Community)	September 2017	March 2018	Set strategic direction for nursing in community settings	Strategy developed to support careers in nursing in a community setting which provides a career framework from initial registration to Advanced Practice. Nursing service supports implementation of new GP contract from October 2017
Develop governance and professional leadership structure for all Practice Nurses Shetland wide	Chief Nurse (Community)	April 2017	September 2017	Framework to support Practice Nursing in Shetland wide context	Standardisation of Practice Nursing service across Shetland enhancing clinical safety Professional support and leadership provided to Practice Nursing workforce
Review model of service provision in remote areas	Chief Nurse (Community) With key partners	April 2016	March 2018	Service model which meets health needs of island communities	Sustainable, safe, effective, person-centred service in place

Key Risks to Delivery

During 2016-2017 the Community Nursing service has continued to experience significant difficulty with recruitment in the service, the effects of this in terms of service provision, being further compounded by a number of staff who have had a period of long term sickness absence whilst awaiting or recovering from surgical interventions.

Some of these issues have now been resolved but these have had an impact on service development in 2016 -2017 as staff have had to focus on meeting the current clinical needs of patients on the active caseloads.

Recruitment and retention issues leading to ongoing reduced staffing levels in the outer and non-doctor island settings in particular is having a significant impact both on service delivery and on the ability of the service to take forward the initiatives above within the timescales outlined. In addition due to the recruitment challenges in the outer areas, the Community Nursing service has had to

resort to using supplementary staffing from an agency which has brought financial pressures to the Board. However, the agency staff have been required in order to main service delivery and patient safety and we have built up an ongoing relationship with 2 particular staff members to support continuity of care as much as possible whilst also ensuring that we can ensure oversight of the maintenance of good standards of care.

The Community Nursing service has previously made approx. £500,000 of savings and is currently facing a further savings challenge of £240,000, which is approx. 10% of current budget. Some of the projects outlined above have the potential to identify savings but have various risks associated both with delivering these and as has already been identified with delivering savings within the outlined timescales. Reductions in Community Services budgets is in direct opposition to the Scottish Government policy of Shifting the Balance of Care to delivery within a Community setting. Reduction in staffing levels will impact on the number of individuals which the Community Nursing service can support in a community setting with the potential for inappropriate hospital admission as the default 24/7 care location.

Performance Targets with links to National Outcomes

The overall aims and objectives of all the constituent parts of the Community Nursing services are to:

- Support and maximise the health potential of individuals, as well as address the health and care needs of various client groups and/or their carers within the wider community; and
- Utilise a holistic approach to providing safe, effective, person-centred care in a variety of community settings.

These aims and objectives contribute to the delivery of the National Health and Wellbeing Outcomes, in particular:

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

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

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

Performance Measure	**Performance 2016/17**	**Target 2017/18**
Number of Early Supported Discharges		
Number of Admissions Avoided through involvement of Intermediate Care Team		
Number of individuals with complex health needs whose care is case managed by a District Nurse		
Number of Anticipatory Care Plans in place and shared across services		
Number of early supported discharges with no re-admission in 30 days		

Performance Measure	Performance 2016/17	Target 2017/18
Number of people supported to die in preferred place of care		
Number of people supported to have a solution to their continence problem which is not a containment solution		
Number of individuals seen by an Advanced Nurse Practitioner as first point of access to healthcare		
Number of individuals seen by an Advanced Nurse Practitioner who subsequently referred to another practitioner for a “second opinion”		
Patient Satisfaction survey of patients seen by Advanced Nurse Practitioners		

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Criminal Justice Service Plan

Joint Strategic Commissioning Plan 2017 – 2020

Policy context

The Strategy for Justice in Scotland sets out the Government's approach to make the Scottish justice system fit for the 21st century. The second phase of the Reducing Reoffending Programme which began in 2012 is focused on making sure that the right services and support are provided so that prolific offenders can address their reoffending and its causes.

The Community Justice (Scotland) Act 2016 sees the responsibility for community justice transferred to 'community justice partners', with oversight and assurance to Ministers being given by a new national body, Community Justice Scotland. In Shetland, a local Community Justice Partnership has been established and reports to the Shetland Partnership. The Partnership will be responsible for producing a strategic plan that will address local and national priorities. Criminal justice social work services are statutory partners in ensuring effective community justice in local communities.

Current Services

The Shetland Islands Council has had a statutory duty to provide criminal justice social work services for individuals awaiting sentencing; subject to community based disposals or custodial sentences. The Service ensures that all people who are referred to the service are appropriately assessed, supervised and risk managed. The service works predominantly with individuals over the age of 16 years and is responsible for the delivery and development of all criminal justice social work services throughout Shetland. This includes the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences. The service also offers support and advice to family members.

Contribution to Local Delivery Plan priorities

The Criminal Justice Service is committed to supporting the Community Health and Social Care Directorate's Vision of "To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community". The Criminal Justice service will do this by working collaboratively with partners to achieve a service that will help make communities safer, prevent victims and reduce crime.

The Service is responsible for delivering outcomes as stated in the Community Justice Partnership Local Outcome and Improvement Plan.

Funding

Funding for Criminal Justice Social Work Services is ring fenced and allocated by the Scottish Government on an annual basis. The funding covers the meeting of statutory duties. The service

works collaboratively with other statutory and third sector partners in Shetland to ensure that individuals receive the assistant and support their need to stop their offending behaviour.

Staffing

The Service comprises of a small team of professionally qualified social workers and support workers who undertake a range of statutory social work functions.

Needs/Unmet needs/Drivers for change

There has been a significant increase in the number of Supervision and Unpaid Work requirements compared to the previous years and this has placed increased pressure on a small team. The service continues to work closely with colleagues in other agencies to ensure that individuals receive the best service possible. Over the past year we have seen an increase in offences that involve violence, domestic abuse, sexual offences and public disorder and we are working with partners to ensure our joint working processes remain effective. Supervision and Unpaid Work Requirements remain the most frequently used disposals and this allows the service to work in a proactive manner with offenders.

Plans for change

Due to the statutory nature of criminal justice social work there will be little change to the core function of the service. However, the establishment of the Shetland Community Justice Partnership will provide opportunities to continue to develop partnership working and look at new ways of delivering services.

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
Review internal processes and intervention to ensure they remain fit for purpose.	Executive Manager	May 17	Effective interventions are delivered to prevent and reduce the risk of further offending
Work with partners to plan and deliver services. Focus on recreation and employment opportunities.	Executive Manager	April 17	Partners plan and deliver services in a more strategic and collaborative way
			Life chances are improved through needs, including health, financial inclusion, housing and safety being addressed.
Raise awareness of criminal justice services within the local community	Executive Manager / SCJP	August 17	Communities improve their understanding and participation in community justice

Key Risks to Delivery

Funding has been reduced for 17/18 and the impact on services is not yet known. Any negative impact on services will be reported to the Shetland Community Justice Partnership and Integration Joint Board.

Performance Targets with links to National Outcomes

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Further Reading

Scottish Government's Redesign of Community Justice Services.
http://www.scotland.gov.uk/Publications/2014/04/7616

Reoffending 2 Agenda.
http://www.scotland.gov.uk/Topics/Justice/justicestrategy/programmes/reducing-reoffending2

Women who offend
http://www.scotland.gov.uk/News/Releases/2012/04/womenoffenders17042012

Risk Management of sexual offenders and high risk violent offenders, through Multi Agency Public Protection Arrangements. http://www.scotland.gov.uk/Topics/Justice/policies/reducing-reoffending/sex-offender-management/protection

Service Plan – Gender Based Violence (Domestic Abuse) 2017-20

- **Policy context**

Equally Safe, the Scottish Government and COSLA's joint strategy for preventing and eradicating violence against women and girls (VaWG) was launched in 2014. Equally Safe is Scotland's strategy to tackle all forms of violence against women and girls: domestic abuse, rape and sexual assault; sexual harassment and intimidation at work and in public; stalking; commercial sexual exploitation such as prostitution, pornography and human trafficking; dowry-related violence; female genital mutilation (FGM); forced marriage; and so-called 'honour' based violence. The strategy recognises that women and girls are at risk of such abuse precisely because they are female and it aligns with the UN definition of violence against women. Clearly, boys and men can also experience violence and the strategy does not diminish the seriousness of that experience or proposing to alter the support on offer to them. However the strategy aims to highlight that being female in itself can lead to a range of discrimination and disadvantage, including experiencing male violence. Furthermore violence against women can have significant consequences beyond those experienced by the individual. Children and young people growing up in the same family setting can be badly affected, whether as victims of violence directly or as witnesses to violence. VaWG is underpinned by gender inequality, and in order to prevent and eradicate it from society efforts must be focused on delivering greater gender equality, tackling perpetrators, and intervening early and effectively to prevent violence.

There are a number of other national policies that impact on the provision of services for domestic abuse.

- Community Empowerment (Scotland) Act and Local Outcome Improvement Plan (LOIP). One of the outcomes in the Shetland Community Planning Partnership LOIP is: 'Shetland is a safe place to live for all our people and we have strong, resilient and supportive communities.' One of the priorities under this outcome is 'Keeping people safe' which has two actions specifically regarding domestic abuse.
- Integration of Health and Social Care. The Public Bodies (Joint Working) (Scotland) Act sets out the legislative framework for integrating health and social care in Scotland. Domestic abuse is one of the services that sits within the remit of the Integration Joint Board.
- The Community Justice (Scotland) Act**.** The redesign of Community Justice will help create a stronger community justice system based on local collaborative strategic planning and delivery, with national leadership, support and assurance.
- National Gender Based Violence and Health Programme.
- Domestic Abuse Commissioning Framework. COSLA is working with Scottish Women's Aid to develop joint guidance for public sector commissioning of domestic abuse services through a focused but participative process.
- Legislative Framework. There are a number of Scottish Acts relating to Gender Based Violence including

  Prohibition of Female Genital Mutilation (Scotland) Act 2005

  Criminal Justice and Licensing (Scotland) Act 2010 - Stalking

  Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011

Domestic Abuse (Scotland) Act 2011

Human Trafficking and Exploitation (Scotland) Act 2015

Proposal for an Abusive Behaviour and Sexual Harm Bill

The Shetland Domestic Abuse Strategy 2013-16 www.shetland.gov.uk/news-advice/documents/SDAPStrategy2013-16.pdf and associated action plan sets out how the Partnership currently addresses and prevents domestic abuse and gender-based violence in Shetland. The strategy is being revised in response to Equally Safe and building on a needs assessment to develop a new strategy for 2017-20.

- **Current Services**

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 come together at a strategic level through the Shetland Domestic Abuse Partnership.The needs of people affected by domestic abuse cannot be met by a single service alone. The following services in Shetland are involved in delivering the action plan, and most are represented on the Partnership:

- Shetland Women's Aid
- Shetland Islands Council (including Adult & Child Protection; Criminal Justice Social Work, Housing Service, Schools Service, Adult Services Social Work, Children & Families Social Work , Community Development)
- Police Scotland
- NHS Shetland (including Reproductive Health Services, A&E, Primary Care; Community Nursing and Health Visiting, Public Health and Mental Health Services)
- Victim Support Shetland
- Community Alcohol & Drugs Services Shetland
- Rape Crisis Shetland
- Local solicitors

The only services from this list above that are dedicated to gender based violence are Shetland Women's Aid (SWA) and Rape Crisis Shetland. SWA is a registered charity offering counselling, advice and support to women, children and young people affected by domestic abuse. It also provides refuge accommodation for women, and their children, who are being or have been physically, emotionally or sexually abused. The accommodation can house one family at a time. Rape Crisis Shetland is a new service set up in 2016 by Rape Crisis Scotland to

For all the other services, responding to domestic abuse and other forms of gender based violence is one element of their overall service.

MARAC

In 2013, the MARAC (Multi-Agency Risk Assessment Conference) was launched in Shetland. This is a monthly, local meeting where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the Independent Domestic Abuse Advocate (IDAA), a risk- focused, co-ordinated safety plan can be drawn up to support the victim. The MARAC co-ordinator is based in Highland and the process is overseen by the Highland & Islands MARAC Steering Group which reports to the Domestic Abuse Partnership and the Senior Officer Group. There is dedicated funding for this service through the Government's Violence against Women and Girls funding stream.

Information on the roles of other services can be found in their individual service plans and here (SDAP Directory of Support Services)
www.safershetland.com/assets/files/Signposting%20Leaflet%20(V2%20June%202013).pdf

- **Contribution to Local Delivery Plan priorities**
  Gender based violence work contributes to tackling health inequalities, and improving outcomes for vulnerable children through the antenatal and early years work.

- **Contribution to Strategic / Cross Cutting Themes**
  Tackling Health Inequality
  Protection (Child and Adult)
  Locality planning and Inter-connectedness with other services

- **Funding**
  It is not currently possible to identify the total Domestic Abuse Services budget because for many organisations it is a small part of their overall workload and there are no dedicated staff or resources. Shetland Women's Aid is funding by a number of sources including a SLA with Shetland Islands Council; the Government's Violence against Women and Girls Funding Stream, National Lottery and charitable donations. The Rape Crisis service is funded by Rape Crisis Scotland, a national charity.

- **Needs/Unmet needs/Drivers for change**
  - Comprehensive needs assessment and review of service provision required to inform future service development and commissioning of services.
  - Need for more preventative work has been identified by the Partnership as a priority
  - Recognition of the actual incidence or potential for other gender based violence issues in addition to domestic abuse including human trafficking; forced marriage; sexual assault and rape; childhood sexual abuse; harmful traditional practices; stalking and sexual exploitation.
  - As awareness raising, publicity and routine enquiry is further developed and implemented, then more people who have experienced domestic abuse are likely to present or be identified.
  - Similarly with increased awareness raising and support available from Rape Crisis Shetland, then more people who have experienced rape and sexual assault are likely to present.
  - Apparent lack of sufficient refuge accommodation and /or need for a different model of providing safe accommodation.
  - Victims of sexual assault and rape currently have to fly with police escort to Aberdeen for forensic examination: this is a huge barrier to people reporting assaults and consenting to examination.
  - Clients are presenting to services with increasingly complex needs.
  - Currently there are no local services for men experiencing domestic abuse (would be sign posted to national helplines and Victim Support provides the MARAC advocacy role for men).

- **Plans for change**

The main piece of work for the Partnership is to revise the Domestic Abuse Strategy in response to Equally Safe and building on a needs assessment to develop a new strategy for 2017-20. This will have prevention as a priority and will include evidence based commissioning of services .

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
New Domestic Abuse and Sexual Violence strategy currently in development.	Susan Laidlaw	2016 - 2017	**Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services **Outcome 5.** Health and social care services contribute to reducing health inequalities **Outcome 7.** People using health and social care services are safe from harm **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services
Action plan for 2017-18 to be developed in response to Strategy	Susan Laidlaw	2017	**Outcomes 4,5,7,9**
Specific piece of work on developing and implementing evidence based preventative approaches.	Susan Laidlaw	2017	**Outcomes 5,7,9**
Specific piece of work on exploring potential scope for providing forensic examination on island	Susan Laidlaw	2017	**Outcomes 4,5,7,9** **Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected

- **Key Risks to Delivery**
  - During 2014, the SDAP chair and the Community Safety Officer, who was the lead officer for the Partnership both left their posts which left a considerable gap in the capacity of the Partnership at that time which has not been completely filled since then. However the chairmanship has been picked up on an interim basis by the Public Health Consultant and some of the administrative functions of the lead officer role have been picked up through Community Planning, but we do not have the dedicated input that was previously provided by the Community Safety Officer.
  - Women's Aid, like most voluntary sector organisations, is dependent on short term funding awards.

- The current one year funding for the MARAC runs up to the end of July 2017; further funding is therefore being applied for.
- Because the other agencies that are involved in tackling domestic abuse and gender based violence have this as only a relatively small part of their remit, there is a risk that services will be diminished as resources become more scarce for every service.

- **Performance Targets with links to National Outcomes**

  Local Outcome Improvement Plan Indicators: One of the outcomes in the Shetland Community Planning Partnership LOIP 2016-19 is: 'Shetland is a safe place to live for all our people and we have strong, resilient and supportive communities.' One of the priorities under this outcome is 'Keeping people safe' which has two actions specifically regarding domestic abuse. The associated indicator is 'Number of domestic abuse incidents reported to the Police'. (Linked to National Health and Wellbeing Outcomes 4 and 7)

  MARAC indicators. There are a raft of process indictors for the MARAC process that are monitored on a quarterly basis including number of referrals, re-referrals, no of children affected, demographics, referral sources and no of actions generated by each MARAC. We are looking at developing more outcome focused indicators for MARAC, linking with the National Outcomes, particularly 4, 5 and 7.

  Equally Safe Measurement Framework: A national measurement framework is being developed as part of the Accountability workstream of the Equally Safe Strategy setting out agreed outcomes; a suite of high-level and intermediate indicators; and (where appropriate) targets . We will be incorporating these into our local Domestic Abuse and Sexual Violence Strategy.

- **Contact Details**

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- **Further Reading**

  Safer Shetland Website: Domestic Abuse webpages
  www.safershetland.com/domestic-abuse

Intermediate Care

Policy context

The background to the implementation of intermediate care is detailed in the Scottish Government's Reshaping Care for Older People strategy: http://www.scotland.gov.uk/Resource/0039/00398295.pdf, and in the Intermediate Care Framework for Scotland: http://www.scotland.gov.uk/Resource/0039/00396826.pdf

The Reshaping Older Peoples Care agenda aims to reduce unplanned admissions to hospital or long term care, enhance discharge planning, recovery and self-management.

Some of the key drivers behind this agenda are:

- HEAT Targets – the delayed discharge target is for no person to wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes
- AHP National Delivery Plan (Scottish Government, 2012)

  http://www.scotland.gov.uk/Resource/0039/00395491.pdf

  - Action 2.3 AHP directors will work with directors of social work and their NHS boards to maximise the AHP contribution to achieving delayed discharge targets and reduce overall length of stay in hospital, which will support the delivery of the legal treatment time guarantee.
  - Action 2.4 AHP directors will work with directors of social work to support older people and those with disability and complex needs to live independently in their own home/homely setting for as long as possible, delaying or reducing admissions into institutional care.
  - Action 2.5 AHP directors will work across directorates of social work and NHS to reconfigure "enabling" services, such as rehabilitation and reablement, to deliver best value and enhance care experiences for people who use services and their families and carers. This will transverse and enhance the experiences of the clients by addressing the holistic needs of the individual clients, family and relative carers. The services to be delivered are carried out on a one to one basis following a multi professional assessment.

Intermediate Care actively supports the delivery of the 6 Primary Care Outcomes.

Current Services

The Intermediate Care Team is a multi-disciplinary, partnership team who provide additional support at home for individuals to prevent unnecessary admission to hospital or provide additional support to increase independence on discharge home from hospital. This additional support is provided on a time limited basis of up to 6 weeks. The team are based at the Independent Living Centre, Gremista, Lerwick.

The Intermediate Care Team was established in June 2014 and received the first individuals into the service as of 8 September 2014.

"The function of intermediate care – inherent in its name – is to integrate, link and provide a transition (bridge) between locations (home/hospital and vice versa); between different

sectors (acute/primary/social care/housing); and between different states (illness and recovery, or management of acquired or chronic disability)."

Ref An Evaluation of Intermediate Care for Older People, Institute of Health Sciences

and Public Health Research, University of Leeds, 2005

The local Intermediate Care Team was established in line with the guidance in Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland (Scottish Government, 2012).

The core principles of Intermediate Care are:.

The purpose of Intermediate Care is to provide **time-limited interventions** at points in a person's life where this will **restore or avoid a loss of independence** and confidence, or **reduce the risk of hospital admission** (or a longer stay in hospital).

Experience suggests that Intermediate Care should **extend for up to 6-8 weeks**. After this period of time, the pace of recovery tends to slow and the person no longer receives the same level of benefit from the intensive interventions associated with Intermediate Care.

However the **period of time** during which Intermediate Care should be provided should **reflect the needs of the individual and be shorter, or longer,** as appropriate.

Intermediate Care is **one form of rehabilitation targeted** at those who will benefit from **short term, intensive, and multi professional interventions**: other rehabilitation services may well continue (as may the period of recovery) well beyond this 6-8 week period.

Intermediate Care should be provided, **free of charge, to people in their own homes where possible**: this reflects the clear priorities of older people. Free and effective Intermediate Care has the potential to pay its own way, when commissioned as part of a wider suite of integrated resources.

Intermediate Care in these circumstances is **additional,** and should be **complementary, to any existing services that the person receives.** It should not displace existing care and support arrangements, but seek to enhance and keep these in place.

This continuity is of particular importance for older people who are confused, and where maintaining routine is a key component of retaining their independence. In other circumstances, this will not be possible and a move to another setting, such as a care home or community hospital, may be required.

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

Needs/Unmet needs/Drivers for change

A proposal to extend the Intermediate Care Team is currently being considered. Expansion of the team will support an increased number of individuals to be supported in a community setting either through Early Supported Discharge or through providing an alternative to admission. Extension of the team will also enable more community based rehabilitation to be undertaken.

With an increasing older population it is important to have additional capacity within the Intermediate care team to ensure that a programme of supportive, intensive rehabilitation measures can be provided in a timely way to support individuals back to an independent life style.

Plans for change

New Planned Actions Due to Start in 2017/18					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Implement sustainable extended Intermediate Care Team with integral overnight nursing/care service	Chief Nurse (Community)/ Intermediate Care Team	April 2017	July 2017	Sustainable service in place	Provides a 24hour nursing and care service at home thus supporting early supported discharge from hospital as well as avoiding unnecessary admissions People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

New Planned Actions Due to Start in 2017/18					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Evaluate service provision	Chief Nurse (Community)/ Intermediate Care Team	Ongoing	Annual Report March 2018	Evidence of effectiveness of the Intermediate Care approach across Shetland	Demonstrates impact of Intermediate care on individual's health and wellbeing outcomes

Key Risks to Delivery

Failure to support the extended Intermediate Care team model will prevent the further development of this service across Shetland thus limiting our ability to maintain people in a community setting. This would also limit the shifting of the balance of care to a community setting, as well as inadvertently continuing to tie up resources in hospital based services by increasing the demand for in-patient care.

Recruitment of Allied Health Professionals and to the Rehab Support Worker posts remain a challenge and risk to increasing the capacity of the team.

Performance Targets with links to National Outcomes

The overall aims and objectives of the Intermediate Care Team are to :

- Support and maximise the health potential of individuals, as well as address the health and care needs of various client groups and/or their carers within the wider community; and
- Utilise a holistic approach to providing safe, effective, person-centred care in a variety of community settings.

These aims and objectives contribute to the delivery of the National Health and Wellbeing Outcomes, in particular:

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

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

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

Performance Measure	Performance 2016/17	Target 2017/18
Number of Early Supported Discharges		
Number of Alternatives to Admission provided through involvement of Intermediate Care Team		
Number of early supported discharges with no re-admission in 30 days		

Contact Details

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Intermediate Care Team Leader
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Mental Health

Policy context

The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in October 2005. The Act contained much more than simply legislation for new forms of compulsory powers and safeguards. Its underpinning principles heralded a new era of rights-based care for people who use mental health services. As well as providing care and treatment, services are now required to promote social inclusion and a wider citizenship agenda.

A number of policy documents have shaped the development of local mental health services. Delivering for Mental Health (2006) set out national policy for the development of Mental Health services and the improvement of mental health in Scotland. This was followed by Better Health Better Care (2007) which established additional improvement objectives and National Targets/Standards. In 2009, Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 outlined the roles and responsibilities of government, local public agencies and third partner agencies in promoting positive mental health.

In August 2012, the Scottish Government published a Mental Health Strategy for Scotland with a renewed emphasis on "prevention, anticipation and supported self management". This focus is central to mental health policy in Scotland and the strategy emphasises a range of improvements and interventions that are in accordance with the best evidence for return against investment over time. The strategy focuses on actions that people can take for themselves and with their communities to maintain and improve their own mental health.

Other strategies closely associated with the 2012 strategy for the delivery of mental health services are Suicide Prevention, Dementia and Substance Misuse.

An updated Mental Health Strategy for Shetland, written in accordance with Scottish Government priorities was agreed by Shetland Islands Council and NHS Shetland in May 2014. The over arching aim of the Shetland Mental Health strategy is to have a single plan that will deliver comprehensive mental health services; use available resources to deliver services in the most effective way and avoid harmful gaps and wasteful overlaps. This will involve health, social care, housing, education, and employment, voluntary and other agencies working jointly in the provision of complementary services across the whole spectrum of mental health support and treatment.

In delivering this aim, we commit to the following principles:

- Wherever practicable and possible, the local service will be provided as a home-based service or in small facilities as close as possible to an individual's home.
- People are central to their own care, treatment and recovery.
- Patients, Service Users and Carers should therefore be partners in designing and delivering services.
- We will continue to provide systematic support for people with long-term conditions.

- We will actively manage admissions to and discharges from hospital in order to minimise the incidence of delayed discharge and inappropriate readmission and to ensure that patients are provided with appropriate support.

The vision of a 21st century mental health service for the people of Shetland is build upon the principle of person centred partnership with patients, carers and staff. This principle will be at the heart of our service change and improvement initiatives.

Current Services

The Shetland Islands Council, Shetland NHS Board and the voluntary sector continue to work together to deliver mental health services to meet the needs of people who require care, treatment and support as a result of their mental health issues.

In Scotland between 25% and 30% of all General Practitioner (GP) consultations involve depression, stress or anxiety. It is anticipated that the incidence of stress related health problems including mental health issues will increase in the current economic climate as people experience financial pressures / job losses. The reduction in funding for public services will pose a significant challenge to services. It is now generally accepted that good mental health underpins all other aspects of health. People with mental health problems have greater risk of, and higher rates of, heart disease, diabetes, respiratory disease and infections. They also have higher rates of smoking, alcohol consumption and drug misuse. They die younger and have a poorer quality of life. In addition there are growing numbers of people with dementia. Evidence shows that people with a mental illness are the highest "at risk" group for suicide, with a rate of suicide 10 times that of the general population.

Dementia is the name given to a group of organic psychiatric/mental illnesses that affect the normal working of the brain. These illnesses interfere with memory and the ability to think and reason. It is recognised that dementia has profound consequences for those affected and their families. The numbers of people in Shetland with dementia are expected to continue to increase as the population ages.

The services that make up Shetland's Adult Mental Health Service are:

- Community Psychiatry Services
- Community Psychiatric Nursing Service
- Psychological Therapies Service
- Substance Misuse and Recovery Service
- Dementia Service
- Community Mental Health Support Service

Referrals for General Adult (16/18-65 years old), Old Age (65+) and Emergency/Liaison categories are received from GPs, Hospital Consultants, and Social Work. The duties of the service are:

- To provide a clinical service in community psychiatry for adults and older people including; out-patient consultations; assessment and treatment of patients in the community and a range of care settings, emergency assessment and treatment.
- To provide assessments and advice on patients in the care of medical and surgical colleagues and those attending accident and emergency with mental health problems.
- To assess patients in police custody on request of a police surgeon (Consultant Psychiatrist).
- Fulfil the duties associated with the Mental Health (Care and Treatment) (Scotland) Act, 2003.
- To contribute to the teaching and training of students, trainees and multidisciplinary staff groups as appropriate.

The service does not provide specialist "in person" care in the areas of Eating Disorder, Forensic Psychiatry, Old Age Psychiatry or Perinatal Psychiatry. Advice and treatment in these areas is available from NHS Grampian. Additionally, an NHS National Service for Treatment Resistant Depression & Obsessive Compulsive Disorder can be accessed, where referral criteria are met. Specialist psychotherapy services are accessed through NHS Grampian as a "tertiary" level service.

The Community Psychiatric Service provides a comprehensive service to adults (18+). Services are provided by:

- Consultant Psychiatrist
- Community Psychiatric Nurses (CPNs)
- Specialist Social Worker/MHO

The Psychological Therapies Service provides access to specialist "talking therapies" for people with mental health needs. The service currently provides a range of psychological interventions, via GP referral, for patients who have moderate to severe distress as a consequence of life events or health conditions e.g. depression, anxiety, personality disorder, suicidal ideation, trauma. The service is delivered by:

- Psychological Therapists
- NHS24 Telephone Service for Guided Self Support and Cognitive Behaviour Therapy

The Community Mental Health Support Service based at Annsbrae House delivers a range of community support services for people who have mental health needs and is proactive in seeking and promoting the views of all those who access this service. Services include:

- Supported Accommodation
- Short break/respite service and Outreach Service
- Skills Centre

There are 8 supported tenancies and one respite place for people living with severe and enduring mental health conditions. The Outreach Service provides support to people with

mental health conditions in their own homes. This service is tailored to individual needs supporting people to live as independently as possible. Support may be provided with a variety of life and social skills, such as cooking, shopping, budgeting and working towards self-help and recovery in daily life.

The Skills Centre offers service users the opportunity to participate in and lead meaningful activities, covering various subjects, both educational and recreational.

The short break/respite service is available to individuals living with a mental health condition. This service provides person centred short term support within a flat in Annsbrae.

Mental Health Officers (MHOs) - qualified social workers - provide support 24/7 implementing the Councils statutory functions with regard to the Mental Health (Care & Treatment) (Scotland) Act 2003.

Dementia is the name given to a form of organic psychiatric/mental illnesses that affect the normal working of the brain. Characteristics of these illnesses are memory deterioration and a reduced cognitive function. The findings of a local Dementia Redesign Project in 2005 highlighted that the number of people in Shetland who will develop dementia will increase. Locality based provision of dementia care and wherever possible in the person's own home remains core to current and future planning.

A specialist diagnostic service for dementia was established in January 2010. The service receives referrals directly from GPs. All referrals are assessed locally by the lead nurse prior to formal diagnosis by an NHS Grampian Consultant specialist in Old Age Psychiatry. The service uses video conferencing facilities to provide "on island" shared care. This model has gained national and international recognition.

The number of violent mentally disordered offenders in Shetland is small. There is an inter-agency approach to working with both violent and vulnerable mentally disordered offenders involving Social Care, Health and the Police.

Specific arrangements are in place for patients requiring specialist Forensic Psychiatry input through the North of Scotland Forensic Mental Health Network.

VOLUNTARY SECTOR SERVICES

Shetland Link-Up - provides support, advice, outreach and drop in facilities to those with mental health issues throughout Shetland.

Advocacy Shetland – provides independent advocates to support and represent vulnerable people. There is a specialist support service for those with mental health problems.

Moving On - (supported employment scheme) identifies work placements and provides support to people on the scheme who have a wide range of needs including mental health difficulties.

Depression Alliance - is a self help group who have regular fortnightly meetings and are now based at Annsbrae House.

Survivors of Sexual Childhood Abuse Information and Resources (SSCHAIR) - is a self-help group, facilitated by a professional care worker, with a help line available.

Mind Your Head - a local charity that aims to promote positive mental health throughout Shetland. Key aims include raising mental health awareness in Shetland; reducing the stigma of mental ill health and promoting positive mental health and well-being.

Alzheimers Scotland - Shetland Branch- local advice, support and organisation of activities that provides for people with Dementia and their carers. The post diagnostic support is a major contributor to the success in Shetland of people with Dementia being able to remain in their own home for as long as possible.

Performance Measures

- Reduce suicide rate (per 100,000 population)
- 18 weeks referral to treatment for Psychological Therapies (percentage of completed waits less than 18 weeks)
- People with a diagnosis of dementia on the QOF dementia register (count)
- All people newly diagnosed with dementia will be offered a minimum of a year's worth of post diagnostic support coordinated by a link worker, including the building of a person-centred support plan (percentage)
- People with newly diagnosed dementia who take up the offer of post diagnostic support (ie have an active link worker) (percentage)

Performance Targets with links to National Outcomes

Measure	**Outcome**
Psychological Therapy HEAT Target	90% of people requiring a psychological therapy intervention will commence treatment within 18 weeks of referral. National Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of service users.
Dementia Diagnosis Standard	The number of dementia diagnoses exceeds 50% of prevalence. National 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.
Dementia Post Diagnostic Support	All people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support. National Outcome 6: People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing.

Off Island Mental Health Activity	The level of "off island" mental health activity will be reduced; fewer people will travel "South" to receive the services they need. National Outcome 9: Resources are used effectively in the provision of health and social care services, without waste.
Reduce Suicide Rates	The number of people completing suicide will reduce year on year. National Outcome 5: Public services contribute to reducing health inequalities

Needs/Unmet needs/Drivers for change

There is limited data on the actual prevalence and incidence of mental health problems and mental illness in Shetland, though GP practices hold registers of patients with serious mental illness (defined as being schizophrenia, bipolar affective disorder or other psychoses as well as dementia).

The Scottish Mental Health Strategy uses European figures to demonstrate the prevalence of mental health problems in the population. Mental illness is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety.

Applying that to the Shetland population, it means that out of 15,000 adults aged 15-65, at least 5,000 will experience some form of mental ill health or distress each year. About 1-2% of the population have psychotic disorders (approximately 150-300 adults in Shetland, which fits with the prevalence from GP data). The ageing population is leading to an increase in the number of people with dementia, 5% of people over 65 (approximately 200 in Shetland) and 20% of those over 80 years of age.

In all countries, most mental disorders are more prevalent among those who are most deprived. The prevalence of mental disorders does not appear to be changing significantly over time, though more people are accessing treatment and support as understanding grows and the stigma of mental illness is reducing.

The Commission on Tackling Inequalities in Shetland[1] heard evidence relating to socio-economic equalities and geography in Shetland. The Foreword states that,

> "Shetland doesn't exhibit the extreme disparities in wealth, health and other indicators that characterise some communities. Nevertheless, the evidence gathered by the Commission confirms that, in 2016, inequality is an inescapable feature of Shetland life. Some of our fellow citizens are struggling. Their circumstances differ, but lack of sufficient money to live a decent life is a common factor. The causes of their difficulties are not simple but it's clear

[1] On Da Level, Achieving a Fairer Shetland, Report and Recommendations from Shetland's Commission on Tackling Inequalities, March 2016

that a variety of influences, including changes in welfare policies, are making their position steadily more precarious.

.... those individuals and families in Shetland who are particularly vulnerable are those:

- with poor educational experiences: engagement is difficult, attainment may be low;
- unable to achieve or maintain employment;
- at risk of homelessness;
- with poor mental health;
- with chronic illness;
- with experience of substance misuse;
- not involved in their local community (this may include not attending pre-school);
- living in remote areas, where employment opportunities are limited and the cost of transport or running a private vehicle can be prohibitive.

And:

- Looked After Children;
- workless or low income households; and
- young.

The 2014 Mental Health Review highlighted a number of unmet needs and service development requirements including; improving access to evidence based psychological therapies and Clinical/Counselling Psychology, support for Adults with ASD, increased availability of OOH psychiatric emergency services and improvements to the facilities available to support those experiencing a psychiatric emergency.

The numbers of people with dementia will increase as the population ages. There is no day care in the evenings or at weekends. People are often not aware of the services available for people with dementia or the support available for carers. It is challenging to take positive risks to ensure people living with dementia live as unrestricted lives as possible. The support of people living with Dementia and exhibiting challenging behaviour or requiring specialist treatment for distressing symptoms linked with the disease is proving extremely challenging in Shetland due to the distance from a mainland specialist unit and the skills required in situ to provide support. Awareness raising is important so that people understand that as their needs change, future proofing their existing home can decrease substantially the need for them to move from their home and that assistive technologies can provide a real safety net in situations where risks require innovative solutions. There is a need to raise public awareness of dementia and encourage people to access advice and support if they are concerned about any mental deterioration.

The key drivers of service change and redesign are the Scottish Patient Safety Program for Mental Health, improved support for Carers, a new emphasis on the importance of Personal Outcomes and growing public pressure for mental health services to match the provision

and responsiveness of physical care services. The Scottish Government "Responding to Distress" initiative and the associated Distress Brief Intervention (DBI) model has also highlighted the potential benefits to patient wellbeing and service effectiveness where frontline healthcare staff are equipped to undertake assessment and signposting of those presenting in distress. Implementing such a model will require a training initiative that will give a wide range of frontline healthcare staff and Third Sector providers, an increased understanding of mental health conditions.

Scotland's National Dementia Strategy 2013-2016 outlines the importance of the provision of support following a diagnosis of dementia, both for the person with the diagnosis and for their families and carers. The 5 Pillar Model of post diagnostic support developed by the Scottish Government and Alzheimer Scotland http://www.alzscot.org/campaigning/five_pillars highlights the key areas that are crucial in delivering this support. Although all five pillars are equally important, the areas that have been found to be especially beneficial are 'Supporting Community Connections' and 'Peer Support'.

People living with dementia need to maintain their links with their own communities and continue to be involved in activities within their communities that help them to maintain their independence as long as possible. The opportunity to meet with other people living with dementia has been shown to be beneficial to a number of people following their diagnosis and helps reduce the stigma that is often associated with dementia. It is equally important that carers of people living with dementia have opportunities to meet with other carers with similar needs to share their experience and support each other. To this end it is crucial that provision of care and services are maintained and developed that help to underpin the five pillars and allow people living with dementia and their carers to access the support that is beneficial to them when they require it.

Plans for change

There is a live action plan that is driving a number of improvements to the service, where those improvements will create better reliance and sustainability. The addition of a Consultant Clinical Psychologist will assist in this work.

The key areas which require focus are summarised as follows:

1. Implement a new service structure so that there is adequate management and professional leadership- by May 17
2. Complete the accommodation moves to bring more of the staff groups together- June 17
3. Complete the production of a Psychiatric Emergency Plan- March 17
4. Provide suitable accommodation for managing mental health presentations in the Gilbert Bain Hospital- June 17.
5. 24/7 availability of staff to de-escalate and physically intervene where disturbed/violent behaviours needing to be managed- May 17
6. Improve access to Primary Care Counselling and Psychology services- March 17

7. Further integrating the health and social care elements of mental health – Dec 17.

Two high profile Scottish Government mental health initiatives have shaped, and will continue to influence, the plans highlighted above. These are: the extension of the Scottish Patient Safety Programme for Mental Health to Community Mental Health Services and a new four year Mental Health Access Improvement Programme. The aim of these initiatives is to ensure all mental health services are safe, efficient and effective so that people can access high quality mental health services in a timely way.

Key Risks to Delivery

There is a national increase in the demand for, and public expectation of, mental health services. The pace and scale of change in this area of service provision presents a significant challenge in a small, remote and rural setting, with pressure on resources. Mainland services are meeting this challenge by enhancing community provision and resourcing the changing focus by disinvesting from inpatient facilities. In the absence of such facilities in Shetland, local services will need to develop capacity in different ways if they are to meet those expectations and deliver safe and sustainable services. The redesign of mental health services requires a resilient workforce with knowledge and skills aligned to the emerging models of delivery.

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Further Reading

The Mental Health (Care and Treatment) (Scotland) Act 2003:
http://www.legislation.gov.uk/asp/2003/13/contents

Mental Health Strategy for Scotland: 2012-2015:
http://www.gov.scot/Publications/2012/08/9714

Shetland Mental Health Strategy:
http://www.shb.scot.nhs.uk/board/planning/MentalHealthStrategy20142024.pdf

Scottish Patient Safety Programme for Mental Health:
http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health

"The Matrix" (NES): http://www.nes.scot.nhs.uk/media/3325612/matrix_part_1.pdf

Shetland Drug and Alcohol Strategy: http://www.healthyshetland.com/resources

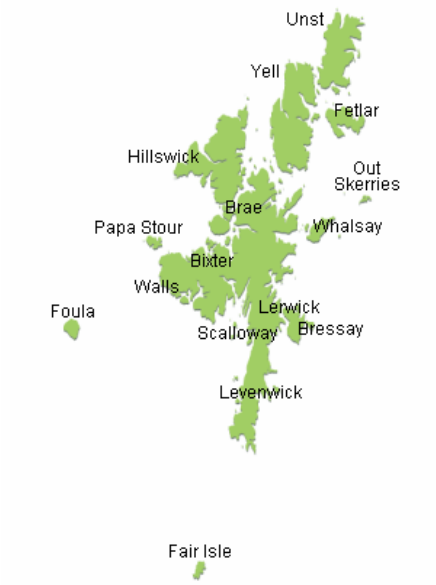
Responding to Distress – DBI:
http://www.chrysm-associates.co.uk/images/DBIpaper8may15.pdf

Equal Partners in Care:

http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partnersin-care/about-equal-partners-in-care.aspx

Carers (Scotland) Act 2016:
http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Carers Bill

Oral Health
2017-18 Public Dental Service Plan



Supporting Community Health and Social Care Departments vision:

“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

Introduction

Every year, each Service within the Community Health and Social Care Directorate is required to produce a Service Plan for the following year. This Service plan contributes to planning for both the Council and the Health Board, and to the Joint Integration Strategy. This Service Plan provides an overview of the Oral Health Service for 2016/17. This plan contains information on major activities, aims, objectives, actions, targets, performance indicators and risks.

Vision Statement

The Public Dental Service (PDS) is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community". This is highlighted by the PDS vision in the Oral Health Strategy called "The Vision of Oral Health for All the people of Shetland" which recognises that each individual is ultimately responsible for their own oral health, and that different age groups in the population have slightly different needs and the vison is summarised in six specific Vision statements.

1. All children in Shetland can develop and shed their deciduous teeth with no significant intervention from NHS dental services, and develop their adult dentition free from the two main dental diseases - dental decay (caries) and gum disease.
2. All adults can maintain a healthy natural dentition through to later life with minimal need for artificial replacement.
3. All age groups of the local population know the causes of common oral health diseases and the measures that can be taken daily to prevent their onset.
4. Effective mechanisms are in place to overcome inequalities in oral health in the local population, with enhanced support and prioritisation being given to disadvantaged individuals and communities.
5. All the population can access high quality, affordable, safe, and effective NHS oral health care services.
6. The vast majority of people requiring specialist oral health care can receive this in Shetland.

Drivers for Change

In 2013/14 the Scottish Government introduced changes to salaried dentistry, combining Community Dental Services and Salaried General Dental Services into the Public Dental Service (PDS). The remit of the PDS, set by Scottish Government, is to:

- provide care for people with special needs, including people who would have difficulties accessing general dental practices
- complement the current General Dental Service and specialist services, especially in remote and rural areas
- have a public health role, and oral health promotion targeted both at populations and individuals
- assess and treat people referred for specialised and specialist services, including the use of sedation and general anaesthesia

In 2016, the Oral Health Strategy 2016-2020 was accepted by NHS Shetland Board and the Integrated Joint Board. The strategy outlines a progression from the PDS providing the bulk of General Dental Service (GDS) provision for the entire Shetland population to providing specialist care for those with additional needs as well as a safety net for those who cannot access GDS independent providers . This evolution will need to be in tandem with the growth of the Independent Dental Sector who will subsume the responsibility for providing the bulk of GDS.

This Service Plan is limited to the Public Dental Service only, unless otherwise stated.

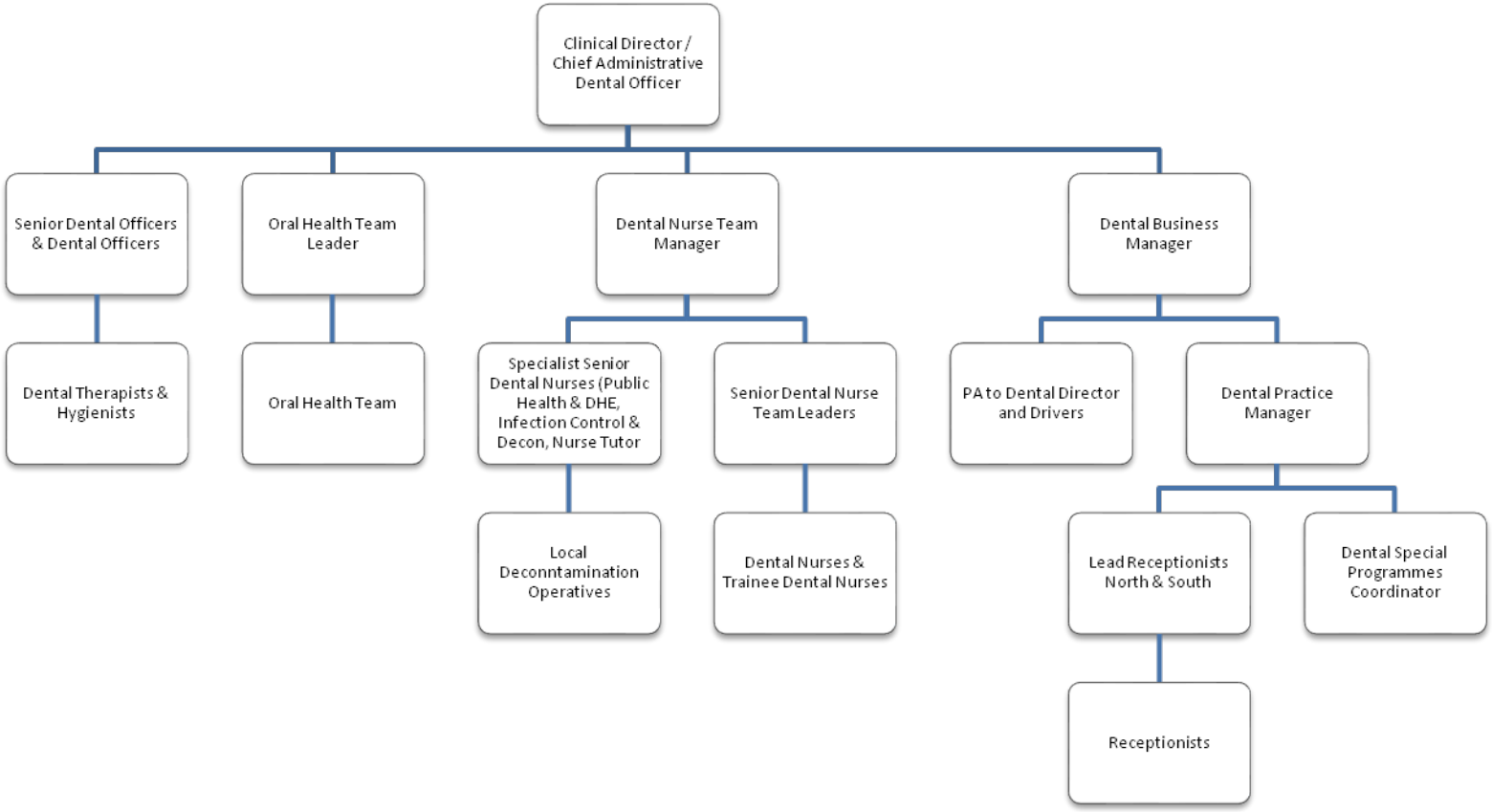
Who We Are

The Public Dental Service employs Dentists, Dental Hygienists &Therapists, Dental Nurses, Dental Receptionists, Trainee Dental Nurses and receptionists, Managers and Administrators, Oral Health Promotion staff, Local Decontamination Unit Operatives and Drivers.

The range of staff is employed specifically to provide:

- Routine clinical primary dental care for people who are registered with the PDS
- Emergency clinical primary care dental services for the whole population, irrespective of whether they are registered or not
- Secondary care oral health services for the whole population – for orthodontics and oral & maxillo-facial surgery in particular
- Dental Public health activities for the whole population of Shetland – through Childsmile, the National Dental Inspection Programme, Oral Health Education and Promotion, Caring for Smiles etc.

Organisational Chart



Locations

The Public Dental Service provides clinical care at three locations in Lerwick - Montfield Clinic, Gilbert Bain Hospital Dental Suite and St Olaf Street Clinic – and three other locations - in Brae, Mid Yell and Whalsay Health Centres. The administrative hub is located at Montfield. Annual dental visits are also held on Fair Isle, Foula and Skerries.

Governance

The Public Dental Service is part of the Community Health and Social Care Directorate and reports to the Integrated Joint Board.

Regulation and Compliance

The role and remit of the Public Dental Service is determined by the Scottish Government, and the Service is expected to fulfil all requirements placed upon it by the Government.

Dentists and Dental Care Professionals (Therapists, Hygienists and Dental Nurses) are registered with the General Dental Council, and practise to the expected Standards set by the GDC. In addition, Dental Care Professionals practise within the Scope of Practice set by the General Dental Council.

The provision and range of clinical dentistry available in the PDS is determined by the Scottish Statement of Dental Remuneration (SDR). This limits what oral health care can be provided through NHS funding, both by NHS-employed dental staff and also by independently-run NHS dental practices. Additional treatments are available from consultant-led secondary care services, or on a private basis from non-NHS dentists.

What We Do

Senior Dental Officers and Dental Officers are responsible for:

Planned Care - Providing routine clinical primary care dental services for people who are registered with the PDS for special care or for GDS oral healthcare.
Unscheduled Care - Providing working hours emergency clinical primary care dental services for registered patients and providing access to out of hours enmergency service for the whole population, irrespective of whether they are registered or not.

Children Services – Providing routine clinical dental care including the delivery of the Childsmile Programme as well as undertaking dental screening procedures required for the National Dental Inspection Programme.
Older People - Providing Dental Screening and oral health promotion in Care Homes, as well as routine oral healthcare for older people

Visiting Consultants from NHS Grampian provide enhanced primary and secondary oral healthcare services for the whole population – this includes orthodontics oral & maxillo-facial surgery and restorative dentistry.

Dental Therapists and Dental Hygienists:

-Provide primary oral healthcare for people who are registered with the PDS within the Scope of Practice for their particular GDC registration.

Dental Nurses and Trainee Dental Nurses:

-Assist Dentists, Dental Therapists and Dental Hygienists to fulfil their clinical duties. The Scope of Practice for Dental Nurses includes the ability to undertake extended duties which includes the application of fluoride varnish, provision of oral health education, taking of radiographs, taking of impressions and the manufacture of orthodontic retainers.

Dental Receptionists and Trainee Receptionists

-Provide the front-line, extra-surgery administrative support for the entire clinical dental team.

Oral Health Promotion team:

- Provide a range of dental public health and health improvement activities for the whole population.
- Carry out Childsmile activities in clinics, schools, and other community settings.
- Carry out Caring for Smiles (C4S) activities in carehomes.
- Provide Oral Health Education to groups and individuals.
- Provide the National Dental Inspection Programme and Childsmile interface.

Local Decontamination Operatives and Drivers:

-Ensure sterilised equipment is always available at all clinic sites

The Managers and Administrative Team:

-Ensure the Service runs efficiently and effectively to maximise the quality and quantity of care provided for the people of Shetland within the available budget.

Our Patients

NHS Shetland has the responsibility to ensure that appropriate oral health care and advice is available for the entire population of Shetland, irrespective of whether they are registered for routine dental care at one of the six sites run by the PDS. There is also responsibility for meeting the urgent/ emergency care needs of visitors and temporary residents.

On 31st January 2017 19,694 people were registered with the PDS for ongoing routine dental care and another 613 individuals wishing to register have placed their names on waiting lists. It is hoped that during 2017-18 both these figures should reduce, as a consequence of patients migrating across to the independent NHS dental practice in Lerwick.

The Emergency Dental Service operates during core working hours to accommodate people needing urgent dental care. This service has been modified to be available to all PDS registered patients. An Memorandum of Understanding has been established between the PDS and Lerwick Dental Practice that unregistered patients will have access to this practice if they require urgent care.

There is an out-of-hours emergency service which incorporates NHS 24 and an on-call dentist to provide advice and access to emergency care. The out of hours emergency service is aligned with SDCEP guidelines to ensure that those who require access to the service can do so in a timely manner. The following are examples of cases which would be able to access the out of hours emergency service.

- People with trauma including facial/oral laceration and/or dento-alveolar bone injuries
- Oro-facial swelling that is significant and worsening
- Post-extraction bleeding that the patient is not able to control with local measures
- Dental infections that have resulted in acute systemic illness and raised temperature

Activities such as the Childsmile programme reach to every child in Shetland and their parents/carers, and Caring for Smiles reaches the older population.

Funding and resources

The current funding and resources reflect that the PDS is currently providing routine General Dental Services care to Shetland in addition to the PDS's own remit. As such, these are liable to change more when more local independent NHS dental practices open.

Aims

The Aims and Objectives of the NHS Shetland Public Dental Service are outlined :

Service Aims/Priorities	Objectives/Actions
To undertake a core PDS and GDS oral health provision for the population of Shetland that remains within budget.	- To prioritise those patients with additional clinical or care needs who require access to the PDS. To include: - Special Care Patients - Vulnerable patients - Children - To utilise any spare capacity to provide a core GDS capability for the population of Shetland.
Develop patient access to PDS services within the wider PDS remit, in parallel with the expansion of the local independent NHS dental sector to provide the majority of GDS oral healthcare provision.	- Use any clinical capacity released by the establishment of a local independent NHS practice to develop - more proactive PDS care for people with special and/or additional needs - more specialised services to reduce reliance on Grampian - To intergrate the principles of NHS Shetland 2020 Vision of community based health and well being into the future delivery of oral healthcare.

Oral Health Service Plan 2017/18

Service Aims/Priorities	Objectives/Actions
A continuing emphasis on prevention to people of all ages. a. Maintain/increase Childsmile activities to meet new Scottish Government targets for caries-free P1 and P7 children (raising target to 89% and 87.8% respectively by 2022) b. Maintain/ increase Caring for Smiles activities.	- To formulate and oral health promotion/prevention strategy specific aligned to the Oral Health Strategy - To ensure prevention is undertaken in accordance with contemporary clinical guidelines. - To review frequency of participation of children with the dental team - To review if skill mix can be further utilised to enhance the preventative programme - To ensure Care Homes are engaged within the Caring for Smiles activity. - To investigate how oral promotion can be undertaken locally and within the community setting. - To establish a children's dental risk register which will be used to target prevention and intervention at those who carry the burden of the dental disease risk in Shetland
Build the capacity of primary dental care services to meet the oral health care needs of the whole population, including Occasional urgent treatments for visitors and temporary visitors. a. Encourage an equitable spread of independent	- Engage with Scottish Government to ensure that Scottish Dental Access Initiative funding is still applicable for areas in Shetland where we would like to develop capacity. - -To work with local practices to build capacity and capability across the whole of Shetland. - To maintain annual visits to outlying areas and to scope the possibility of treatment being undertaken in these areas.

Service Aims/Priorities	Objectives/Actions
NHS dentistry across the islands. b. Recognise the PDS will keep a “safety net” role especially in the more remote locations including the populated islands.	- To ensure that the PDS remains fit for purpose for undertaking GDS work in areas that cannot access independent NHS dentistry. - To ensure that the emergency dental service is fit for purpose. - To build capacity aligned with Scottish Government direction that this is done in the best environment for the patient. - To ensure that primary dental care services is patient focussed and aligned with the values of realistic medicine.
Support independent NHS dentistry, including a focus on quality.	- To engage with independent NHS Practices to ensure that a Quality Agenda is implemented through all NHS practices in Shetland. - To ensure that there is appropriate use of DPAs to ensure that all NHS practices in Shetland are benchmarked to the national standards for provision of quality NHS dentistry. - Robust oversight of and support for the independent sector growth in Shetland. - Support the Area Dental Committee as a forum for the coordination of local NHS dentistry and maintaining clinical quality - To oversee and support the NHS practitioners clinical audit system. - To implement a peer review system for all dentists and Dental Care Professionals undertaking NHS practice. - To ensure that there is a pathway for dealing underperforming practitioners.

Service Aims/Priorities	Objectives/Actions
Develop an Island-wide training plan and a continuing development plan for clinicians.	- To undertake an annual training needs analysis for dentists and coordinate local Section 63 courses to ensure that they are appropriate for all NHS clinicians in Shetland. - To undertake a training needs analysis for all Dental Care Professionals that will be underpinned by the concept of skill-mix. - To provide an enduring training pathway for the provision of Childsmile activities to ensure that they are appropriate and aligned with contemporary Scottish Government direction and guidance. - The PDS will be the focal point for the provision of core Continuing Professional Development opportunities for all individuals involved in the provision of NHS dentistry.
Develop a range of local clinicians able to provide complex care, in particular people with expertise in orthodontics, oral surgery, special care dentistry, paediatric dentistry and perhaps restorative dentistry	- To scope the delivery of Level 1+/Level 2 services for orthodontics, oral surgery, special care dentistry, paediatric dentistry and restorative dentistry on-island. - Engagement with Managed Clinical Networks to bridge current capability gap and future service provision. - Investigate the future utility of collaboration with neighbouring health boards in planning for the specialist aspects of oral health care.
Review orthodontic provision in Shetland to substantially improve access, and to reduce the	- Scope all possibilities for the provision of an Orthodontic Service in Shetland. - To ensure that current patient referrals into the orthodontic service are

Service Aims/Priorities	Objectives/Actions
risk of service failure	appropriate.
Encourage the establishment of a Dental Technical Laboratory in Shetland.	- To scope the real estate, equipment and manpower requirements to establish a dental laboratory in Shetland. - To engage with local business support services to seek their views on developing such a business. - To learn lessons from other Health Boards who have taken on such a venture.

Detailed Actions/Plan for Change

Ongoing Actions/Projects Started prior April 2015					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Encourage/facilitate at least one new independent NHS dental practice to open in Shetland	CADO & CADO/DBM	2015	3/2018	An increase in dental capacity outside the management of the PDS	Will relieve PDS access difficulties by re-registering existing PDS patients, and also take unregistered people from the PDS registration waiting list.

New Planned Actions Due to Start in 2017/18

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
To draft an NHS Shetland PDS Oral Health Promotion framework aligned from 2016-2020	CADO, OHITL		7/2016	NHS Shetland Oral Health Promotion Framework	An framework which will direct Dental Public Health/Oral Health Improvement work aligning it to the Oral Heath Strategy aims and wider NHS Shetland strategies to improve oral health and decrease health inequalities.
To publish a use of fluoride protocol for all NHS practices in Shetland (in accordance with national guidelines)	CADO/OHITL		6/2017	More effective use of topical vehicle for exposure to fluoride	Increase in the number of caries-free children.
To scope the risks/benefits of undertaking a fissure sealant programme for children in Shetland.	CADO/OHITL		6/2017	Increased utility of fissure sealants as part of a caries prevention regime.	Increase in the number of caries-free children especially within the NDIP P7 age-group.
To scope a project for direct engagement with schools to promote oral health promotion principles and healthy eating	CADO/OHITL		6/2017	Schoools engaged in a local healthy eating/tuckshops programme	Decrease children's exposure to cariogenic food as well as algning with a Common Risk Factor Approach to combat other child health areas (eg obesity)
To publish a synopsis on the current NICE guidelines for the recall of	CADO/OHITL		6/2017	Providing access to oral healthcare for those	Increase the number of caries-free children especially within the NDIP

New Planned Actions Due to Start in 2017/18

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
children iaw their caries risk and to align the PDS to this guidance.				who need it most.	P7 age-group.
To implement a child dental risk register	CADO/OHITL		06/17	To ensure that those carrying the burden of dental disease are engaged by the dental team appropriately.	Decrease caries incidence and decrease health inequalities.
To engage regularly with local independent practices to ensure those children be deemed to be high caries risk are participating adequately.	CADO/OHITL		12/17	To engage with practices on a quarterly basis and to host a formal Childsmile event on an annual basis locally.	Decrease caries incidence and decrease health inequalities.
To implement an annual training programme for all care home staff and older person carers iaw the Caring for Smiles Programme.	CADO/OHITL		03/18	To ensure all care homes receive a visit from the Caring For Smiles Team annually.	To decrease health inequalities.
To monitor PDS and Independent registrations and “pinch-point” areas for access to GDS care to accurately inform the SDAI process.				Review of registration statistics on a quarterly basis.	To improve access to oral healthcare.
To produce a remote island examination protocol which will facilitate on-island examination in	QIG		12/17	A PDS protocol outlining provision of oral healthcare to the	To improve access to healthcare and decrease health inequalities

New Planned Actions Due to Start in 2017/18

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
outlying areas, and prioritise mainland appointments for those requiring further oral healthcare.				remotest areas of Shetland.	
To ensure all PDS practices are compliant with CPI practice inspection regulations.	QIG		07/17	All practices CPI compliant	Quality Assurance of PDS Dental Practices.
To review the emergency dental service and produce a report assessing its fitness for purpose.	QIG		07/17	An review report outlining that the EDS for Shetland is effective and efficient	Quality Assurance of PDS Activity.
To use the CG framework to undertake patient quality assessment of the service provided and to encourage independent practices to do the same.	QIG		03/18	A Patient Quality Assessment of the PDS aligned to the values of realistic/patient-centred healthcare	Quality Assurance of PDS Activity.
To formulate a robust clinical audit policy and process for all practitioners undertaking GDS provision in Shetland	QIG		12/17	All PDS clinicians engaged in an audit cycle to ensure they achieved their mandated hours for Quality Improvement audit work.	Quality Assurance of PDS Activity.
To undertake annual appraisal for all PDS dentists.	CADO		07/17	To ensure all dentists have an opportunity to be developed to their potential.	Quality Assurance of PDS Activity.

New Planned Actions Due to Start in 2017/18

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
To produce a review and options paper of current provision of OMFS, Special Care dentistry, paediatric dentistry and restorative dentistry.	QIG		04/2017	An options paper which will dictate a way forward for future provision of Level 1+ services in Shetland	Service Quality Improvement.
To produce a separate review and options paper for the provision of an Orthodontic Service for Shetland (in conjunction with Ortho Consultant).	QIG		03/2017	An options paper which will dictate a way forward for future provision of orthodontic services in Shetland.	Service Quality Improvement.
To produce a scoping paper for the establishment of a dental laboratory in Shetland and a subsequent options paper for the provision of dental laboratory work within NHSS.	QIG		03/2018	Possible establishment of a dental laboratory in Shetland	Service Quality Improvement.
To review the role of skill mix and upskill within the dental team to enhance oral health promotion and clinical effectiveness within the dental team.				A stable and sustainable manpower prfile aligned to NHS Shetland 20:20 vision of care in the best environment for the patient.	Improved patient outcomes

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plan.

Risks to Delivery

The shortfall in primary dental care capacity – reconfiguration of the PDS is predicated on adequate growth of the independant NHS sector in Shetland. The rate of this growth will dictate the momentum of change within the PDS as described in the Oral Health Strategy.

The geographical isolation of remote, rural and island communities, challenges the cost-efficient provision of oral health care. Patient perception in a rural environment can also impact on service delivery. If patients do not want to register with independant providers then this will impact on service capacity.

The increasing number of elderly people requiring domiciliary visits for high-maintenance dental care of their own teeth.

The ability to recruit suitably experienced dentists to build sustainable, long-term dental services for Shetland residents.

Performance Indicators

Performance Measure	Performance 2013/14	Performance 2014/15	Performance 2015/16	Target 2017/18
Planned Care - Providing routine clinical primary care dental services for people who are registered with the PDS for special care or for GDS oral healthcare.				
The ratio of the wte of primary care dentists providing NHS oral health care to the total resident population of Shetland at the end of the year	1:3013	1:2500	1:2438	1:2000
The percentage of the adult and child populations who are registered with Shetland dentists for NHS dental care	-	88.06%	Adults: 84.7% Children: 94.4%	Adults: 90% Children: 95%
Level of unmet capacity: Numbers of people on waiting lists to register for		1120	613	Nil by end FY 2017/18

Performance Measure	Performance 2013/14	Performance 2014/15	Performance 2015/16	Target 2017/18
NHS dentistry				
Percentage of Shetland population registered with Independant NHS Practices.	N/A	N/A	6.5%	20%
Children Services – Providing routine clinical dental care including the delivery of the Childsmile Programme as well as undertaking dental screening procedures required for the National Dental Inspection Programme.				
The percentage of newborn children in Shetland enrolled into the Childsmile Programme				
The percentage of P1 children who have consented to participation in the Fluoride Varnish Application programme			78%	90%
The percentage of P1 validated and consented children receiving at least one Fluoride Varnish Application per annum.			93%	90%
The percentage of schools in Shetland having access to the National Dental Inspection Programme for P1 and P7 pupils.			100%	100%

Performance Measure	Performance 2013/14	Performance 2014/15	Performance 2015/16	Target 2017/18
Percentage of P1 Children in Shetland with no obvious decay.			79.4% (Scottish Average 69.4%)	88.1% by 2022
Percentage of P7 Children in Shetland with no obvious decay		80% (Scottish Average 75%)		Increase from 80%
Decay experience of children in P1: The mean dmft (decayed, missing or filled teeth per child) of children aged 5-6 years in P1 attending SIC primary schools.	dmft 0.64 (Scottish av dmft 1.27)		dmft 0.7 (Scottish Average: 1.21)	Less than 0.7
Decay experience of children in P7: The mean dmft (decayed, missing or filled teeth per child) of children aged 10-11 years in P7 attending SIC primary schools.		0.42 (Scottish Average: 0.44)		Less than 0.42
Those children deemed to be at higher risk as assessed by being on the Dental Risk Register are recalled in accordance with current SDCEP Guidance.				90%

Oral Health Service Plan 2017/18

Performance Measure	Performance 2013/14	Performance 2014/15	Performance 2015/16	Target 2017/18
Unscheduled Care - Providing working hours emergency clinical primary care dental services for registered patients and providing access to out of hours emergency service for the whole population, irrespective of whether they are registered or not.				
The percentage number of days when out of hours dental cover is available to the Shetland population.				100%
The percentage of emergency patients dealt with in accordance with SCEP timeline guidance				100%
Older People - Providing Dental Screening and oral health promotion in Care Homes, as well as routine oral healthcare for older people				
Percentage of Carehomes who have at least one individual who has completed foundation training with the Caring for Smiles Team				100%
Percentage of Carehomes with a Caring for Smiles/Oral Health Champion				50% (by 2019)
Percentage of Carehomes who have had a dentist visit			100%	100%

Contact Details

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Service Plan – Pharmacy

Policy context

The Pharmacy and Prescribing Service is committed to supporting the Community Health and Social Care Directorate's Vision of "Ensuring that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community*".* The Pharmacy Vision statement which facilitates this is drawn from the Scottish Government *Prescription for Excellence* states, "that everyone should receive the same standard of pharmaceutical care, regardless of where they live"*.*

Prescription for Excellence builds on the Government's 2020 Vision Route Map and Quality Strategy Ambitions. It recognises pharmacists as experts in the therapeutic use of medicines and highlights their potential contribution through integration into health and social care teams. Over the next three years significant changes will occur in medicine and therapeutics. These changes necessitate the development of new and innovative models of care to enable patients to obtain maximum benefit. The Scottish Government is committed to implementing the National Clinical Strategy and with the associated move towards Realistic Medicine in order to achieve this. The process is starting and in 2017 the Montgomery report will be published which will give direction on how medicines should be selected for use in Scotland.

Pharmacists will have a key role in this. Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and reduce the likelihood of adverse events.

Current Services

The pharmacy service exists in Shetland to provide expertise on medicines and to make them available in a safe and effective way. The service is based in Health and Community Care, but provides in-reach services into the Acute sector, particularly to the Gilbert Bain Hospital.

Within the hospital, the modern pharmacy service operates in line with standards laid down by the Royal Pharmaceutical Society, which includes: procurement and dispensing, teaching junior doctors, medicine reconciliation, providing safety and clinical checks, providing information and support to all prescribers. Many patients are now treated with hospital type medicines in their own homes, these high-tech medicines include those supplied directly to patients by Homecare companies and the service provides governance around this process.

Increasingly also the pharmacy activity is designed to support General Practices in demonstrating safe and effective prescribing. Dispensing practices receive input from pharmacists in line with *Prescription for Excellence.* The need for pharmacy staff to be working within Care Homes and patients own homes is increasing, helping to ensure patients are receiving medicines safely and that waste is avoided.

The pharmacists clinical skills are being utilised in prescribing clinics, these clinics run by pharmacists, such as polypharmacy reviews which are designed to minimise the harm and maximise the effect of medicine regimes.

The traditional role of the community pharmacist is being developed through community pharmacies to ensure the continuity of contracted arrangements including: the delivery of safe and effective dispensing, patient safety programmes, a modern substance misuse service, Minor Ailments Service, Public Health Service and the Chronic Medication Services

Contribution to Local Delivery Plan priorities

The ambition of the pharmacy service is to support NHS Shetland in achieving the 2020 vision and the plan therefore reflects the Local Delivery plan (LDP) which strives "*to deliver sustainable high quality, local health services, that are suited to the needs of the population; to make best use of our community strength, community spirit and involvement; for people to make healthy lifestyle choices, and to use their knowledge and own capacity to look after themselves and each other".*

This plan is particularly focussed on Safe and Person Centred Care and specifically Pharmaceutical Care delivered in both the *Scheduled* and *Unscheduled* settings.

Safe Care

Pharmacy is committed to supporting the Scottish Patient Safety Programme (SPSP) both within the Acute setting and the Integrated Joint Board. The priority is to expand efforts in respect of medicines reconciliation. We have recruited a fulltime pharmacist to the largest practice which has resulted in medicines reconciliation for all patients discharged from hospital within that practice which covers just under half of the population of Shetland. The appointment of this pharmacist has freed up time for other pharmacists to concentrate their effort in the remaining practices within Shetland. The pharmacy service contributes to several aspects of SPSP within the multi-disciplinary team. Safe prescribing is also promoted measured within antimicrobial treatment.

We will ensure that resources are directed towards those aspects of patient safety that appear to be in need of some improvement particularly discharge arrangements and the transfer of information between primary and secondary care, and the use of medicines which are known to have risks in use. We will ensure that we contribute the National safety initiatives including the reporting of antibiotic use and the use of the Yellow Card System.

Person Centred Care

Person centred care is at the heart of what a modern pharmacy service is. At a local level we have been developing systems, with a specific focus on identifying areas for improvement and affirming that fundamental standards of care and service are being met. This work has included, developing clear governance arrangements to support staff to gather, utilise and report on improvements through patient feedback. We will continue to work closely with the Public Partnership Forum (PPF) to develop areas of joint working e.g. projects in Primary Care and Mental Health services generating ideas for improvements and actions that can be delivered collaboratively. We will continue to involve patients representatives in decisions made by the Area Drug and Therapeutics Committee and have fully participated in a further radio series called 'Heart Beat' which includes contributions from patients, staff, third sector organisations and is organised and presented by PPF.

The development of governance and quality framework in pharmacy has led to improvements being made and we will strive to introduce patient views within an improvement cycle and using feedback

pre and post intervention as a means of understanding the impact of changes that we have made, e.g. we are currently contacting patients post discharge and proactively contacting patients with complex medicine regimes to ensure they have the information, pharmaceutical care, and support that they require.

The person centred care principles are explicit in our pharmacy governance and quality framework – the greatest focus in terms of improvement work has been on older people's services and long term conditions but we are expanding the scope of this work to include mental health/dementia and primary care service services.

We will continue to focus on medicines waste through local publicity and direct action through the utilisation of pharmacy technician in the community. These technicians adopt a person centred approach and help to optimise the patient's wishes and understanding within a holistic approach of self management and pharmaceutical care.

The use of technology, such as remote dispensing and innovative use of VC is reducing unnecessary patient travel allows the person centred care agenda for personal outcome approaches for patients living in more remote areas of Shetland.

Plans for 2016-17 include:

Contribution to Strategic / Cross Cutting Themes (as required)

The Pharmacy plans support the delivery of national outcomes. Community Pharmacies are being encouraged to support people as they look after and improve their own health and wellbeing. Pharmacist and Technicians also need to be available in order to support people with their medicines. This is true particularly for those with long term conditions or who are frail and live at home or in a homely setting in their community.

As *realistic medicine* becomes established, people who use health and social care services will increasingly need support as they make choices about their medicines. Investment in medicines is appropriate when followed by positive experiences of those medicines. Choice needs to be centred on helping to maintain or improve the quality of life of people who use services. And as people using services need to be supported so carers and those who provide unpaid care need advice and support.

As medicines are increasingly potent, and medicine regimes increase in complexity, review of treatment is increasingly important. This is the area where a pharmacists skills will be increasingly needed. People using health and social care services should be kept safe from avoidable harm. Polypharmacy reviews and general medicine reviews reduce harm and also help ensure resources are used effectively and efficiently in the provision of health and social care

Needs/Unmet needs/Drivers for change

Over the next few years significant changes will occur in medicine and therapeutics. These changes necessitate the development of new and innovative models of care to enable patients to obtain the maximum benefit. Pharmacists will have a key role in this. Pharmaceutical care is a key component

of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and reduce the likelihood of adverse events.

Patients, regardless of their setting or where they live should receive high quality pharmaceutical care. This is particularly important for patients with complex health issues including multimorbidities and those living in care homes. Going forward, pharmaceutical care provision should complement and support dispensing doctors' services and their patients, with a shifting emphasis towards enhancing safety and pharmaceutical care.

These aspirations will result in clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners

An essential role of the clinical pharmacist working within the team will be to initially assess the patient for potential issues to help inform the choice of medication. In addition they will be responsible for the continual monitoring of the effects and side effects and making adjustments to dose.

The NHS continues to face increasing workforce pressures. The inclusion of NHS accredited clinical pharmacists into the primary care team is intended to increase the clinical capacity and assist in addressing the growing demands in primary care, particularly as our population in Shetland ages, and the complexity of their care increases.

Assessing and forecasting medicine needs of patients before prescribing, following treatment plans and to judge when risks overtake benefits will be increasingly important as the population ages and long term conditions

Plans for change

The Scottish government has allocated specific funding to recruitment of pharmacists. This is partly in response to the difficulties in recruiting GPs and is also in recognition of the particular skill set which pharmacists have. There will also be a local requirement to invest further in technicians. Technicians in particular will help to realise savings, and there are significant savings opportunities for Shetland if investment can be identified.

Pharmacists will continue to increasingly focus on supporting the clinical and quality aspects of prescribing, often this happens best in the acute setting, a Prescribing Action Plan is in place which has a primary focus on quality prescribing as the best evidence indicates that quality prescribing is efficient prescribing.

A 5 Year Strategic Prescribing Program has been established.

The program will achieve the following service outcomes:

- To ensure there is an effective medicines management approach in place across pharmacy in Shetland, which mindful and efficient prescribing is part of.

- To ensure that our systems and processes are fit for purpose and as lean as possible in order to reduce waste

- To increase multidisciplinary working

The change outcomes will be:

- A focus on services delivered for customers that make improvements to the customer's experience of services
- Adherence to evidence based care pathways including re-ablement
- Evolution, building on what has been achieved so far
- Improved efficiency and value for money; providing efficiency savings for the public sector in Shetland
- Reduction in bureaucracy; eliminating duplication and improving the speed of decision making
- Adoption of one system and using national systems where they provide Best Value

Savings will be sought, not by a cost driven approach but by a strategic approach to quality and effective medicines management.

Within 5 agreed workstreams the priority projects are:

  - Safe transfer of medicines on admission and discharge
  - Pharmacists or nurse led interventions for high risk patients groups/patients
  - Develop the pharmacy technician role
  - Biologicals/Biosimilars
  - Diabetes prescribing
  - Respiratory Prescribing
  - Polypharmacy
  - Non clinical medical reviews
  - Review of the repeat prescribing system
  - Paracetamol Prescribing

- **Key Risks to Delivery**
  Recruitment
  Tardy investment
  Clinical engagement
  Short term thinking

- **Performance Targets with links to National Outcomes**

Performance Measure	**Latest Performance 2016-17**	**Target 2017-18**
Cost per patient (GP Prescribing) should be less than Scottish average ie less than 100% (national outcome 9)	97.1%	100%
Number of prescriptions for antibiotics per 1,000 patient population should be less than the Scottish average ie less than 100% (national outcome 7)	104%	95%
Number of polypharmacy reviews completed per	46	40

month (national outcome 7)		
Percentage of patients who's medicines are reconciled within 72 hours of admission per month (national outcome 7)	57%	75%
Number of medicines dispensed out of hours by nursing staff should be less than 50 per month (national outcome 7)	31	48

Contact Details
The pharmacy department can be contacted on 743370.
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Further Reading
The pharmacy and prescribing services has pages on the NHS website.
National Polypharmacy guidance describes the national context for planned pharmacy work within the context of the national Pharmacy vision and work plan, Prescription for Excellence.

Service Plan – Primary Care

Joint Strategic Commissioning Plan 2017 – 2020

Policy context

- Integration of health and social care and implementation of Health and Wellbeing Outcomes.
- Introduction of a new GP contract during 2017/18
- Primary Care strategy (implementation plan)
- National Out of Hours review implementation

Primary health care services will be required to adapt to meet the health care needs of an ageing population that has rising expectations of health care and treatments. Other factors that affect the development of services include statutory guidance on working hours, rising professional standards and a shortage of health care professionals.

The key drivers for looking at how primary care operates are:

- We want to improve the health of the people in Shetland and ensure healthcare services are meeting public expectation;
- There is greater demand on local health services in part due to an aging population, with greater health needs;
- A hospital setting is not always the answer; more care can be delivered in primary care and community settings than ever before and patients benefit from care provided closer to their home;
- There are workforce challenges (for example recruitment of GPs) which currently affect delivery of the best quality care and optimal patient outcomes;
- We need to adopt new models of care and best practice which can deliver better health outcomes for patients;
  We want to ensure care is safe, effective, efficient and patient centred.

Current Services

Traditionally, the "four pillars" of Primary Care have been GP Services, Pharmacy Services, Dental Services and Ophthalmic Services. There are separate dental and pharmacy departments in Shetland and these are therefore not covered in this section.

For GP Services, there are currently ten Health Centres in Shetland, together with five non-doctor islands which are staffed by Community Nurses and who receive GP services from a local health centre. Of the ten GP Practices, four are directly salaried to NHS Shetland (all staff are employed by NHS Shetland), a further practice will become salaried from January 2017 and the other five are what is known as independent practices – this means they contract with NHS Shetland to provide core GP services to their practice population, for which they receive funding worked out through a national formula and it is the responsibility of the independent GP practice to decide how to use this funding to provide the contracted services. It should be noted that the NHS in Scotland will see the introduction of a new GP contract in 2017/18, although details on the format of this new contract are still to be released. It is expected that substantial work will be required across Scotland to introduce the new contract and Shetland will be no different in this regard; there were transitional arrangements in place for 2016/17 and this service plan will be updated once the detail of the contract has been negotiated.

Within Ophthalmic services, there are three providers of general ophthalmic services in Lerwick, which are open to all Shetland residents. There are also visiting Ophthalmic Consultants who hold clinics in Gilbert Bain Hospital for patients referred to them with complex eye problems. NHS Shetland contracts with NHS Grampian for the provision of an Optometry Advisor role, with the Optometry Advisor undertaking three yearly Ophthalmic Premises inspection visits in conjunction with the local Primary Care Manager, in addition to being a member of the Eyecare Managed Clinical Network. The most recent visits were completed in September 2015 and will be undertaken again in 2018.

- **Contribution to Strategic / Cross Cutting Themes (as required)**
  Primary Care teams work with a range of individuals, which includes patients and carers and work closely with Health improvement colleagues. There is ongoing work looking at self care and self management, as part of a project being taken forward by Public Health colleagues.

- **Staffing**
  Please note that workforce figures for independent practices are not available as staff in these practices are not employed by NHS Shetland.

- **Needs/Unmet needs/Drivers for change**
  Primary Care has been set a savings target for 2016/17 of £275,000. This will be across all areas of the budget although the actual detail of savings will not be examined until after the publication of the primary care strategy.

  Drivers for change:
- The Primary Care Strategy implementation plan sets out the need to explore different service delivery models within existing resources;
- There is variation in opening times, different appointment systems and waiting times for appointments between practices;
- There is variation in additional services provided, for example enhanced family planning and minor surgery;
- There are current difficulties with balancing the requirements to provide enough appointments to meet demand within waiting times, with the need to spend sufficient time with patients;
- There are geographical issues, which may influence ease of access;
- There are noticeably different arrangements in hours and out of hours;
- Recruitment and retention has proven to be problematic in recent years, across all Practices in Shetland. It is not unusual for there to be several rounds of advertising and it is becoming more difficult to recruit staff who wish to work in a remote and rural location;
- Two practices have requested a move from independent to salaried in 2016/17 owing to viability and recruitment concerns;
- A changing workforce profile and changing skills set needed for new models of care;
- Changes to secondary care provision in terms of services now being offered through primary care providers rather than the hospital;
- Inequity of funding provision across Primary Care in Shetland;
- Clinical/medical innovations and improvements such as telehealth.

- **Plans for change**

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
Implement 2017/18 GP Contract and QOF amendments	Lisa Watt	April 2017	All Shetland practices to have a contract based on 16/16 contract and transitional arrangements once issued by Scottish Government. (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Plan and negotiate for implementation of new GP contract for 2018/19 once the detail has been agreed and notified to Boards.	Lisa Watt	April 2016	Smooth implementation for go live date of 1st April 2018, ensuring seamless transition and no disruption to services (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Develop capacity to do prevention, early intervention, supported self-management and anticipatory care planning effectively	Primary Care Manager/LMC/Health Improvement	March 2017	There are several pieces of work underway looking at self management and anticipatory care planning is a major feature of the new GP cluster model which has been introduced in 2016/17. (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Develop a comprehensive website with links to self care advice for common conditions	Health Improvement/LMC/IT	March 2017	Links with action above. The existing NHS website has links to NHS24 self care, the NHS Shetland self care leaflet, NHS Shetland

			Health Improvement and "Know who to turn to". (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Recognise the value of and invest in good quality administration, management and clinical leadership in Primary Care	DCHSC/Medical Director/Primary Care Manager	Dec 2016	There is currently no Lead GP for Primary Care in Shetland, although there is a Cluster Quality Lead under the new transitional year arrangements (H&WO 4, 5, 7, 8, 9)
Increase the role and availability of Pharmacists in Primary Care	Director of Pharmacy	March 2017	Ongoing piece of work – external funding has been secured for a fixed period to provide additional pharmacy support to general practices (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Improve the recruitment and retention of GPs in Shetland	Primary Care Manager/Medical Director/LMC	March 2017	Shetland is part of a remote Scotland group which successfully bid for monies for a National Remote & Rural Scottish website. This section will be updated as the work progresses (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Influence partner organisations such as Scottish Ambulance Service, Shetland Islands Council with regard to transport issues and Scottish Government on national policy that	Medical Director/Head of Planning & Modernisation	March 2017	Other services to understand the impact of any service changes that they plan or make, and to put in

will affect local services			mitigations where there is adverse impact for health services or for the health of local communities (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Actively pursue schemes such as Remote & Rural Fellows Scheme	Medical Director		There were no applicants for the Remote & Rural Fellow Scheme in Shetland in 2016, a further advert will be placed for the 2017 scheme. (H&WO 4, 5, 7, 8, 9))
Increase the number of training practices in Shetland	Medical Director/LMC	Dec 2016	(H&WO 4, 5, 7, 8, 9))
The development of a locality primary care team to include GP roles as envisaged in the new GP contract, pharmacy, and health improvement practitioner time, working with community nursing, social care and other professionals such as OT to develop a more integrated model of health and social care, as part of integrated locality working	Community Health & Social Care operational team		Discussions regarding locality service models underway; detail on the new GP contract is not yet known and will be incorporated into this action plan once this is available (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Provide skills development and training	Medical Director/LMC/Staff Development	Mar 2017	This should include a structure which provides guidance on roles and responsibilities, including specifically 'end of life' conversations and the use of advanced directives, primary/ secondary prevention, supporting self-

			management with assets-based approaches, and an holistic approach to primary, community and social care. This action has been given a timescale of March 2017, in recognition that the training schedule for 2016/17 will already be in place. Medical Director has held discussions with GPs on the possible format of future training and is collecting responses. (H&WO 4, 5, 7, 8, 9)
Understand how we can use existing communication structures and pathways more effectively, or reform them to meet the needs of Shetland;.	Medical Director/LMC	Dec 2016	For example, consider how we use representation on professional consultative committees, how well they engage, or changing the way they work to make communication easier, quicker and more effective (H&WO 4, 5, 7, 8, 9)
Consider development of additional GP with Special Interest roles as part of repatriation of services back to Shetland	Medical Director	Dec 2016	Where it is possible to enhance GP roles by offering special interest roles this should be done, on the understanding that this can make existing GP roles more attractive but at the same time backfill will be required

			to free up GPs to do this work. (H&WO 4, 5, 7, 8, 9)
Use the planned Review of Nursing in the Community to develop the nursing workforce so that there is an appropriate skill mix including healthcare assistants, nurses working at the top of their licence, including a range of specialist practitioners – specialist nurses, advanced nurse practitioners and nurse prescribers	Chief Nurse (Community)	Dec 2016	The Review of Nursing has already commenced and this action will be taken forward directly as part of that project (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Develop collaboration between practice and community nursing, recognising community nurses as part of the core primary care team, to make best use of the range of skills available.	Chief Nurse (Community)	Dec 2016	The Review of Nursing has already commenced and this action will be taken forward directly as part of that project (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Review the nursing service provided to remote areas as part of the planned project for Review of Nursing in the Community, and take account the views of the responsible GPs in doing that	Chief Nurse (Community)	Dec 2016	The Review of Nursing has already commenced and this action will be taken forward directly as part of that project (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Implement the national Out of Hours review locally in a way that will improve primary care delivery in Shetland, particularly in terms of access to services for unscheduled care, and GP recruitment and retention	Medical Director	Mar 2017	A local Out of Hours review is already underway and this action will be taken forward directly as part of that project. This action will also include the need to work with the Scottish Ambulance Service to understand the gaps in on-island transport. (H&WO 1, 2, 3, 4, 5, 6,

			7, 8, 9)
Develop service models for Shetland to suit the local context	LMC/Primary Care Manager/Medical Director	Mar 2017	This should include small practices that work well in serving small and isolated populations, collaboration between practices in shared service or confederated models, ensuring that larger practices maintain or develop systems for continuity of care for patients and a close working relationship with their locality, ahead of a more integrated approach to locality teams when the new GP contract is introduced. This will also include reviewing how primary care resources (both services and staffing) are distributed across Shetland (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Develop an ambitious programme in the use of IT to support single system working, for instance one IT-supported remote access, and one single electronic record	IT/Medical Director/LMC	March 2017	Work is in hand looking at a single electronic record, primarily around the use of EMIS web. This will be a national framework model available in 2017 (H&WO 3, 4, 5, 7, 8, 9)

- **Key Risks to Delivery**
  Brief details of any risks that threaten the delivery of services and what is being done to address/mitigate these risks.

Risk	Mitigation
GP Recruitment across Practices in Shetland	Different types of advertising are being used, including Facebook and attendance at the RCGP conference to promote Shetland as a place to work and live. Promote Shetland and NHS Shetland have worked jointly on publicity to promote Shetland . There is increased interest in ANP posts following the successful service model change in Lerwick.
Recruitment and retention of staff at all grades	There is low unemployment in Shetland at the moment, which is leading to difficulties in recruitment. Promoting NHS Shetland as a favourable place to work and actively supporting training schemes (such as the GP Training scheme) has benefits to recruiting staff.
Capacity in small Primary care management team required for day to day management and ongoing service redesign	Under review

- **Performance Targets with links to National Outcomes**
  HEAT, Single Outcome Agreement or any other performance targets and outcome measures.

Measure	National Outcome
Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre	Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer
Percentage conversion of OOH GP house visits converting to admission to hospital	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

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Key Aims and Outcomes

The current Shetland ADP Strategy covers the period 2015 – 2020. The main aim of the strategy is to provide the framework for a continued move to outcome-focused services.

A new approach to the delivery of our services, in particular Tier 3, has been the main focus of the Shetland ADP over the previous Delivery Plan.

Our key strategic aims (stated below) are what we intend to achieve over the life of this Delivery Plan

Our strategic aims and local outcomes are aligned with the National Core Outcomes. Indicators, targets and activities have been agreed. These will be monitored via the Shetland ADP on a regular basis.

Our key strategic aims are: -

1. Reducing prevalence of problem alcohol and drug use in adults by 5%, by 2020, through prevention, early intervention and detection;
2. Reducing alcohol and drugs related harm to children and young people;
3. Improving recovery outcomes for Service Users;
4. Reducing drug related deaths and/or alcohol/suicide to 2 or fewer a year by 2020;

Governance Arrangements:

The Shetland ADP reports through the Community Safety and Resilience Board to the Community Planning Partnership (Shetland Partnership) and the Integrated Joint Board. It primarily contributes to the Safer and Healthier sections of the Community Plan.

Shetland ADP's 2015 – 2018 Delivery Plan and Annual Report will be submitted to the Community Safety and Resilience Board, Shetland Partnership Board, Integrated Joint Board, partner agencies, Alcohol and Drug Forum and Scottish Government.

National Support and Engagement

Shetland ADP accesses support through a number of national bodies in order to deliver on its outcomes:

Scottish Drugs Forum

- To assist in the development and roll out of the Local Naloxone Programme
- To assist in the development of user involvement
- To assist in the delivery of training.

Scottish Recovery Consortium

- To coordinate action to promote recovery
- To support "Recovery Month" activities.

In terms of further support requirements from National Organisations in order to deliver on our strategy and delivery plan we may require advice and assistance to:

- Encourage the development of mutual aid groups
- Develop our workforce
- Extend the range and focus of whole population approaches to alcohol misuse.

Fund Disbursement/Commissioning of Services:

Services are commissioned via the local Joint Strategic Commissioning Plan through the Integrated Joint Board.

A small sub-group of Shetland ADP oversees the recommendations for the funding process in as transparent a way as possible. All alcohol and drug money is discussed at this meeting and distributed amongst service providers according to need and the outcomes required.. Service providers are invited to submit bids that address the work prioritised in SADPs Delivery Plan. All bids are then considered at the Fund Disbursement Group and recommendations are made to the IJB for the final decision.

The Fund Disbursement Group is guided by the following principles: -

1. Funding should be allocated in line with the agreed Delivery Plan priorities
2. Decisions on funding should only be made through the IJB
3. Shetland ADP and the Shetland Alcohol and Drug Forum should be involved in consultations/discussions on the priorities of the Delivery Plan and therefore priorities for funding.
4. All agencies should declare additional funding sources pursued/received to enable effective planning and use of resources
5. It is appropriate to review historical agreements made by Shetland ADP re allocation of funds and not to assume that these should remain the same.
6. All projects/staffing should be funded at cost- any additional funds should be offered up back to SADP to reallocate appropriately.
7. All organizations / groups/ agencies in Shetland with a role in tacking drugs and alcohol misuse are encouraged to sign up to these principles.
8. There will be Full cost recovery
9. Service levels agreements will accompany funding
10. Monitoring and evaluation to be undertaken in line with quality standards
11. Quarterly funding updates to be submitted from disbursement parties

*The above information (points 2 & 4) has been updated since the production of the Delivery Plan in line with new legislation regarding the IJB.

Current Service Model

Tier 1: Tier 1 interventions include provision of alcohol and/or drug-related information and advice, screening and referral to specialized treatment.

Interventions include; alcohol and/or drug treatment screening and assessment, referral to specialized alcohol and/or drug treatment, alcohol and/or drug advice and information, partnership or 'shared care' working with specialized treatment interventions for alcohol and/or drug misusers within the context of their generic services. Specific treatment liaison schemes may be specifically designed for alcohol and/or drug misusers i.e. housing projects for those leaving rehabilitation.

Provider	Activity	Funding/resource
Youth Services Staffing: 2 x part time (5 hrs a week)	Education and Awareness Programme for P1 – S6 • Annual alcohol and drug awareness sessions (projected 800+ pupils for 17/18 as new service) Drop-in support service • Weekly drop-in delivered in AHS and Brae High School in partnership with other orgs.	£11,000 ADP funding
OPEN Peer Project Staffing: 4 x part time (equivalent 1 FTE) 10 volunteers	Peer led education programme for S1 – S6 • 400+ pupils • Alcohol and drug sessions • Sexual health • Mental Health	£13,000 ADP funding + external funding
Dogs Against Drugs Staffing: 2 x full time staff	Drugs and the law education programme for P1 – P7 • 800+ pupils • 62 teachers Awareness raising sessions to the general public, youth	£27,000 ADP funding + external funding

Provider	Activity	Funding/resource
	groups etc showing how detection dogs operate • 140+ adults Provide the deployment of detection service at main points of entry into Shetland as and when appropriate • 28 positive incidents in 15/16	
Health Improvement Contribution towards Staffing: 4 x full time 5 x part time	Alcohol brief intervention (ABI) training delivered 3 times a year as part of blended learning ABIs delivered through Keep Well Checks • 150+ annually Alcohol screening undertaken at all counterweight and smoking cessation appointments Drink Better lead Alcohol and drug profiling projects	£27,000 ADP funding + NHS Health Improvement and Public Health funding

Tier 2: Tier 2 interventions include provision of alcohol/drug related information and advice, triage assessment, referral to structured treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.

Interventions include; triage assessments and referral for structured drug treatment, Drug intervention which **attracts** and **motivates** drug misusers into local treatment systems, including engagement with priority groups, such as pregnant women, offenders and stimulant users, Interventions to reduce harm and risk due to BBVs and other infections for active drug users, including dedicated needle exchanges and the support and co-ordination of pharmacy-based needle exchanges, Interventions to minimise the risk of overdose and diversion of prescribed drugs, Brief psychosocial interventions for drug and alcohol

misuse (including for stimulants and cannabis problems if it does not require structured treatment), Brief interventions for specific target groups including high-risk and other priority groups, Drug-related support for clients seeking abstinence, Drug-related aftercare support for those who have left care-planned structured treatment, Liaison and support for generic providers of Tier 1 interventions, Outreach services to engage clients into treatment and re-engage people who have dropped out of treatment, A range of the above interventions for drug-misusing offenders

Provider	**Activity**	**Funding/resource**
Shetland Community Bike Project Staffing: 2 x full time 1 x full time 4 x volunteers	Employability Pipeline Project • 12x alcohol and drug placements per annum (2 x 6 places) • Monday – Saturday work placements, learning work-related skills • All participants earn a wage • 6 x mental health placements per annum	£39,500 ADP funding for 12 placements (£3,300 per client) £25,000 European Structural funding for 6 placements
Voluntary Action Shetland Staffing: 1 x full time 1 x volunteer	Providing Families Affected By support	No ADP funding – from VAS funding
Substance Misuse Recovery Service (SMRS) Staffing: 2 x full time nurses 1 x full time dual diagnosis CPN 3 x full time Recovery Workers 1 x part time Specialist Doctor 1 x part time GPwSI	Interventions to engage people into treatment • ABIs • Assertive Outreach • Liaison with Primary/Secondary Care • Liaison with Police Scotland Recovery Groups – Mutual Aid Partnerships	£437,522 ADP funding (this is for both Tier 2 & Tier 3 services)
NHS Shetland	ABIs undertaken in:	No ADP funding – NHS funded

Provider	Activity	Funding/resource
	• Maternity • A&E • Primary Care • Sexual Health Clinic	
Adult Social Work 1 x full time Social Worker	Advice to SMRS Assessment of 'suitability' for detox/rehabilitation programmes.	No ADP funding – SIC Funded
Criminal Justice	Overall responsibility for the delivery for community based sentences in Shetland. Alcohol and drug work undertaken as part of an offending programme. Drug Treatment Testing Orders (DTTOs) are treatment focused rather than focusing on offending behaviour and is delivered in partnership with SMRS.	No ADP funding – Criminal Justice funded
Community Pharmacy	Needle Exchange Observed substitute prescribing	No ADP funding – NHS funded £30,000 ADP funding

Tier 3: Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison.

Interventions include; Comprehensive Substance misuse assessment, Care planning, co-ordination and review for all in structured treatment, often with regular keyworking sessions as standard practice, harm reduction activities as integral to care-planned treatment, a range of prescribing interventions in the

context of a package of care, a range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviours, structured day programme and care-planned day care, liaison services for acute medical and psychiatric health services (i.e. pregnancy, mental health and hepatitis service), liaison service for social care services (i.e. child protection and community care teams, housing, homelessness), a range of the above interventions for drug-misusing offenders.

Provider	**Activity**	**Funding/resource**
Substance Misuse Recovery Service Staffing: 2 x full time nurses 1 x full time dual diagnosis CPN 3 x full time Recovery Workers 1 x part time Specialist Doctor 1 x part time GPwSI	Comprehensive Assessments Recovery planning – recovery indicators set Prescribing specialist doctor Dual Diagnosis GP- GPwSI Dual Diagnosis CPN	£437,522 ADP funding (this is for both Tier 2 & Tier 3 services) Includes £30,000 for specialist doctor and £37,937 for GPwSI

Tier 4: Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.

Interventions include; Inpatient specialist alcohol and drug assessment, stabilisation and detoxification/assisted withdrawal services; a range of alcohol and drug residential rehabilitation units to suit the needs of different service users; a range of halfway houses or supportive accommodation for substance misusers; residential alcohol and drug crisis intervention units (in larger urban areas); inpatient detoxification/assisted withdrawal provision, directly attached to residential rehabilitation units for suitable individuals, provision for special groups for which a need is identified (i.e. pregnant women, substance users with liver problems, substance users with severe and enduring mental illness). These interventions may require joint initiatives between specialised substance use services and other specialist inpatient units; a range of the above interventions for substance misusing offenders.

Provider	**Activity**	**Funding/resource**
NHS SIC	On/off island detox Off island rehab	No ADP funding - within NHS/SIC funding

Emerging Trends

The illicit use of drugs and particularly opiates, benzodiazepines and psychostimulants, causes significant problems within Shetland as it does in other parts of the UK and Europe.

Some of these problems are primarily social in nature, involving, for example, increases in acquisitive crime, prostitution, unemployment, family breakdown and homelessness. Others are more clearly associated with health problems, for example, the transmission of communicable diseases (HIV, hepatitis), injecting related injuries and increased demands upon health care services.

When comparing against Scotland the male prevalence of problem drug use in Shetland is significantly worse, the number of child protection case conferences with parental drug or alcohol misuse is significantly worse and the number of weekly drinkers (aged 15) is significantly higher.

Although illicit drug misuse in Shetland continues to be a concern that needs to be addressed with early intervention, prevention and detection; treatment, support and aftercare, alcohol misuse continues to cost Shetland society up to £10.8 million a year.

The costs of alcohol in Shetland per year (from Alcohol Focus Scotland)

Outcome C in Shetland's Local Outcome Improvement Plan states the following: -

<u>Priority: Reduce the harm caused by alcohol</u>
The misuse of alcohol is a common factor in a number of areas that impact negatively on the quality of life of people in Shetland. Alcohol contributes to harm to people and property through vandalism, anti-social behaviour, drink-driving, violence (domestic and non-domestic) and fires (deliberate and accidental).

There is a distinct overlap between mental health and substance use/misuse; ongoing audits of suicide and sudden deaths in Shetland show that alcohol is almost always a factor – either a significant quantity has been used immediately prior to death, or there has been a history of unhealthy drinking patterns.

Almost 1 in 10 cases in Accident and Emergency are alcohol related, and of these, a third have Mental Health issues.

Alcohol and drugs are the top cause for child protection referrals in Shetland, and resulted in 11 registrations on the Child Protection Register in 2013/14.

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

Future Challenges

The Shetland Alcohol and Drug Partnership is committed to its overall vision; that 'individuals, families and communities live in an area where fewer people are using alcohol and drugs and, for those that do, recovery is a realistic option.'

With the ever changing landscape of substance misuse, in particular with New Psychoactive Substances, the pressure on budgets and diminishing resources there are a number of challenges the ADP and service providers will face in the future.

- How do we protect our children and young people from the harm caused by substance misuse; both their own and that of their parents, carers and communities?
- How do we continue to reduce our prevalence rates?
- How do we support the Licensing Board and Licensees to implement the Public health outcome as part of the Licensing Act?
- How do we continue to embed the Drink Better ethos across Shetland?
- How do we continue to provide harm minimization services i.e. needle exchanges in a safe and effective manner that will encourage our most marginalized individuals into treatment services?
- How do we support our older drug using population with complex co-morbidities and increasing social needs?

Shetland ADP cannot answer these in isolation. These are challenges that we should all meet; working together in partnership; enabling individuals and communities to become more resilient and accepting and sharing resources.

Suicide Prevention Service Plan 2017-2020

Vision
Our vision is: that Shetland should be a community that is aware of suicide and suicidal behaviour, where there are appropriate responses to suicidal behaviour, and 24 hour access to support when someone is feeling suicidal.

Policy Context
The Government's strategic focus is that suicide is preventable, that it is everyone's business and that collaborative working is key to successful suicide prevention.

Current Services
Services to support suicide prevention are included in the core service provision across the public and voluntary sector. The Government supports work on suicide prevention through their Choose Life project and a coordinator is appointed in each area. This work is incorporated into the substantive post of the Alcohol and Drug Development Officer, within the Public Health team.

The work is in support of the National Suicide Prevention Strategy themes of:

- Responding to people in distress
- Talking about suicide
- Improving the NHS response to suicide
- Developing the evidence base and
- Supporting change and improvement, including specific training programmes.

There are links with:

- Mental Health, including long term conditions, depression and anxiety, self harm, domestic abuse, etc;
- Attendance at Accident and Emergency;
- Frequent attenders at a primary care setting, eg Health Centre; and
- Drug and Alcohol Misuse.

Performance Measures

Local Outcome Improvement Plan Indicators
(All linked to National Health and Wellbeing Outcomes 1,4 and 5)

- Reduce suicide rate

Public Health Ten Year Plan Targets and Indicators (due to be reviewed) :
(All linked to National Health and Wellbeing Outcomes 1,4 and 5)

- To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s).

Needs / Unmet Need / Drivers for Change
Although the actual numbers were small, in the past Shetland has experienced higher than average incidents of suicide. The last recorded suicide was Sept 2015.

The approach follows the public health model of capacity building and education to challenge and change the behaviours of individuals, families and communities which might impact negatively on their health. The overall aim of this preventative work is to: increase capability, capacity and the

contribution of non specialist staff; increase self resilience; embed health improvement in routine practice; and increase community based work and the use of volunteers.
A multi-disciplinary review of each suicide incident is undertaken to identify any lessons to be learnt to improve service responses.

Key Risks to Delivery

- Suicide prevention work sits across all health and care sectors – hospital, primary care and social care – and the management arrangements for the Choose Life Coordinator post sits within Public Health. It would be useful to clarify the governance and accountability arrangements for the delivery of the Suicide Prevention Action Plan.
- Individuals and families affected by suicide are often not know to health and care services so preventative work is challenging and reliance needs to be placed on a whole population approach and targeted work at identified high risk groups.

Further Reading:

Scottish Government: Suicide Prevention Strategy 2013-2016
http://www.gov.scot/resource/0043/00439429.pdf

Contact:

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Health Improvement
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Suicide Prevention Action Plan 2015 - 2018

National Suicide Prevention Strategy theme:		**(A) Responding to people in distress** **(B) Talking about suicide** **(C) Improving the NHS response to suicide** **(D) Developing the evidence base &** **(E) Supporting change and Improvement**
Local Strategic Aim:		Responding to people in distress including developing arrangements for support following suicide attempts and completed suicides; Develop community resilience and awareness raising; Understand local need/trends and act on preventative factors.
Local Outcomes Communities, families, carers and individuals are aware of where to access support/information when someone is feeling suicidal. Communities, families and carers feel able to support someone who is feeling suicidal Individuals receive an appropriate, compassionate, consistent response from professionals when presenting with distress and/or suicidal behaviours. Understanding of the patterns in Shetland of self-harming and suicidal behaviour.	**Reach** Whole population. Targeted at risk groups i.e. domestic abuse, offenders, substance users. Individuals in treatment. Individuals identified as high risk. Professionals At risk groups	**Activities** Provide information on where to access support/information i.e. GP, Duty Social Work, A&E, Samaritans, Breathing Space etc. Develop data gathering systems across a wide range of partners that is consistent and meaningful. Develop systems that can confidentially identify repeat attenders and develop appropriate support packages. Develop and implement 'Responding to Distress/Suicide Protocol' for professionals. Develop Distress Brief Interventions proposal ➢ Raise awareness of distress in communities and appropriate responses from families, carers etc. ➢ Provide training to front-line responders ➢ Develop DBI practitioner model. Review formal arrangements for post suicide attempts support for NHS.

Individuals are able to speak openly about suicide and suicidal behaviour. Communities, families and carers are offered appropriate support following a suicide. Individuals receive appropriate support following a suicide attempt Services implement improvements in delivery to support vulnerable people		Develop arrangements for support following completed suicides Continue a programme of awareness raising activities for throughout the year to establish a continued reminder. Target 'Grubby Huts' at male oriented places of work. Target ASIST training towards workplaces. Deliver a high profile 'roadshow' during Suicide Prevention Awareness Week (September) Audit all potential suicides and/or drug-related deaths.

	Local indicator	**Baseline**	**Scotland**	**Target**
1	Decrease in the number of suicides	24.1%	15%	Decrease to 15%
2	Decrease in repeat attenders at A&E	New		Set baseline
3	Decrease in repeat attenders with Police Scotland	New		Set baseline
4	Decrease in repeat attenders with SAS	New		Set baseline
5	Decrease in inappropriate referrals to CMHT	New		Set baseline
6	Increase in number of people trained in ASIST	540	Not available	45 per year

Joint Strategic Commissioning Plan 2017-2020 – Set Aside Services

Policy Context

Unscheduled care is an umbrella term used to describe services which provide an emergency or unplanned service response. The majority of unscheduled care takes place in the community setting and is managed by community health and social care teams.

The overarching aim of services aligned to unscheduled care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services 'in an emergency'. Unscheduled care takes place across community, hospital and specialist settings.

The national policy context is very broad and includes: the Public Bodies (Joint Working) (Scotland) Act (2014); 20:20 Vision (2011) and the Patients Rights Act (2011).

Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The importance of planned care services is described in local strategies and plans e.g. the older people's strategy (2015), dementia strategy (2015), mental health strategy (2013), integration fund plan (2016-17, refreshed annually), corporate action plan (2016-17, refreshed annually), unscheduled care plan (2016-17) and winter plan (2016-17, refreshed annually).

Our high level aims to support the delivery of unscheduled care services, which are also aligned to the unscheduled care collaborative essential actions include ensuring that we deliver:

- Clinically Focussed and Empowered Hospital Management
- Hospital Capacity and Patient Flow (Emergency and Elective) Realignment
- Patient Rather Than Bed Management – Operational Performance Management of Patient Flow
- Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway
- Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working
- Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting

Current Services Provided

The majority of healthcare services have an unscheduled care pathway, but the main ones can be defined[1] as:

- **Out of Hospital Services – e.g. community nursing and primary care services 'out of hours'**
- **Accident and Emergency Services**
- **Acute Inpatient Medical Services (including admission of renal patients)**
- Acute Inpatient Surgical Services
- Critical Care Services
- Theatre Services
- Obstetric Services
- Emergency Service provision at NHS Grampian for patients requiring specialist interventions
- Diagnostic Services (e.g. Medical Imaging, Laboratory Services)

[1] The services shown in bold are part of the joint service planning arrangements set out in the Integration Scheme – known as part B 'set aside' services.

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of unscheduled care, including the provision of air transfer and critical care retrieval for adults, children accessing tertiary care centres and patients accessing specialist mental health facilities.

Other services which are part of the Set Aside plan and are subject to joint commissioning arrangements include:

Sexual Health, Renal, Medical Outpatient Services

The services which are shown in bold are part of the integrated commissioning arrangements.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery. Child and Family Health Services and specialist off island services are also shown in separate plans. Health Improvement also has a specific plan which is part of the wider Public Health arrangements for the Board.

Drivers for Change

Over recent years, services that provide unscheduled care have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs
- Increasing public expectation of and access to health and social care services
- Delays in accessing up-to-date patient information - impacting on or slowing down clinical decision making
- Need for improved team working and better co-ordination of care between NHS partners (primary care, SAS, NHS 24, secondary care and tertiary care)
- Need for greater collaborative working to reduce delays particularly at the health and social care interface
- Need for closer working between health and social care services to develop integrated models of anticipatory and community based care
- Challenges in training, recruitment and retaining of staff

Another important factor impacting on unscheduled care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways. Our winter planning arrangements as well as a local focus on the strategic development of primary care services and medical staffing models help to support the sustainable delivery of unscheduled care and planned care services.

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies
- Promoting personal and community level resilience and accountability for health and wellbeing
- Developing an integrated approach for older peoples services delivery across health and social care
- Developing robust models for dementia care and community mental health services
- Effective health and care pathway design across primary, secondary and specialist care
- Effective models of planned care delivery e.g. the Modern Outpatient programme (published in 2016)
- Strategic plans to support palliative and end of life care

Plans for Change

The indicative savings target for unscheduled and associated services identified in the 'Set Aside' budgets in 2017-18 is £450,000 from a budget of £4.255M. This is equivalent in staffing costs to a reduction of **WTE 14** Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Deliver care closer to home through locality based teams and services (reducing reliance on hospital and care home resources). Enhancing the role and resources aligned to the Intermediate Care Team (ICT) is one of the key areas of redesign identified in the Commissioning Plan.
- Invest in patient education, self care and self management
- Use technology more to support people at home e.g. telecare, tele-health
- Working collaboratively with the third sector to provide services which help people to access services/support in the community
- Streamlining pathways – reducing the reliance on outpatient services and delivering more complex assessments with practitioners in the community
- Reduce inefficiency and short term spending on locum/supplementary staffing by changing the skill mix in teams

Our strategic priorities for planned care as set out in the Corporate Action Plan (2017-18 and beyond) and the various strategies referenced above can be summarised as follows:

- Managing patient flow - recognising the increase in admissions and demographic changes meaning patients with more complex needs are presenting through emergency care services and models of anticipatory care and early supported discharge continue to need to grow and evolve
- Implementing a joint strategic approach to the delivery of older peoples care across health and social care sectors – particularly our objective to develop a locality based approach to provide more community support options (e.g. for reablement and community based rehabilitation)
- Ensuring that we review our acute and specialist care model, to identify risks and services which are fragile so that we can look at alternative models which are more sustainable (e.g. long term condition management such as rheumatology)
- Focusing on ensuring that we can provide appropriate care settings/resources/pathways (jointly) to ensure that clinical and care needs are met in the community, whenever it is safe to do so
- Continuing to focus on reducing the number of people who are delayed in hospital
- Reviewing the current provision of Out of Hours (OOHs) services to ensure they are sustainable and developing an options appraisal to support new models of working
- Developing ambulatory care and day care models as a safe alternative to inpatient care
- Role development to support unscheduled care service delivery – particularly the positioning of advanced NMAHP practitioners in Acute and Community based care settings (e.g. covering weekend clinics and closer working with A&E services)

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
Review NMAHP skill	Director of	Scoping exercise	Increased role development	Resources are used

mix to support sustainable workforce (incorporating the medical staffing review)	Nursing & Acute Services (DNAS)/ Director of Community Health & Social Care	2016-17 Options selection and implementation (from Q4 2016-17 onwards)	for NMAHPs with advanced practice skills Increased number of NMAHPs supporting unscheduled/primary care e.g. OOHs Increased anticipatory care plan development/access Increased access to care to OOHs care packages Reduced locum costs (e.g. for GP and junior doctor vacancies)	effectively and efficiently H&SC services are centred on helping to maintain or improve quality of life People using services are safe from harm
Reviewing out of hours service provision (including medical staffing, primary care configuration and locality based services)	Director of Nursing & Acute Services (DNAS)/ Director of Community Health & Social Care	Scoping exercise 2016-17 Options selection and implementation 2017-18 onwards	Clearly defined model of OOHs service delivery for mainland Shetland and remote isles Better match of OOHs activity with resources/practitioners available More resilient models identified and implemented Increased provision of overnight care in localities Reduced reliance on supplementary staffing e.g. locum medical posts	Resources are used effectively and efficiently

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
Reviewing the model for Acute and Specialist Care in Shetland, to ensure that the hospital is able provide sustainable services	Director of Nursing & Acute Services (DNAS)	Scoping exercise 2016-17 Options selection and implementation 2017-18 onwards	A more resilient model for renal services is developed to meet growing patient needs We understand the demand and capacity available across services – particularly the balance of off island, inpatient and ambulatory care services. So that we can shape the hospital to meet future service requirements e.g. plan to increase surgical activity previously undertaken in Aberdeen We have a hospital environment which supports specialist care – e.g. enhanced ambulatory care facilities and diagnostic testing. And services that can be safely provided in the community are the norm	Resources are used effectively and efficiently

Key Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Unscheduled care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a 'whole system' strategic exercise with all partners working to shared objectives
- Pace of change – developing robust community based models will take time and resources. We need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented
- Increase in demand for acute services due to demographic changes and case complexity

Targets/Outcomes

There are a number of HEAT targets that specifically relate to quality or performance markers for effective emergency care systems and they are summarised below with a snapshot of the Performance Dashboard (February 2017).

	Measure		Month	Performance		Previous Performance			Target		Interpretive Notes

T.10	Rate of attendance at A&E (rate)	M	Dec 2016	2807	Nov 2016	2539	G	↓	3061	2016-17	Lower number of A&E attendances during winter 2016-17 compared with 2015-16 – reflecting the success of the work to develop more community based services
A.7S	A&E 4 Hour waits (percentage)	M	Dec 2016	97.5	Nov 2016	97.5	A	↑	98	2016-17	Despite increasing patient complexity – we have maintained very good performance with access to emergency care via A&E in winter 2016-17. This is in part due to increased anticipatory care and availability of community support

	Measure		Month	Performance		Previous Performance			Target		Interpretive Notes
A.8.1S	48 hour Access - GP Practice Team (percentage)	A	2016	93.6	2014	93.5	G	↑	90	2016-17	Continued improvement in access supported by redesign of primary care skill mix and introduction of ANPs
A.8.2S	Advance booking - GP Practice Team (percentage)	A	2016	76.4	2014	73.2	R	↑	90	2016-17	Improving performance, target not achieved because of ongoing workforce challenges in Primary Care
BSC17	Level of Older People with Complex Care Needs Receiving Care at Home (percentage)	Q	2016 Oct-Dec	51	2016 Jul-Sep	51	G	→	39	2016-17	We have always performed well against this target, but we have continued to exceed the SoA trajectory in 2016-17
T.12	Emergency bed days rates for people aged 75+	M	Dec 2016	410	Nov 2016	230	G	↓	500	2016-17	Lower number of bed days utilised for older peoples care during winter 2016-17 compared with 2015-16 – reflecting the success of the work to develop more community based services
E.9	No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs	M	Dec 2016	0	Nov 2016	0	G	→	0	2016-17	Lower number of people delayed in hospital during winter 2016-17 compared with 2015-16 – reflecting the success of the work to develop more community based services

Contact Details

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Further Reading

Older Peoples Strategy, Corporate Action Plan, Unscheduled Care Strategic Plan

http://www.isdscotland.org/Health-Topics/Emergency-Care/

Service Plan – Public Health Directorate 2017-20

- **Policy context**

The Public Health Team provides public health services to NHS Shetland and the local community. Our purpose is to promote, improve and protect the health and wellbeing of the people of Shetland, to prevent ill-health, and to reduce health inequalities.

The Public Health Directorate is responsible for three main areas of work: health improvement, health protection and population health in service planning and delivery.

We work to deliver the requirements of the Public Health Etc (Scotland) Act 2008, which governs the requirements and arrangements for public health in Scotland.

There is has been a national review of public health in Scotland, and the service will need to take account of any change that results from that review. It is not yet clear what those might be. There is also a North of Scotland review to strengthen public health in the north with a focus on the future resilience of public health in the Island Boards which will inform future service redesign and succession planning. These reviews could potential result in major changes to the way Public Health is delivered Scotland as a whole including Shetland.

- **Current Services**

The Directorate is split into two teams, with a single line management structure and overlapping areas of work. The bulk of the health improvement work is delivered by the Health Improvement Team, along with some service planning work and activity to support health protection work. All the other health protection work, service planning work and a smaller of health improvement work is done by the Public Health Team.

Our work includes:

Health protection:

- Surveillance and response to communicable disease and environmental health threats
- Public health Incident and Outbreak Management
- Healthcare associated infection surveillance and outbreak management
- Emergency planning and resilience, including Prevent and Pandemic Flu Planning
- Co-ordination and monitoring of immunisation programmes
- Co-ordination and monitoring of screening programmes

Health Improvement and Reducing Health Inequalities:

Activities include services provided directly to the public / patients; information resources, awareness raising and training. There are a range of health improvement services and resources available for people and communities in Shetland, most of which are open access and delivered in a variety of settings, particularly on a locality basis. There are also a number of training programmes, usually for staff and volunteers, but some are also open to members of the public. Specific activities include

- **Keep Well** Health Checks in workplaces and primary care
- **Smoking Cessation** Services in primary care and other settings
- **Weight Management** including Counterweight in primary care (for adults) and a range of Child and Family healthy weight interventions
- **Falls prevention work** including Chair-Based Exercise
- **Health walks (**locality based)
- **Healthy Working Lives** which includes advice, resources and training for employers and workplaces

- **Health Improvement work in schools** on a range of topics
- **Health Promoting Health Service**
- **ASIST (Suicide Prevention)** and **Mental Health First Aid training**
- **Active Travel** initiatives
- '**Help Yourself to Health'** information and resources based in the Shetland public library
- **Tackling health inequalities**: multi-agency work on Welfare Reform & Financial Resilience; Fuel Poverty; Community Connections / combating loneliness.

Focus on population health through service planning

- strategic partnership work, including in the areas of Mental Health; Domestic Abuse; Drugs and Alcohol; Sexual Health & Blood Borne Viruses; Community Justice ; Community Learning & Development; Children and Young People; Physical Activity and Sport
- health intelligence work
- health needs assessment
- health impact assessment
- service evaluation.

- **Contribution to Local Delivery Plan priorities (as required)**

Extract from 2016-19 LDP

NHS Shetland Corporate Objectives	**NHS Shetland 2020 Vision Outcomes**	**National 2020 Route Map Priority Areas for Improvement**	**Shetland strategies / plans / programmes**
To improve and protect the health of the people of Shetland National 2020 Triple Aim: Health of the Population	For people to feel responsible towards each other within their own community, which includes making healthy lifestyle choices, and using our own knowledge and capacity to look after ourselves and each other	Prevention Person Centred Care Health Inequalities	Public Health / Health Improvement 10 Year Plan - Smoking - Obesity - Exercise - Healthy eating - Mental health promotion Self-management programme
	To tackle the major threats to our health with reduced impact of early death and illness from the major preventable diseases	Prevention Health Inequalities	
	Fewer than 10% of people in Shetland smoking	Prevention Health Inequalities	
	To cut obesity by 50%	Prevention Health Inequalities	
	To do more exercise and have healthier eating	Prevention Health Inequalities	
	We teach and support children and families in emotional and mental well-being from an early age	Prevention Health Inequalities Early Years	Children's Plan / Early Years Collaborative / Mental Health Strategy

- **Contribution to Strategic / Cross Cutting Themes (as required)**
  Tackling Health Inequality
  Health promotion (including self care and self management)
  Locality planning and Inter-connectedness with other services

- **Needs/Unmet needs/Drivers for change**
  External and national drivers include:

  - A persisting, and possibly worsening, inequality gap between the most advantaged and the most disadvantaged in our society
  - Increasingly challenging national targets (e.g. HEAT target for smoking cessation which is now focussing on the hardest to reach groups)
  - Increasing emphasis on doing things 'with' people rather than 'for' them, including using co-production[1], enablement, and asset based[2] approaches
  - Fewer public sector resources to meet increased demand due to factors such as changing demographics (the aging population) and global economics.
  - Changes in lifestyle and culture (for example more sedentary work and leisure pursuits, and the use of games consoles and portable devices)
  - Changes in diet (for example increased consumption of processed and convenience food, and larger portion sizes)

- **Plans for change**
  The Public Health Directorate went through a major redesign last year which has been implemented from April 2016. We have no plans for further significant re-design of the Directorate in the next year 2017-18 unless imposed by changes to the way public health is delivered nationally. However, the model of locality working for the health improvement team may need to be changed due to reduced funding and staff capacity.

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
Review 5yr progress with Implementation of Public Health 10 Year Plan (2012- 2022); re-prioritise actions and review models of delivery based on reduced staff capacity and funding	Susan Laidlaw	2017	**Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer **Outcome 4:** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services **Outcome 5:** Health and social care services contribute to

[1] **Co-production is a new vision for public services based on recognising the resources that citizens already have, and delivering services** *with* **rather than** *for* **service users, their families and their neighbours.**

[2] Asset based approaches are based on the principles of appreciating and mobilising individual and community talents, skills and assets, rather than focussing on problems and needs

			reducing health inequalities **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services
Health Needs Assessment Children and Young People	Elizabeth Robinson	2017	**Outcome 1** **Outcome 4** **Outcome 5** **Outcome 9**
Anticipated major changes to the delivery of the National Immunisation Programme	Susan Laidlaw	2017 – national timescales - tbc	**Outcome 1** **Outcome 9**
Development and Implementation of Action Plan to meet the national Resilience Standards	Susan Laidlaw	2016 – 2018 tbc	**Outcome 7.** People using health and social care services are safe from harm?? **Outcome 9.**
Priorities in LDP 2016-19 Increasing capability, capacity and the contribution of non specialist staff: including work with the wider workforce through the Health Promoting Health Service programme to embed health improvement in routine practice; increasing community based work and the use of volunteers. 'Invest to save' to support accelerated health improvement programmes tackling key risk factors and positive lifestyles with a focus on physical activity, reductions in smoking and alcohol misuse; utilising the increased capacity and capability as above. Community capacity building and work in partnership with voluntary sector partners.	Susan Laidlaw / Elizabeth Robinson	2016-2019	**Outcome 1** **Outcome 4** **Outcome 5** **Outcome 9**

- **Key Risks to Delivery**
  There has been a reduction in local and national funding for the Directorate, affecting the health improvement team primarily. This has been managed through the service redesign in 2016; not recruiting when individuals have left post or reduced hours; careful financial management and securing some short term grant funding for specific projects. Grant funding has enabled us to retain some good staff, albeit on a short term basis, and to continue to deliver some key services.
  However, we are reaching the point where we can no longer make the savings required without cutting services or areas of work; and it is likely that in 2017-18 there will be changes to the way services are delivered and what we can provide. This is likely to mean a move away from the very successful locality and primary care based working; and a subsequent impact on our targets, for example for smoking cessation.

Some of our key areas of work for 2017-18 are national projects and will therefore be prioritised over locally developed pieces of work.

- **Performance Targets with links to National Outcomes**

  Local Outcome Improvement Plan Indicators
  (All linked to National Health and Wellbeing Outcomes 1,4 and 5)
  - Reduce suicide rate
  - Reduce the percentage of the adult population who smoke
  - Reduce alcohol related acute inpatient hospital discharges
  - Increase the proportion of adults completing 30 minutes of at least moderate exercise 5 days a week

  Public Health Ten Year Plan Targets and Indicators (due to be reviewed) :
  (All linked to National Health and Wellbeing Outcomes 1,4 and 5)

  - To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s).
  - To reduce the number of alcohol related admissions (discharges) from a baseline of 761/100,000 discharges in 2009/10 to a target of 500 / 100,000 discharges by 2014/15. (This target is based on the best performing Boards in Scotland) and 300/100,000 by 2012/22.
  - To reduce the percentage of adults who smoke from 15% in 2010 (as measured by Scottish Household Survey) to 10% by 2015, and 5% by 2022
  - To reduce the percentage of adults who smoke in the two most deprived SIMD quintiles in Shetland to match the overall smoking rate for Shetland by 2015.
  - To achieve the annual HEAT target for inequalities related smoking cessation successful quits at 4 weeks by end of March each year. Not yet set for 2017-18
  - To increase the proportion of people aged over 65 who live in a housing rather than hospital or care setting: This is currently high at 974.7/1000 but needs to be maintained despite an increasing elderly population.

- **Contact Details**
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  Contact via the Public Health Secretary Kim Govier on 01595 743340 or by email to Susan.laidlaw@nhs.net or shet-hb.publichealthshetland@nhs.net

  Elizabeth Robinson, Public Health Principal
  Health Improvement Department, Grantfield, Lerwick ZE1 0NT
  Contact via the Health Improvement Office on 01595 807494 or by email to elizabethrobinson2@nhs.net or shet-hb.healthyshetland.nhs.net

- **Further Reading**
  More detail of Shetland public health services is available on the web-site http://www.shb.scot.nhs.uk/board/publichealth/index.asp

  Public Health Annual Report 2016 which includes progress against the Directorate Work Programme and the Public Health Ten Year Plan

Human Resources and Support Services

Scope

The Human Resources and Support Services Directorate has responsibility for a range of support services functions, as follows:

- Human Resources
- Information Management and Technology and eHealth
- Occupational Health
- Spiritual Care
- Staff Development

Human Resources

Purpose
The Human Resources function supports NHS Shetland, its managers and staff to comply with relevant legislation, strategies and policies and apply best practice in the field of Human Resource Management.

The service also indirectly supports integration, by working in partnership with colleagues in Shetland Islands Council, on services under the direction of the Integration Joint Board.

Policy context
Service changes are currently being driven by the introduction of a National IT platform EESS. NHS Shetland commenced implementing the system in 2012 at Phase 2 of the national programme. There have been numerous setbacks and delays involving developments to the system. Successful implementation will support the progression of the national HR Shared Service (HRSS) agenda that will centralise some HR services.

The Strategic Commissioning Plan recognises a number of workforce challenges, including: recruitment and retention; integrated working and professional support; pension age changing; generic and specialist skills mix; single handed practitioners; expectation that staff will deliver the 'transformational change'; technological advances; ability to 'compete' with other employers.

Each of the Strategic Programmes will require an assessment of staffing arrangements and may make proposals for significant and transformational change across the workforce.

There is also a recognitions that the support services functions can be better aligned between NHS Shetland and Shetland Islands Council to support managers and staff to only have to do a policy, system or procedure 'once for Shetland'. This will include many aspects of the human resources function. One of the actions in the National Plan will be to undertake workforce planning across health and care services.

The Scottish Government's recently published National Health and Social Care Delivery Plan

highlighted a number of challenges around workforce. This is in response to Audit Scotland's Report on the NHS in Scotland in 2016, where it stated that, "*The NHS workforce is ageing and difficulties continue in recruiting and retaining staff in some geographical and specialty areas. Workforce planning is looking for new models of care to deliver more community-based services. There is uncertainty about what these models will look like and the numbers and skills of the workforce required. NHS boards' spending on temporary staff is increasing and this is putting pressure on budgets".*

The Human Resources services will need to support NHS Shetland to respond to some significant strategic challenges set out in the National Plan, including

- *"By 2018, we aim to have commenced Scotland's first graduate entry programme for medicine. This will focus on increasing the supply of doctors to rural areas and general practices more generally.*
- *In 2017, we will put in place new arrangement for the regional planning of services....NHS Boards will work together through three regional groups. In 2018, the appropriate national and regional groups will set out how services will evolve over the next 15 to 20 years, in line with the National Clinical Strategy.*
- *By 2019, we aim to: support a new, single national body to strengthen national leadership, visibility and critical mass to public health in Scotland. Such a body will have a powerful role in driving these national priorities and providing the evidence base to underpin immediate and future action.*
- *By 2020, we aim to: have set up local joint public health partnerships between local authorities, NHS Scotland and others to drive national public health priorities and adapt them to local context across the whole of Scotland. This will mainstream a joined-up approach to public health at a local level".*

From an organisational perspective, the Human Resources function will be part of an emerging programme to provide services on a national basis, as follow:

- *"In 2017, we will:*
    - *Review the functions of existing national NHS Boards to explore the scope for more effective and consistent delivery of national services and the support provided to local health and social care systems for service delivery at regional level.*
    - *Ensure that NHS Boards expand the 'Once for Scotland' approach to support functions – potentially including human resources, financial administration, procurement, transport and others. A review will be completed in 2017, and new national arrangements put in place from 2019".*

The National Plan has specific section on how to make the Workforce Planning arrangements much more robust, with a national discussion document being published in early 2017 feeding a National Health and Social Care Workforce Plan by the spring of 2017.

Current Services
The department provide the following services:

- Job Evaluation
- Recruitment planning and advertising
- Coordination of recruitment interviews
- On Boarding Administration for new starts
- Pre-employment checks
- Relocation costs monitoring
- Variations to contract
- Exit interviews
- Professional Registration monitoring
- Issue of ID badges
- Absence monitoring / promoting attendance
- Employment law / employee relations /case management advise, conduct , capability,
- grievances, whistle blowing, bullying and harassment
- From informal to formal investigation / hearing / appeal / tribunal
- TUPE guidance and due diligence administration
- Consultation on change
- Workforce data monitoring / returns (vacancy, FTE/ turnover/FOI's/ Junior Doctor)
- Workforce planning data reports and Workforce projections
- Redeployment
- Policy and procedure development / implementation
- Training delivery
- Equality and Diversity – policy, monitoring, action plans

Policy and procedures can be found on the department intranet page
http://intranet/departments/hr/index.html and website
http://www.shb.scot.nhs.uk/board/policies.asp

Needs/Unmet needs/Drivers for change

HRSS will continue to shape skills and requirements within the team.

Plans for change

National HR Shared Services for Recruitment and Medical staffing
Responding to the national 'Once for Scotland' approach to Human Resources function
Responding to local 'Once for Shetland' approach to partnership working through the Integration Joint Board and the National Plan arrangements for integrated Workforce Planning.

Projects
Improving Business Performance and Efficiency:
- Building staff organisational resilience and capacity
- Maximising local opportunities from national shared services programmes
- Doing things 'Once for Shetland'

Key Risks to Delivery
HRSS is nationally driven programme that will aim to centralise administration of recruitment and medical staffing within the next 2-5 years. There will be some discretion to determine what staff are required locally to support local service delivery. Staff and Manager's will require training for the EESS system to enable them to self administer recruitment administration activities within the system, including vacancy and candidate administration / coordination of short listing, interview and on boarding which is currently carried out by HR. Capacity in the HR team will need to be maintained to deliver this. Replacement of the IREC system, currently in place has caused significant delay to progress. Longer term costs may shift from HR if the demand for administration support across other services increases to supp0ort a new system and local pay costs may increase overall rather than decrease, with a reduction in local HR expertise.

Partnership working and the potential needs of one organisation being paramount to the integrated services needs to do things as efficiently and effectively as possible.

The tension between the drive for more national working 'once for Scotland' and the local drive to work efficiently and effectively locally across the Health and Social Care Partnership becomes insurmountable.

There are conflicting priorities for local integration of services and national once for Scotland, differences in cultures in respect of aligning policies, procedures and structures.

Performance Targets with Links to National Outcomes
Reduction in administration demands will enable HR resource to refocus responsibilities on supporting resource planning, redesign, integration of services, effective performance management and management of change, policy development and training delivery. This will include monitoring and reporting of absence / attendance against the 4% HEAT target.

Contact Details
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Further Reading
HRSS project Initiation document:
http://www.qihub.scot.nhs.uk/media/611088/hrss%20-%20pid%20-%20may%202014.pdf

Quality Improvement Hub:
http://www.qihub.scot.nhs.uk/quality-and-efficiency/shared-services.aspx

Staff Development

Purpose

To provide a comprehensive training and development service to enable staff to fulfil their potential and develop their careers.

Policy context

Joint Development Review (JDR) and Personal Development Planning (PDP)
Staff Development Policy
Fire Safety Policy
Manual Handling Policy
Policy and Guidelines for the Prevention and Non-Physical Management of Aggression and Violence (PMAV) in the Workplace
Volunteering Policy

Current Services

The Staff and Organisational Development Team is responsible for the collation and production of a joint training plan, ensuring the delivery and the co-ordination of key personal and professional training to enable employees across the workforce including those in training to deliver safe and effective care.

The department also has a service improvement lead that provides training and project support across Health and Social Care.

The Staff and Organisational Development Team are responsible for offering wide range of training covering all areas required by the Board ensuring compliance with statutory requirements. The staff and Organisational Development Team are also responsible for assisting teams achieve targets and objects through specific interventions and for supporting staff with the KSF and JDR programme.

The Clinical Education Team is responsible for creating and maintaining a clinical learning environment for all students. The team also delivers and coordinates a range of clinical training events and programmes to support the aim of appropriately trained staff.

The Service Improvement Team is responsible for providing training and project support across the organisation. The team utilises a range of tools and techniques that are fundamental to getting to grips with the challenges of everyday service delivery and trialling and measuring ideas for change.

Needs/Unmet needs/Drivers for change

The Organisational and Staff Development Department delivers high quality education, organisational development and continuous service improvement across NHS Shetland supporting the Board achieving it Corporate Objectives.

Drivers for change include:

Internal
Local delivery plan
HR/OD strategy
Integration – IJB Workforce Development Strategy and Action Plan, Organisational Development Action Plan and Training Plan
Leadership
Culture

External
Quality Strategy
20/20 vision
SGAP
Staff Survey
iMatter
Leadership
Revalidation

Service Aims/Priorities Objectives/Actions

Staff and organisational Development
Compulsory
Corporate Induction
Induction Refresher
Induction of Temporary Staff
Training Plan
EESS
KSF
Appraisal
iMatter

General
LearnPro
BCP
Recruitment
Interview skills
E-Learning
Project Management
Volunteers

Service Improvement
Improvement Methods
Leadership
Change Management
Psychometrics/CER
Integration

Project Management
Project Support
AHP Education
Supervision
Staff Survey

Clinical Education
Resuscitation
Moving and Handling
Developing the Clinical HCSW
CPD for Nurses, Midwives
Supporting Undergraduate Nurses and Midwives in practice
Mentor support and development

Plans for change
To support the continued mainstreaming and embedding of the NHS Update Learning materials

To support the continued use of e-KSF and effective and effective annual reviews

Corporate Induction and Compulsory Refresher Training.

Provide support for projects as requested by the Senior Management Team e.g. localities and pathways projects.

Establish a Service Improvement Forum where staff can share knowledge, skills and experiences in a safe learning environment.

iMatter Staff Experience Tool Implementation. Support the implementation of the programme with Cohort 1, 2 and 3 staff in line with SGHD plan.

Board Quality Group. Actions carried out by Quality Working Group - Currently under review

Transition from registration to revalidation for nurses and midwives

Design and deliver workshops for registrants, confirmers and non registrant managers, support practitioners through process as needs are identified.

All nursing and midwifery staff will successfully complete revalidation process between April 2016 and April 2019 (first round of new process)

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery
The team is small and carries out a diverse range of actions across the organisation. Risks associated with the outcomes of these actions are:

Leave
Vacancies not being filled
Posts not being renewed
Capacity

Performance Indicators

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Information Management & Technology and eHealth

Purpose
The Information Management and Technology function supports NHS Shetland, its managers and staff to comply with relevant legislation, strategies and policies and apply best practice in the field of ICT and phone systems.

The service has a specific role in developing and implementing the Board's approach to eHealth, where investment in digital technology is used to improve services for both service users and staff .

The service also indirectly supports integration, by working in partnership with colleagues in Shetland Islands Council, on services under the direction of the Integration Joint Board.

Policy context
To support the delivery of the Scottish Government's e'Health Strategy.

Current Services
The department provide the following services:

- Installation, management and support of IT infrastructure including servers, storage and network services.
- Management of Clinical, and Business application systems
- Installation, management and support of telephony including landlines, mobile phones, and pagers
- Multifunction devices (scanner/copier/printers)
- System integration services
- Freedom of Information administration
- Information Security
- Information Governance
- Information services and healthcare intelligence
- National eHealth leadership
- North of Scotland regional eHealth leadership and programme delivery
  Policy and procedure development
- Training delivery

Needs/Unmet needs/Drivers for change

The use of technology in NHS Shetland is increasing, and the number of systems supported continues to increase. The department has recently taken responsibility for training staff on a number of clinical systems and provides administration of those systems.

All public sector organisations will be required to comply with the Public Records Act in 2016/17. This will involve significant change in the management of information assets across all areas. On this basis 1 FTE Band 6/7 will be required to meet the requirements of

the Public Records Act, and provide ongoing stewardship of information assets thereafter. It is anticipated that such a resource would organisationally fit within this department.

Plans for change

Increased use of technology to reduce patient and staff travel
Implementation of Records Management Plan to support compliance with Public Records Act
Implementation of on-line services for patients
Improving Business Performance and Efficiency:

- Maximising eHealth, Telehealthcare and Telecare opportunities
- Doing things 'Once for Shetland'

Key Risks to Delivery

Cost pressures – savings targets for core budgets, and reduction in Scottish Government eHealth allocations.

Insufficient staff – change programmes that will deliver recurrent savings are challenging to implement as staff are fully utilised supporting and maintaining existing systems.
Skills gaps – records management (Public Records Act) is a fundamental change to management of information assets, and suitable skills are challenging to recruit in remote areas.

Performance Targets with links to National Outcomes

The national eHealth Strategy, which supports the national Quality Strategy, includes outcome measures that we report to Scottish Government quarterly.

Contact Details

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Further Reading

Scottish Government / NHS Scotland eHealth Strategy 2014-18:
http://www.gov.scot/Resource/0047/00472754.pdf

Occupational Health

Purpose
Occupational Health delivers a wide range of services to help protect staff from hazards of their work and to support staff with health problems to continue at, or return to, their work.

Policy context
Service changes are currently being driven by external and NHS local demand for services and nationally with national performance target for sickness absence of 4% and the introduction of the Fit for Work Service Scotland and also requirement for accreditation via SEQOHS.

Current Services
The department provides a range of services including:

- Management referrals for absence / performance case management
- Self Referral -NHS Staff
- CBT relating to personal or workplace issues / change
- Health Surveillance
- Immunisations
- Pre-employment screening
- Health Checks
- Work related Vaccinations
- Workplace/ workstation assessments
- Night Worker assessments
- Needle stick Injury response
- Stress management
- Medicals
- Ill Health Retirement
- Staff Training

Details can be found on the staff intranet http://intranet/departments/oh/index.html
In addition to a local OH service the department are set up to support the delivery of the Fit for Work Service Scotland as this is rolled out.

Key Drivers for change

Legislation: Equality Act provides an increasing need for assessment and supportive adjustments in the workplace
Demographics - Ageing workforce - complex health needs
Increase in stress & MSK related absence
Need to work more efficiently within reduced budgets
Local business demand for services has increased. This has enabled our consultant to become an approved Doctor for the MCA, so we can offer ENG1 medicals to our customers
Requirement for SEQOHS professional accreditation for which the department are working towards

National Fit For Work Service implementation programme – local participation in national implementation plan

Plans for change
The introduction of the FFWS in Scotland, funded through the Department of Working Pensions (DWP) may reshape external customer service demands as this service will focus on referral from the GP / employer into a national service, for those with 4 or more week's sickness absence from work. NHS Shetland will participate in service delivery with allocation of referrals via a central call centre (NHS 24). The service level will be managed separately via a defined SLA. Telephone equipment and system are in place. Additional resource will be required to be trained to deliver this contract, for which funding allocation is to be agreed. Current SLA with SIC will cease 31 March 2016. NHS Shetland has submitted a tender for a revised contract for services commencing 1 April 2016.

Introduction of Fit for Work Service
OH Tender for SIC

Key Risks to Delivery
The FFWS set up costs to be recovered from DWP January 2016 – awaiting confirmation of ongoing funding / service demand. Service Level Agreement is in place for FFWS for 0.5 FTE Band 6. Current staff have supported 'set up' in readiness for commencement of the service. Local start delayed, awaiting training from NHS Lanarkshire, the FFWS lead for Scotland.

There is a risk that we may lose income if Shetland Island Council do not accept the occupational health tender submission. Failure to generate sufficient income to replace this would require a reduction in staff required to deliver remaining demands.

The department are set up to participate in the delivery of the Fit for Work Service Scotland. Reimbursement from DWP is outstanding for set up arrangements / training costs. No funding has been received yet and unlikely until January 2016. Resource to deliver will be dependent on availability and level of funding provided.

Retention of skilled staff will be essential to maintain service delivery levels – local availability of appropriate skills is very limited therefore national recruitment or use of a specialist agency would be required to fill any turnover or any increase in resource requirements.

Performance Targets with links to National Outcomes
In the event there was a reduction in income and demand, service would continue to provide support for NHS staff in maintaining health, wellbeing and fitness for work. The service supports the achievement of the 4% performance HEAT target for absence and reduces risk in relation to the Equality Act 2010, providing guidance on adjustments. Without a local service we would unlikely maintain current performance which is consistently below the Scottish average or achieve the 4% absence target.

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Further Reading
FFW: http://www.fitforworkscotland.scot/
Equality Act: http://www.legislation.gov.uk/ukpga/2010/15/contents
NICE Guidelines https://www.nice.org.uk/guidance/ng13

Procurement Highland local authority:

http://www.google.co.uk/url?url=http://www.highland.gov.uk/download/meetings/id/40290/item20res7710pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBQQFjAAahUKEwi9qeTamMLIAhXCPxQKHTxaAIw&usg=AFQjCNHoPUDGtqKdggY1JgymN0NA7RSdOw
Previous OH tender: http://www.publictenders.net/tender/349150

Spiritual Care

Purpose

The Spiritual Care Service offers support to patients, their families and carers through times of illness, change and loss. Patients in hospital and in the community, and those who care for them, sometimes have particular concerns that raise questions about deep things in life and may find it helpful to talk things over with someone in a supportive and confidential way. The staff and volunteers in the Spiritual Care Service are available to listen to people's concerns and to offer support and care in a way that responds to the individual needs of each person, whether or not they have a particular religious faith, and whatever their outlook and philosophy of life.

Policy context
The current NHS Shetland Spiritual Care Policy dated Sept 2006 was to be reviewed Sept 2008. The policy will be updated in 2016 reflecting the NHS HDL (2015) National Delivery Plan for Spiritual Care 2015 – 2020, due to be published in 2016. Boards and Spiritual Care departments have worked hard to implement the recommendations made in CEL (2008) 49. The revised guidance (Annex A) and the new national delivery plan (Part Two) aim to further develop the Spiritual Care Service in the light of the integration of Health and Social Care. The 2020 vision, the integration agenda for health and social care and person centred care.

Current Services
There is a full time Spiritual Care Lead chaplain in a joint/shared post with NHS Orkney who oversees a multi faith spiritual care service. The spiritual care lead's main remit is staff support and to develop and ensure the delivery of spiritual and religious care across NHS Shetland.

The Spiritual & Religious Care Service provides spiritual and religious care to NHS Shetland across primary and acute healthcare and social care in the local community. The intention would be to further expand the service over the next 5 years to create a well-integrated service that will meet the spiritual and religious care service for staff, patients, family, carers and the community.

Due to the geographical factors of NHS Shetland, and to ensure equity of spiritual care provision across Shetland, 6 volunteers have been recruited and trained by the spiritual care lead who will provide spiritual care on the wards in the Gilbert Bain hospital, for patients, families and carers supervised by the spiritual care lead. There will eventually be volunteers recruited and specialist trained to provide a listening service, attached to GP surgeries, under the umbrella of CCL – Community Chaplaincy Listening, this is a GP referral service to benefit all patients which includes carers and family members. Staff support is provided on an ad hoc basis by referral, for e.g. from HR and Occupational Health, self referral and via managers, team leaders and working relationships with departments and professional teams. This includes following the asset-based approach of networking within the community.

A tool that enables staff wellbeing is VBRP – values based reflective practice, facilitated by the spiritual care lead in regular sessions across health and social care and are is introduced through staff education and development. VBRP is also included as a useful tool within the nursing revalidation. The bereavement support lead role involves the spiritual care lead attending occasional quarterly meetings in person and via Video Conferencing at National Education NHS Scotland, Glasgow to remain up-to-date with current and national bereavement support policies and guidelines which will benefit staff, patients, families and carers.

Needs/Unmet needs/Drivers for change

Spiritual & Religious Care assessment to be undertaken in 2016 with the update of the Spiritual Care Policy. A service priority will undertake a needs analysis in terms of service delivery and it is anticipated that the review will examine access to the service and ongoing provision of support to staff, patients, families and carers. A needs analysis will recommend future staffing levels for a service which is appropriately responsive to the needs of staff, patients, families, carers and users and in accordance with key government drivers and the CEL.

Plans for change

Service redesign has been the main purpose of the spiritual care lead's remit throughout 2015.

Guided by the CEL update, VBRP for staff support, ensuring evidence and outcomes meet national guidelines. Quarterly attendance at SLG meetings, NHS Education for Scotland and annual professional SLG conference. More volunteers will need to be recruited to fulfil equity of spiritual and religious care across primary care. The spiritual care lead in 2016 has also taken on the role of Bereavement Support Lead for NHS Orkney and NHS Shetland. Working with colleagues across health and social care in Shetland, the revised bereavement support policy will reflect and include input from Shetland Islands Council, Choose Life, Shetland Bereavement Support Service, NHS Shetland Midwifery and Palliative Care.

Key Risks to Delivery

Recruitment to vacant post.

The service being professionally single-handed, there is a risk from the lack of financial input in terms of linking the spiritual care lead to the wider spiritual care network throughout NHS Scotland.

There must be adequate opportunity for supervision and support on an ongoing basis provided through work time.

Service provision in terms of meeting the needs of patients, families and carers who are acutely unwell is a risk, because the spiritual care lead cannot be as responsive as is necessary. The national standard currently suggest 24/7 provision of support which NHS Shetland does not provide. Limitations of travel and inclement weather is a risk.

Performance Targets with links to National Outcomes
Based on the national and local delivery plans will be constructed both for NHS Orkney and NHS Shetland which will be required for service delivery.

Contact Details

Further Reading
CEL (2015) XXXX and The National Delivery Plan for Spiritual Care in Scotland 2015 – 2020 (Version 10) to be published in 2016.
Spiritual Care Matters:
http://www.nes.scot.nhs.uk/media/3723/spiritualcaremattersfinal.pdf –
Tel: 0131 313 8000
A Multifaith Resource for Healthcare Staff:
http://www.nes.scot.nhs.uk/media/3720/march07finalversions.pdf.pdf
Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains:
http://www.ukbhc.org.uk/sites/default/files/nes_chaplaincy_capabilities_and_competencies.pdf

The spiritual care lead is involved in a core group from within the larger spiritual care lead group for NHS Scotland to update the Spiritual and Religious Care Competencies to reflect the newly revised CEL (2015) and The National Delivery Plan for Spiritual Care in Scotland 2015-2020 (Version 10) to be published in 2016. All spiritual care guidelines, standards and policies include patients, families, loved ones and carers.

Health and Safety

Purpose

To provide safe, high quality, sustainable healthcare and health improvement services to the people of Shetland and to do so the Board recognises that it cannot provide these services unless it ensures, so far as is reasonably practicable, freedom from risks to the health, safety and welfare of staff and others affected by the work undertaken and/or the nature of the business. The prevention of injury and ill health together with the continual improvement in health and safety performance are primary objectives of the Board and are prioritised equally alongside other business and operating objectives.

Policy context

Safety is a principle dimension of quality and both are underpinned by NHS Shetland's values. The policy underpins the **2020 Workforce Vision, the Staff Governance Standards** of being 'provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community" and "being appropriately trained and developed" and CEL 13 (2011) Safe and Well at Work: Occupational Health and Safety Strategic Framework for Scotland

The current NHS Shetland Health and Safety Policy has just been updated following consultation. This policy is based on UK Health and Safety Legislation and:

- demonstrates the Board's commitment to health and safety and sets out aims and objectives in relation to this;
- identifies the individual health and safety roles and responsibilities and the communication channels within the organisation; and,
- summarises the practical ways in which health and safety is managed and objectives met.

The Board is required to have a written health and safety policy in order to comply with the Health and Safety at Work etc Act [HSWA] 1974. The act is the primary piece of health and safety legislation within the UK. It is an enabling act, often referred to as an "umbrella" act, which means that regulations can be introduced without the need for additional primary legislation.

This policy is written as a primary policy to allow existing and any new Health and Safety (H&S) regulations and any amendments to be implemented timely as procedures.

The HSWA 1974 states that employers must, so far as is reasonably practicable, provide:

- A safe place of work;
- A safe working environment and adequate welfare facilities;

- Safe equipment and systems of work;
- Safe arrangements for using, handling, storing and transporting articles and substances associated with work; and,
- Sufficient information, instruction, training and supervision for employees.

The act is supported by many other regulations and pieces of legislation, one of the most significant being the Management of Health and Safety at Work Regulations [MHSWR] 1999. A crucial element of these regulations is the requirement for employers to have in place systems to manage health and safety. The technique of risk assessment - used to identify hazards, evaluate risks, support planning and put effective control measures in place - underpins such systems.

Whilst the Health and Safety Policy and its implementation are kept under Bi-Annual review by the Health and Safety Committee, this is a live document with legal force and as such all NHS Shetland employees are to familiarise themselves with this document and mangers are to bring it to the attention of all new, existing staff and third parties where appropriate.

Current Services
Currently recruiting for a part time Health and Safety manager
The postholder is responsible for advising managers and staff about their legal obligations and for providing specialist advice and support to tackle problems relating to health, safety and welfare.

The Health and Safety Manager is required to have an advanced qualification in Health and Safety Management to ensure that the Board complies with Regulation 7 of the Management of Health and Safety at Work Regulations 1999, which require the employer to appoint a competent person to assist with the delivery of the organisation's health and safety agenda. The Health and Safety Manager is responsible for:

- The day to day management of health and safety, advising the Board on health and safety matters and for ensuring that the Board meets all Health and Safety Legislative requirements.

- Formulating and developing health and safety policy

- Undertaking the Equipment Co-ordinators role and functions

- Supporting NHS Shetland in ensuring that appropriate action is taken as a result of Health and Safety adverse event reporting

- Advising and overseeing the management of adverse events relating to Health and Safety

- Ensure any RIDDOR reportable adverse events are reported to the Health and Safety

Executive within the appropriate timeframe

- Managing administrative support in delivering the functions of health and safety

The H &S Manager is responsible for supporting the delivery of the Board's Health and Safety Policy and ensuring that health and safety is integral to all the Board's activities by:

Needs/Unmet needs/Drivers for change
HSE regulation and compliance visits

Plans for change
The post has been reviewed on a number of occasions (see below)
The Board are currently rolling out the Health and Safety Control Book
COSHH training is being sourced for local delivery
Safety Sharps have been rolled out across the Board

Key Risks to Delivery

Recruitment to vacant post – advertising locally – have asked Shetland islands Council if they are interested in provision of a joint post under a SLA.
Lack of clinical engagement to health and safety agenda
The service being professionally single-handed, there is a risk from the lack of financial input in terms of linking the health and safety agenda to the wider health and safety agenda and network throughout NHS Scotland.

Performance Targets with links to National Outcomes
Based on the national and local delivery plans will be constructed NHS Shetland which will be required for service delivery.

Contact Details
Currently vacant post

Further Reading

http://www.shb.scot.nhs.uk/board/policies.asp for HR Policies
http://intranet/committees/healthandsafety/documents/TermsOfReference-

July2014.pdf

Finance

Policy context
The organisation has a statutory duty to break even and the directorate role is to ensure efficient stewardship of resources and delivery of the government best value programme for public funds.

Current Services
The Finance Directorate includes the Board Finance Department, the Finance Department, the Patient Travel Department and the Central Stores Department.

Board Finance – This department represents the Board's Director of Finance and central corporate expenditure such as insurance costs, legal expenses and audit fees.

Finance Department – Responsible for the financial stewardship of the Board and has a statutory obligation to produce annual accounts and associated reports. The department provides timely, accurate financial information to heads of departments to aid them in their organisational decision making. Through service level agreements with NHS Grampian provides the Board's Payroll Service and Accounts Payable/Receivable functions.

Patient Travel – Responsible for the booking of all patient travel to and from various mainland health Boards particularly NHS Grampian. The department manages the Highlands & Islands Travel Scheme (HITS) and all relevant reimbursements to patients.

Central Stores Department – Responsible for the five rights of procurement to ensure Goods / equipment / services are available of the right quality, in the right quantity, in the right place, at the right time, at the right price. Being an Island Board the department must ensure there are adequate stock levels across the Board to deal with adverse weather conditions frequently experienced in Shetland. A service level agreement is now in place with National Services Scotland to provide strategic procurement and systems management for the Board.

Funding and Resources

Needs/Unmet needs/Drivers for change
Drivers for change include reducing budgets combined with a greater appetite for financial information in the current climate. With demand increasing on the department it will be very difficult to maintain the level of service whilst continuing to find additional savings year on year. There is also a shared services initiative under way where Finance/Stores may be merged with other Boards or nationally into central hubs.

Plans for change
With demand for financial information increasing the Finance Department has recruited a band 4 Finance Officer to assist with the monthly closedown process. This will allow us to achieve an 8 working day closedown which corresponds to best practice in the NHS. This has released more accountant time to support redesign projects and efficiency schemes. Service levels in Shetland have now been reduced to a minimum with Payroll, Accounts Payable & Receivable and Strategic Procurement outsourced to NHS Grampian and National Services Scotland through a Service Level Agreement. Meaningful financial information and analysis will be an essential component of all the Strategic Programmes to secure sustainable services.

As a result of outsourcing these services, the Finance Directorate has achieved all of its savings target up to and including the financial year 2017/18.

The Finance Service leads on the Patient Travel method project, which seeks to reduce overall the cost of travel to/from Shetland by investigating alternative methods of travel and escort / support arrangements for patients deemed unable to travel on their own.

The Finance Services will contribute to the Improving Business Performance and Efficiency Strategic Programme and specifically:

- National Shared Services
- Procurement and Commissioning
- Working out ways to do things 'once for Shetland'

Key Risks to Delivery

Budget constraints may result in a lower level of service and there is ongoing difficulty in recruiting and retaining staff.

Performance Targets with links to National Outcomes

No performance targets as such but regular scrutiny by External & Internal Audit which results in continuous improvement of the service.

Contact Details

NHS Switchboard 01595 74 3000

NHS Support Services Plans

Estates, Facilities and Medical Physics

Policy context
The Estates, Facilities and Medical Physics services are designed to support the overall vision of NHS Shetland.
It therefore aspires to provide and maintain ***sustainable, high quality properties and facilities services*** that allow the effective delivery and continuous improvement of healthcare across Shetland.

Current Services
A detailed summary of the physical assets supported by the Estates department are included in the PAMS and the SAFR (see link). These include the Gilbert Bain Hospital, the Montfield site including Dental services, Staff development and Board HQ and 10 Health centres and 4 clinics spread across the Shetland mainland and outer isles. There are also a number of other small owned properties (i.e.

St Olaf Dental practice) and privately owned premises from which NHS contractor services are provided (i.e. Pharmacies and Opticians). The Board also leases property at Breiwick House for office accommodation, junior doctor's accommodation and Mental Health services.

All the NHS Shetland owned and leased buildings, Health centres and Medical equipment assets are supported by an Estates function that carries out planned and reactive maintenance, capital planning, minor repairs and capital project schemes and a Medical Physics function.

The facilities services provided by the Directorate include Domestics, Catering, Porters and Laundry and Linen services.

The service is obliged to maintain compliance with a range of indicators, such as SCART. A number of these are national KPIs and others link to legislative requirements (e.g. Legionella, Hospital Gases, Building regulations, Fire safety, Medical equipment, Infection Control, Food Hygiene, Waste, etc.)

Funding and Resources

The savings target for 2016/17 was a further target of £177k and this was achieved.

The savings target for 2017/18 is a further target of £122k and outline plans are in the process of being submitted for approval to achieve this.

Future year on year targets are anticipated to be 3% which will be challenging for support services to achieve while remaining within statutory compliance and best practise and existing clinical service delivery models.

Needs/Unmet needs/Drivers for change

The savings target for 2017/18 is a further target of £122k and outline plans are in the process of being submitted for approval to achieve this through operational savings.

Future year on year targets are anticipated to be 3% which will be challenging for support services to achieve while remaining within statutory compliance, best practise guidance and the existing clinical service delivery models.

Plans for change

Description Lead Officer Start date/target Expected Outcome(s) (link to National Outcomes)

Property and Assets	Management Strategy 2015 (PAMS) sets out the list of priorities over next year, five years and 10 years.
NSS Shared Services	Work on the potential to share services on a regional or national level.
Ambulatory Care	Investment in Ambulatory Care and Day Surgery Facilities at Gilbert Bain Hospital.
Sustainable service structures	Contributing to the strategic priorities workstreams, including: - A safe and effective model of unscheduled care; and - Sustainable hospital and acute services, primary care and social care models

Key Risks to Delivery

The key risks remain:

The availability of adequate resources to support the services currently required.
This includes both staffing, linked to recruitment, retention, no redundancies policy, specialist staff and the age profile.
Finances (revenue and capital budgets have been significantly reduced to date and will be further reduced in future years).
Clinical service redesign has potential to increase support services demand.
Along with other support services the E&F directorate is currently working to deliver a 25% efficiency target over a 5 year period this will impact on service delivery, staff performance, increase risk to statutory compliance and Scottish Government guidelines and initiatives.

Performance Targets with links to National Outcomes

The PAMS sets out a range of KPIs and mechanisms for performance monitoring. This includes indicators on:

- Energy Efficiency (HEAT)
- Property: SCART (quality indicators); Backlog maintenance; Property Facets etc
- Facilities: Patient Satisfaction (IP survey); Cleanliness Audits; Benchmarking
- Within the SAFR all Estates, Facilities and Medical Physics services across Scotland are also measured for efficiency, condition and comparative cost

Contact Details

Lawson Bisset
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Service Area	Services Summary	Performance Measures	Performance	Projects / Activities
Community Nursing	District Nurses, Practice Nurses, Advance Practitioner Nurses, Specialist Nurses, Non Doctor Islands, Out of Hours and Intermediate Care Team	Number of anticipatory care plans in place.	Target 700, achieving 940 at Quarter 2 2016-17.	Community Nursing Capacity / Demand
		Percentage of Catheter Associated Infections in individuals with an indwelling urinary catheter.	Consistently acheiving 0%.	
Intermediate Care	Reduce unplanned admissions to hospital or long term care, enhance discharge planning from hospital	Delayed Discharge from Hospital - no delays exceeding 14 days.	Target no. 2, achieving 2 at Quarter 2 2016-17.	Intermediate Care
Mental Health	Community Psychiatry Services, Community Psychiatric Nursing Service, Psychological Therapies Service, Substance Misuse Recovery Service, Dementia Services.	People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support	Target 50% (interim measure), achieving 43.7% Quarter 2 2016-17	Developing a sustainable model for mental health services, including appropriate crisis and emergency arrangements
		People with a diagnosis of dementia on the QOF dementia register	Target no. 184, achieving no. 173 in Quarter 2 2016-17.	
		18 weeks referral to treatment for Psychological therapies	Target 90%, achieving 77% Quarter 2 2016-17	
		Admission Rates to Psychiatric Hospitals	Target no. 6, achieving 3 at Quarter 2 2016-17 (proxy measure for effectiveness of local services)	
Oral Health	Primary Dental Care will be provided predominantly through independent NHS practices. Public Dental Service will cover: special needs; remote and rural; public health; oral health promotion; specialist services.	Number of people who are waiting to register with the Public Dental Service for ongoing care.	Target 500, achieving 704 at Quarter 2 2016-17.	
		The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland.	Target 1,670, achieving 2,167 at Quarter 2 2016-17.	
		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).	Target 75% in 2015-16, achieved 79%.	
		The percentage of the adult populations who are registered with Shetland dentists for NHS dental care.	Achieving 84% in 2015-16.	
		The percentage of the child populations who are registered with Shetland dentists for NHS dental care.	Achieving 94% in 2015-16.	
Pharmacy and Prescribing	Community and Hospital Prescribing Services	Percentage rate of antiobiotic prescribing in relation to Scottish average.	Target 99%, achieving 96.1% at Quarter 2, 2016-17.	Effective Prescribing - working with patients and prescribers to ensure that evidenced, best value, medicines are started and stopped appropriately
		Number of polypharmacy reviews completed.	Target no. 30, achieved no. 121 at Quarter 2 2016-17. (Nos fluctuate)	
		Number of discharge prescriptions dispensed out of hours by nursing staff.	Target no. 48, achieving 34 at Quarter 2 2016-17. (Nos fluctuate).	

Service Area	Services Summary	Performance Measures	Performance	Projects / Activities
		Percentage spend for Shetland on GP Prescribing compared to the national average.	Target 99%, achieving 97% Quarter 2 2016-17.	
Primary Care	GP Services and Ophthalmic Services (Pharmacy and Dental included elsewhere)	48 hour access or advance booking to an appropriate member of the GP team	Annual target 90%, achieved 76% in 2015-16.	Developing a sustainable primary care model for Shetland, with clear links to the 7 locality areas and the Gilbert Bain Hospital
		Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre.	Consistently achieving 100%.	
		Percentage access to a primary care health professional for an appointment within 48 hours at any Shetland Health Centre.	Consistently achieving 100%.	
Substance Misuse	Information and advice, screening and referrals, treatment, residential treatment (outwith Shetland) and aftercare	Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery.	Target 90%, achieving 100% at Quarter 2 2016-17	
		Clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery.	Target 90%, achieving 78% at Quarter 2 2016-17 (7 of 9 clients)	
		Sustain and embed alcohol brief interventions in 3 priority settings and broaden delivery in wider settings.	Target no. 129, achieved 77 at Quarter 2 2016-17	
Nutrition and Dietetics	Dieticians assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. They use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.Dieticians treat complex clinical conditions such as diabetes, food allergy and intolerance, IBS syndrome, eating disorders, chronic fatigue, malnutrition, kidney failure and bowel disorders. They provide advice to caterers to ensure the nutritional care of all clients in NHS and other care settings such as care homes, they also plan and implement public health programmes to promote health and prevent nutrition related diseases. A key role of a dietician is to train and educate other health and social care workers. Dieticians also advise on diet to avoid the side effects and interactions between medications.			

Service Area	Services Summary	Performance Measures	Performance	Projects / Activities
Occupational Therapy	Occupational therapy takes a whole-person approach to both mental and physical health and wellbeing, enabling individuals to achieve their full potential. It provides practical support to enable people to facilitate recovery and to overcome any barriers that prevent them from doing the activities (occupations) that matter to them. This helps to increase people's independence and satisfaction in all aspects of life. Occupational therapists work with adults and children of all ages with a wide range of conditions; most commonly those who have difficulties due to a mental health illness, physical or learning disabilities. They can work in a variety of settings including health organizations, social care services, housing, education and voluntary organisations. In Shetland the Occupational Therapy Team provides Occupational Therapy Assessments at home, in the Gilbert Bain Hospital or as outpatient appointments, a rehabilitation and reablement service, advice, Wheelchair Assessments and Blue Badge Assessments	Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count).	Target no. 10, achieving 12 at Quarter 2 2016-17 (nos fluctuate).	
Orthotics	Orthotists provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. They are able to design and provide orthoses that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They treat patients with a wide range of conditions including Diabetes, Arthritis, Cerebral Palsy, Stroke, Spina Bifida,Scoliosis, MSK, sports injuries and trauma.	Percentage Waiting Time from referral to Treatment for Orthotics Services (18 weeks).	Target 90%, achieving 100%.	
Physiotherapy	Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, educ ation and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible. Physios use their knowledge and skills to improve a range of conditions associated with different systems of the body, such as: Neurological (stroke, multiple sclerosis, Parkinson's); Neuromusculoskeletal (back pain, whiplash associated disorder, sports injuries, arthritis); Cardiovascular (chronic heart disease, rehabilitation after heart attack); Respiratory (asthma, chronic obstructive pulmonary disease, cystic fibrosis).	Percentage Waiting Time from Referral to Treatment for Physiotherapy Services (18 weeks).	Target 90%, achieving 99%.	

Service Area	Services Summary	Performance Measures	Performance	Projects / Activities
Podiatry	Podiatrists triage, assess, diagnose and treat the full range of podiatric conditions of the foot and lower limb. We provide treatment for nail management, wound management, vascular and neurological assessment, advise on foot health and footwear, provide advise and practical solutions for personal footcare, work with the multidisciplinary "high risk limb" team, musculoskeletal clinics, manufacture and prescription of orthoses, nail surgery, undertake diabetic foot screening and assessment, assist patients in preventing trips and falls, work towards prevention of foot problems therefore reducing non-planned hospital admissions, provide treatment for patients with long term conditions (LTC), work jointly with other health care professionals, provide training to care workers, hold joint assessments with Physiotherapy and work closely with the Shetland Voluntary Nail Cutting Service (SVNCS)	Percentage Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)	Target 90%, achieving 100% Quarter 2 2016-17.	
Speech and Language Therapy	Speech and language therapists (SLTs) provide life-improving treatment, support and care for children and adults who have difficulties with communication, eating, drinking or swallowing. SLTs assess and treat speech, language and communication problems in people of all ages to help them communicate better. They also assess, treat and develop plans to support people who have eating and swallowing problems. Using specialist skills, SLTs work directly with clients and their carers and provide them with tailored support. They work closely with teachers and other health professionals such as nurses, doctors and other AHPs and psychologists to help develop programmes.			
Health Improvement	Information and advice, awareness raising / training (including Training for trainers) and education on a range of topics and in a range of settings.	Smoking rate (percentage)	2016, 16%, target 5%	Implementing an asset based approach to health care prevention
	Direct delivery of health improvement prevention programmes: Keep well checks, alcohol brief advice, physical activity brief advice, school based S3 screening	Number of successful quits for people residing in the 60 per cent most-deprived datazones in Shetland (count)	Sept 2016, 12, Target 43	
	Direct delivery of health improvement interventions: adult and child healthy weight management at tier 2, smoking cessation, physical activity brief interventions and mild to moderate mental health issues in adults.	Alcohol Brief Interventions (count)	Nov 2016, 115, target 261	
	Conduct Health Needs Assessment, Health Impact Assessments and Evaluation.	Reduce the proportion of children with their Body Mass Index outwith a healthy range (>=85th centile) (percentage)	Sept 2016, 22%, Target 15%	

Service Area	Services Summary	Performance Measures	Performance	Projects / Activities
	Undertake healthy public policy development (translating latest national policy at local level), implementation and monitoring with a focus on wider determinants of health, reducing health inequalities, capacity building and individual/ community empowerment (topic areas: smoking; inequalities; obesity; alcohol, mental health, sexual health, healthy eating, physical activity).	Proportion of adults meeting moderate/vigorous physical activity (MVPA) guidelines: at least 150 minutes of moderately intensive physical activity or 75 minutes vigorous activity per week or an equivalent combination of both. (percentage)	2014, 64%, Target 50% (under review)	
Unscheduled Care	Emergency or unplanned service responses in community, hospital or specialist settings, including (list limited to integrated services): community nursing and primary care out of hours services; Accident and Emergency service; admission to hospital for medical services.	4 hours from arrival to admission, discharge or transfer for A&E treatment.	Target 98%, achieving 95% Quarter 2 2016-17 (582 presentations out of 627 left A&E within 4 hours)	Developing an Unscheduled Care Hub (for mainland Shetland) and developing sustainable out of hours models for the outer isles.
Renal				
Sexual Health				
Directorate				

Service Area	NHS Budget	Savings Target	Option 1 Net Budget = Recovery Plan	Projects / Activities and Notes	Further Efficiencies / Hold Current Vacancies	Option 2 Net Budget = Negotiated Position	Ideas to Explore for further savings / efficiencies	Consequences and Risks : Generic	Consequences and Risks : Service Specific	Theoretical Cut for Zero Recovery Plan	Equivalent No. Of WTE Posts using average salary of £35K	Expressed as a percentage cut on the current Budget	Option 3 Net Budget = No Recovery Plan
	£000	£000	£000		£000	£000				£000	Number	£000	£000
Community Nursing	2,330	240	2,090	Community Nursing Capacity / Demand		2,090	Levels of Service: mainland and isles with resident GPs.	Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).	No out of hours nursing cover on islands - Gp only cover. Limited / no support from other services so GP effectively single handed in the absence of an out of hours nursing service. Centralisation of District Nursing into larger teams - no local presence at each health centre going forward	300	8.6	23	1,790
			-			-	Levels of Service: Non Doctor Islands	Reduced Service Levels; potential negative impact on current performance, waiting times (eg delayed discharge from hospital).	No resident nursing cover, visiting services only. Immediate response for emergencies via 999 call				-
			-			-		Reduction in Primary Care investment contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend.					-
			-			-		Community Confidence / Resilience: potential impact on sustainability of remote and rural communities.					-
Intermediate Care	410		410	Intermediate Care		410		None; service to be established on permanent basis as a key delivery mechanism for Shifting the Balance of Care from Hospital to Community.				-	410
Mental Health	1,353		1,353	Developing a sustainable model for mental health services, including appropriate crisis and emergency arrangements		1,353	Grampian pathways.	Reduced Service Levels; potential negative impact on current performance, waiting times for potentially high risk individuals / scenarios.		100	2.9	7	1,253
			-			-	Back office support functions	Recent organisational development and management arrangements review: potential to disrupt improvement plan.					-
Oral Health	3,123		3,123	Ring Fenced Allocation.		3,123		No change, within allocation level		0		-	3,123
Pharmacy and Prescribing	6,393	329	6,064	Effective Prescribing - working with patients and prescribers to use minimally disruptive interventions (including lifestyle changes)		6,064	Accelerated Efficiency Programme (potential require spend to save)	High number of prescribing points / individuals. Speed with which savings can be generated dependent on cultural / behavioural change or taking a more restrictive approach to prescribing.	Ability to secure savings in the order of £329K should be considered 'high risk'.	200		8	5,864
			-			-		Risk of prescribing budget being fully utilised part way through the year with no recourse to additional funding / reserves.	As regards accelerating the pharmacy work, this is difficult but certainly not impossible. It would require the following investment: dedicated data analysis; dedicated medical leadership; recruitment strategy for enhanced pharmacy team; and medium - long term funding.				-

Service Area	NHS Budget	Savings Target	Option 1 Net Budget = Recovery Plan	Projects / Activities and Notes	Further Efficiencies / Hold Current Vacancies	Option 2 Net Budget = Negotiated Position	Ideas to Explore for further savings / efficiencies	Consequences and Risks : Generic	Consequences and Risks : Service Specific	Theoretical Cut for Zero Recovery Plan	Equivalent No. Of WTE Posts using average salary of £35K	Expressed as a percentage cut on the current Budget	Option 3 Net Budget = No Recovery Plan
	£000	£000	£000		£000	£000				£000	Number	£000	£000
			-			-		An ageing population, often living with complex long tem conditions, will inevitably result in prescribing increases.	Recruiting staff with correct skill sets is a challenge. Some Government funding available for part tunding posts but would have to find match-funding.				-
Primary Care	4,571	150	4,421	Developing a sustainable primary care model for Shetland, with clear links to the 7 locality areas and the Gilbert Bain Hospital	0	4,421	Levels of Service: Shared GP provision across 5 employed practices	Savings beyond current staffing levels in the 5 employed GP practices; redeploymnet or redundancy (only if Scottish Government approval).	Three of the salaried practices are on islands. Owing to geography, there is an option to look at merging the Yell and Unst practices; this would however mean a visiting service only to Unst with a reduced overnight service and would also see a reduction in administrative staff. Actual costs and what this model would look like are still to be understood.	300	It should be noted that administrative staff are mostly Band 3, so well below the average salary, which in effect means more posts may have to be lost to meet this target, which would further impact on the running of the practices.	10	4,121
			-	The current arrangements will be 5 independent and 5 directly employed practices.		-	Shared premises	Reduced Service Levels; potential negative impact on current performance, waiting times (eg delayed discharge from hospital).	2 practices have become salaried in the last year and there is a risk that more practices will follow - there is a national trend occuring whereby practices are becoming salaried owing to recruitment and viability issues. There is a sustainability tool under development by SG which we will use to better understand potential risk in Shetland of more practices becoming salaried. It is clear however that there are service issues when practices become salaried owing to recruitment issues, as this can mean employing locums to ensure service provision, which is not sustainable.				-
			-	The Board has contractual obligations with the independent practices which means that any savings will fall to the 5 directly employed practices.		-	Shared back office support functions	Reduction in Primary Care investment contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend.	The funds for independent practices are ring fenced, as is funding for specific pieces of work e.g. Enhanced services. This means that any savings will come from the salaried practices, which have already made substantial savings in previous years - the only place left for savings is to remove posts. This will have an impact on appointment availability, typing of referrals, scanning of patient information etc and will lead to a reduction in service, which in turn will very likely result in an increase in complaints.				-
			-			-		Potential for shared premises / ICT resources etc dependent on partner engagement / approval and financial business case.	Shared premises would reduce overheads without affecting staffing; this is possible only with partner engagement and is dependent on suitable premises being available. There is low risk for service delivery.				-
Substance Misuse	496		496			496	Levels of Service, including commissioned services from third sector.	Savings beyond current staffing levels; redeploymnet or redundancy (only if Scottish Government approval).	Higher risk of unsafe injecting practice – leading to increase in risk of Blood Borne Viruses (BBV) or drug deaths.	35	1	7	461
			-			-		Reduced Service Levels; potential negative impact on current performance for potentially high risk individuals / scenarios and not meeting specific waiting times targets.	Higher risk of losing pre and post treatment clients. Early intervention for the pre-contemplative keeps people safe till they ready to engage in treatment				-

Service Area	NHS Budget	Savings Target	Option 1 Net Budget = Recovery Plan	Projects / Activities and Notes	Further Efficiencies / Hold Current Vacancies	Option 2 Net Budget = Negotiated Position	Ideas to Explore for further savings / efficiencies	Consequences and Risks : Generic	Consequences and Risks : Service Specific	Theoretical Cut for Zero Recovery Plan	Equivalent No. Of WTE Posts using average salary of £35K	Expressed as a percentage cut on the current Budget	Option 3 Net Budget = No Recovery Plan
	£000	£000	£000		£000	£000				£000	Number	£000	£000
									Less support available for community alcohol detox – are labour intensive as always start on a Monday and someone has to do home visits every day for 2 weeks				
Nutrition and Dietetics	112		112			112	Levels of Service	Savings beyond current staffing levels; redeploymnet or redundancy (only if Scottish Government approval).	Activity will be limited to covering Wards, Outpatients and Telephone appointments. There will be a withdrawal of patient and staff education programs. Not able to deliver on Tier 3: Individually tailored weight management intervention as required by Scottish Government. Risk of losing external funding. Knock on impact on other services of poorly managed diabetes and weight; increased GP attendance, community nuring input, medication,and impact on care services.	35	1	31	77
			-			-		Reduced Service Levels; potential negative impact on current performance, waiting times.					-
			-			-		Reduction in AHP services contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend.					-
Occupational Therapy	185	-	185	Plan release of 10 hours per week support worker time	7	178	Levels of Service	Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).	Significant impact on speed and success of discharges. Work limited to acute only, reduction in input to orthopaedic clinics, withdraw from following patients into community, no cover to A&E as currently proposed	35	1	23	143
			-			-		Reduced Service Levels; potential negative impact on current performance, waiting times, including delayed discharges.					-
			-			-		Reduction in AHP services contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend.					-
Orthotics	143	-	143	Supply Orthotic service to NHS Orkney	20	123	Levels of Service	Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).	Reduction in technician time would mean buying in ready made items - likely to be more expensive and take longer to provide. Reduction in orthotist time means prioritising Wards, A&E and Fractures, reduced input to outpatients meaning decreased function and mobility, increased pain, impact on GP visits and pain medication, increase in falls.	20	0.6	28	103
			-			-		Reduced Service Levels; potential negative impact on current performance, waiting times.					-
			-			-		Reduction in AHP services contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend.					-
Physiotherapy	603		603			603	Levels of Service	Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).	Inability to offer treatment to people with long term conditions/ focus on crisis response and advice. Patients with more complex needs e.g. advance neurology and continence will travel to Aberdeen for input. Telehealth, spinal triage and development of physiotherapy injection therapy would be stopped leading to these patients travelling to the mainland at significant cost. Self referral would be stopped; this has a hidden cost as a cost saving of self referral was estimated at £35 per patient in 2012.	35	1	6	568
			-			-		Reduced Service Levels; potential negative impact on current performance, waiting times, including delayed discharges.					-
			-			-		Reduction in AHP services contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend.					-
Podiatry	225		225	Possible £3K (reduce lease car to 1 vehicle)	3	222	Levels of Service	Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).	Increase in infection rates; greater demand upon GP, practice and community nursing teams; hospitalisation; increase in amputations. Both New and Review assessed waiting/return times not met. Acute conditions become chronic requiring greater clinical input from team and other services. Reduced input into falls prevention, dementia and joint working.	20			202
			-			-		Reduced Service Levels; potential negative impact on current performance, waiting times.					-
			-			-		Reduction in AHP services contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend eg falls prevention.					-

Service Area	NHS Budget	Savings Target	Option 1 Net Budget = Recovery Plan	Projects / Activities and Notes	Further Efficiencies / Hold Current Vacancies	Option 2 Net Budget = Negotiated Position	Ideas to Explore for further savings / efficiencies	Consequences and Risks : Generic	Consequences and Risks : Service Specific	Theoretical Cut for Zero Recovery Plan	Equivalent No. Of WTE Posts using average salary of £35K	Expressed as a percentage cut on the current Budget	Option 3 Net Budget = No Recovery Plan
	£000	£000	£000		£000	£000				£000	Number	£000	£000
Speech and Language Therapy	83		83			83	Levels of Service	Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).	Already limited in ability to provide full range of services to children and adults. Lack of speech therapy leads to poorer outcomes; high risk of poor mental health, lower attainment, social disadvantage, higher risk of crime.			-	83
			-			-		Reduced Service Levels; potential negative impact on current performance, waiting times.					-
			-			-		Reduction in AHP services contrary to Scottish Government policy direction (based on best outcomes for patients / service users) and preventative spend.					-
Health Improvement	310		310	Implementing an asset based approach to health care prevention		310	Levels of Service	Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).	Health Improvement and Preventative work is a national priority area.			-	310
								Reduced Service Levels will lead to worse performance against HEAT standards / targets; increase waiting times for services and increase inequalities (because services will become centralised with less flexibility and ability to focus on individual patient / client needs).	Shetland is currently not meeting all of the HEAT targets, largely because preventative work is predominantly carried out by Health Improvement practitioners, rather than being mainstreamed into core services. Whilst self help / self management will assist, it will take time to carry out the cultural and behavioural changes necessary to see a direct impact on the level of health and care services needed to meet the populations needs.				
								Reduction in Health Improvement services contrary to Scottish Government policy direction (based on best outcomes for patients / service users) through preventative spend.	The overall approach of the Health Improvement Team is to build the capacity of others to deliver the behaviour change services directly. As the primary care workforce reduces, this becomes ever more unlikely and preventative work will reduce if the health improvement resources is also reduced.				
			-			-			As well as direct health improvement interventions the Health Improvement practitioners carry out activities to tackle the wider determinants of health which is the only way we are going to get significant progress in the longer term.				-
			-			-			Staff have been funded substantially from external funding which is now reducing or stopping. Some staff are employed on temporary contracts if and when we are successful in applying for small pots of time limited funding from the Government and other sources.				-
									If staff numbers / time are reduced then there will be reduction in staff time to carry out core health improvement work (including Keep Well checks, ABIs, 1to1 smoking cessation and weight management; and supporting health improvement work in workplaces, schools and communities.) as well as additional work such supporting mental health services.				
Unscheduled Care	3,190	472	2,718			2,718		Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).				15	2,718
		100	- 100	Developing an Unscheduled Care Hub (for mainland Shetland) and developing sustainable out of hours models for the outer isles.		- 100		Reduced Service Levels; potential negative impact on current performance, waiting times.					- 100

Service Area	NHS Budget	Savings Target	Option 1 Net Budget = Recovery Plan	Projects / Activities and Notes	Further Efficiencies / Hold Current Vacancies	Option 2 Net Budget = Negotiated Position	Ideas to Explore for further savings / efficiencies	Consequences and Risks : Generic	Consequences and Risks : Service Specific	Theoretical Cut for Zero Recovery Plan	Equivalent No. Of WTE Posts using average salary of £35K	Expressed as a percentage cut on the current Budget	Option 3 Net Budget = No Recovery Plan
	£000	£000	£000		£000	£000				£000	Number	£000	£000
Adult Services	66		66			66		Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).				-	66
						-		Reduced Service Levels; potential negative impact on current performance, waiting times.					-
Sexual Health	38		38			38		Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).				-	38
						-		Reduced Service Levels; potential negative impact on current performance, waiting times.					-
Renal	145		145			145		Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).				-	145
						-		Reduced Service Levels; potential negative impact on current performance, waiting times.					-
Directorate	94		94			94		Savings beyond current staffing levels; redeployment or redundancy (only if Scottish Government approval).				-	94
Pay Reserve	391		391			391		Will be required to meet cost of current establisment pay awards and incremental points.				-	391
SG Reserve	110		110			110		If fully utilised to balance the budget, no protection for addressing increased demand or costs throughout the year.				-	110
Total	**24,371**	**1,291**	**23,080**	-	**30**	**23,050**				**1,080**	**16**	**10**	**21,970**

Summary:	**Target**	**Proposal**
	£000	**£000**
Planned Projects	1,291	1,291
Further Temporary Savings / Efficiencies	30	30
Theoretical Cuts	1,208	1,080
Overall Savings Target	**2,529**	**2,401**
Balance		128

NHS Funding Offer 2017-18	**£000**
Gross Payment to IJB	23,135
Less: Adjustments for:	
IJB Administration Costs	15
Additional Funding for Social Care	938
	340
	1,293
Net Adjustted Payment to IJB	**21,842**
IF 'No Recovery Plan':	
Budget Proposals	21,970
Balance	128

Housing Contribution Statement

March 2016

Introduction

The Housing Contribution Statement (HCS) is a statutory requirement, as set out in the Government's Housing Advice Note, 'Statutory Guidance to Integration Authorities, Health Boards and Local Authorities on their responsibilities to involve housing service in the Integration of Health and Social Care, to support the achievement of the National Health and Wellbeing Outcomes'.

The HCS sets out the contribution of housing and related services in Shetland towards helping achieve priority outcomes for health and social care. It serves as a key link between the Strategic Commissioning Plan and the Local Housing Strategy and supports improvements in aligned strategic planning and the shift to prevention.

As a local housing authority, the Council has a statutory duty and a strategic responsibility for promoting effective housing systems covering all tenures and meeting a range of needs and demands.

The Council's strategic housing plan is articulated in the Local Housing Strategy[1] which is underpinned by the robust and credible evidence from the Housing Need and Demand Assessment (HNDA)[2].

Health & Social Care Partnership

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care to ensure joined-up, seamless services. In 2015 the Integrated Joint Board (IJB) was established as a separate legal entity.

The IJB has a responsibility to produce a Strategic Plan by April 2016.

The Executive Manager – Housing is represented on the Strategic Planning Group to actively promote the housing sector's role in health and care integration. The Chief Executive of Hjaltland Housing Association is also a member of the Strategic Planning Group.

[1] http://www.shetland.gov.uk/housing/policies_housing_strategy.asp

[2] http://www.shetland.gov.uk/housing/policies_housing_need.asp

National Outcomes

The national health and wellbeing outcomes to be delivered through integration set out 9 specific outcomes. Outcome 2 is of particular relevance to setting out the housing contribution.

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

Locality Planning

Locality planning has been established and unified in Shetland at a Community Planning level. This means that strategic documents such as the LHS reflect the same 7 localities. This will allow for integration of services operationally as the local implementation plans develop.

Delegated Function

The Act sets out a range of health and social care functions, including functions under housing legislation which 'must' or 'may' be delegated to the IJB. These are contained in the Health and Social Care Integration Scheme approved in June 2015.

The housing functions that are delegated to the IJB are:

- Housing Adaptations (General Fund and Housing Revenue Account) – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living. The General Fund adaptations are carried out by Hjaltland Housing Association through their One-Stop-Shop and are for owner occupiers and tenants of private landlords. The Housing Revenue Account is where any adaptations for tenants of Council houses are funded.

Other housing functions which have a close alignment with health and social care outcomes but are not part of any delegated functions are:

- Housing support services and homelessness
- Other wider functions to address future housing supply, specialist housing provision and measures to address fuel poverty.

Local Housing Strategy

The Local Housing Strategy (2011-2016) sets out the vision for Housing in Shetland:

"to work in partnership to enable everyone in Shetland to have access to: A choice of affordable housing options across all tenures that are warm and safe, energy efficient and in keeping with the Shetland environment, of good quality and in good repair, able to meet demand and the particular needs of households in inclusive and vibrant communities."

The Local Housing Strategy sets out 5 key themes/priorities:

- Future Housing Supply
- Fuel Poverty
- Housing Support/Housing for an Ageing Population
- Homelessness
- Private Sector Housing

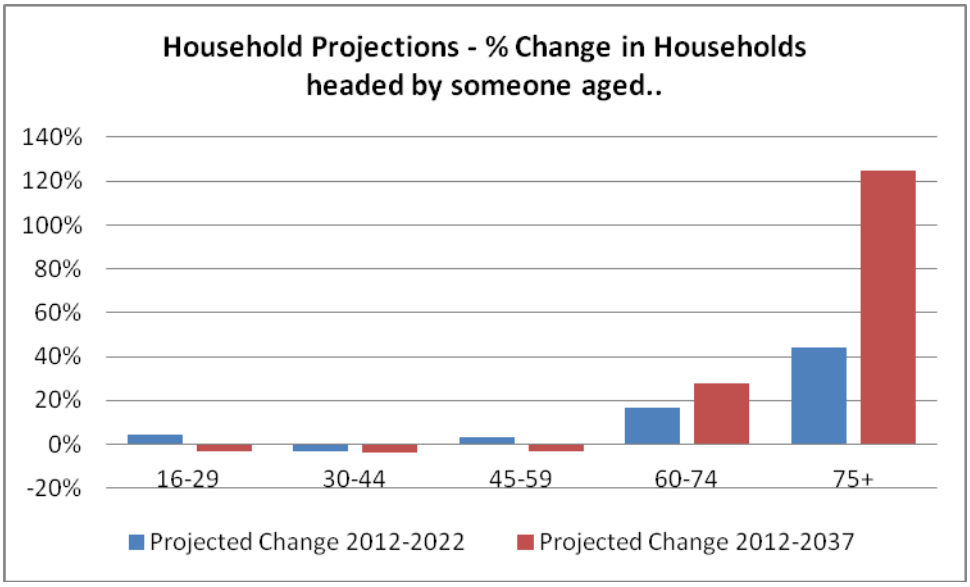
All of the key themes of the LHS are relevant to the HCS.

Key Issues for Shetland

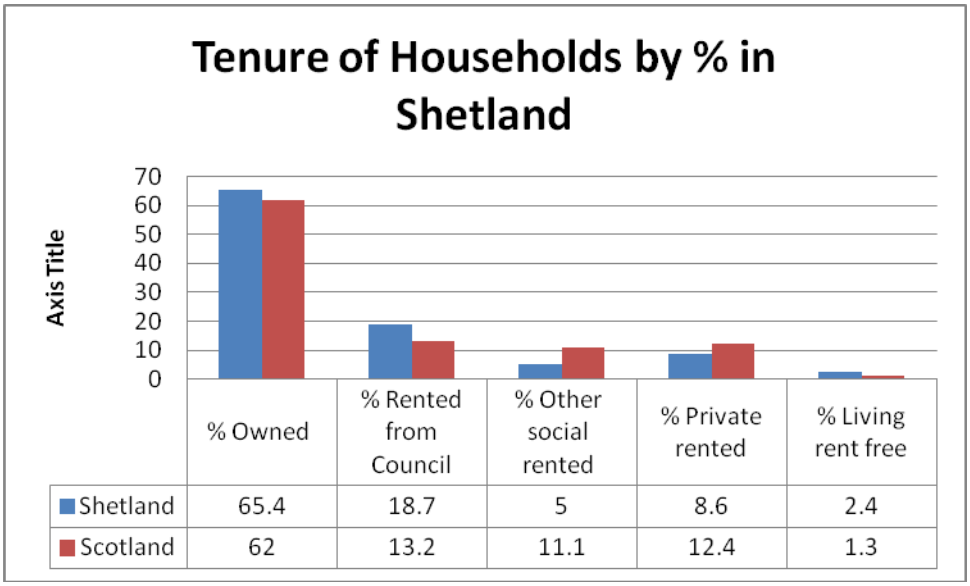
Housing Profile

Population	• 23,230[3] • 3,946 (17%) aged over 60 years
Households	• 10,201 • 9.8% increase 2004-2014 • Average household size 2.26 • 3.8% decrease 2004-2014
Household Composition	• 33% single adult households[4] • 58% small family households • 8% large family households
Dwellings	• 10,950 • 8.2% increase 2004-2014
Completions	• Annual average 94 (2010-2015) • 47% Affordable housing • 53% Private housing
Tenure	• 65% Owner occupied • 24% Social rented • 9% Private rented • 2% other
Specific needs	• 83% of the population do not consider that they are limited by a disability[5]
Specific Housing Provision	• 273 sheltered houses (social rented) • 25 extra care units (social rented) • 15 Homes for Life units (social rented in pipeline)
Adaptations	• 223 adaptations to private sector properties through Scheme of Assistance since 2011 • 70% to provide level access shower • 15% to provide ramped access • 8% both shower and ramp provision • 3% to provide WC upstairs/downstairs • 3% extension/conversion • 1% driveway/external access • Adaptations to Council properties in graph below

[3] GRO Scotland mid-2014
[4] National Records of Scotland 2012
[5] Census 2011



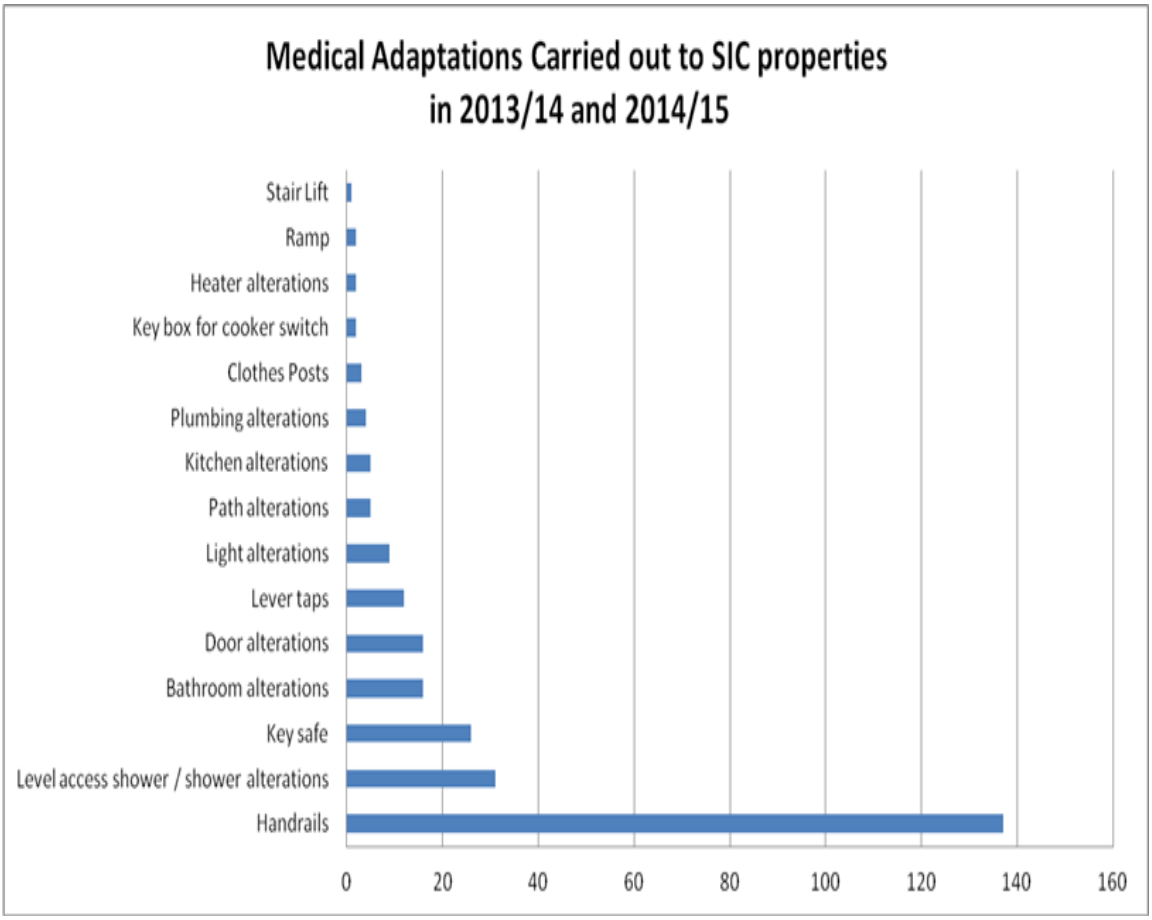
Source National Records Scotland



Source: Census 2011

Age group	Total no.	Day to day activities limited a lot	Day to day activities limited a little	Day to day activities not limited
65-74	2143	266 (12%)	505 (24%)	1372 (64%)
75-84	1178	337 (29%)	398 (34%)	443 (38%)
85 and older	456	265 (58%)	123 (27%)	68 (15%)

Source 2011 Census


Medical Adaptations Carried out to SIC properties
in 2013/14 and 2014/15
Stair Lift
Ramp
Heater alterations
Key box for cooker switch
Clothes Posts
Plumbing alterations
Kitchen alterations
Path alterations
Light alterations
Lever taps
Door alterations
Bathroom alterations
Key safe
Level access shower / shower alterations
Handrails
0
20
40
60
80
100
120
140
160

Housing Contributions to Integration

- Encourage future housing supply that is the right size and in the right location across all tenures ; built to modern standards and future-proofed design, mainstreaming of barrier-free, dementia friendly design and promoting provision for the use of assistive technologies.

- Moving away from ‘sheltered housing’ and ‘very sheltered housing’ labels to accessible housing, homes with support and homes for life.

- Developing better shared assessment processes with health and care teams in localities to link with housing support plans and housing allocation process.

- Reviewing housing allocations policy to ensure that it continues to match people with housing that is suitable for their needs.

- Developing a housing options approach which would assist with longer term planning and anticipating future needs by fostering a prevention/early intervention approach to housing need. This will include developing a range of information and advice access points in partnership with a range of agencies in all localities.

- Providing a flexible and adaptable housing support service in all localities.

- Anticipate an increase in the number of adaptations required. The range and flexibility of adaptations should be reviewed to enable choices and to allow for future planning to happen as early as practicable. Timescales and priorities for adaptations to be kept under review.

- Increase the number of accessible houses in the Council’s housing stock. There is a template for this from the North Isles pilot project.

- Integrating telecare and telehealth technology with provision of adaptations

- Review and develop the Handyman service for all tenures

- Recording and analysing a range of data and indicators on housing need, demand and provision to provide a robust baseline of future and anticipated needs.

Challenges

Demographic – projected rapidly ageing population will present a universal challenge in terms of delivering services to meet projected increased demands.

Financial – continued financial pressure on public sector budgets will present a number of challenges going forward. Changes to welfare benefits will impact on the housing sector.

Knowledge – there is a real need to develop better, shared baseline information about the housing and support needs of people with long term, multiple health conditions and complex needs.

Support needs – demographic change suggests that there will be a small but significant number of people who will require intensive levels of support and care. This will bring challenges in a small, mainly rural local authority where availability of specialist services may not always be locality based. There is also likely to be an increase in the demand for lower level housing support to enable people to sustain their own tenures and allow them to continue to be supported at home as far as is practicable.

Housing Stock – Shetland has an imbalance in its housing stock with a prevalence of larger sized properties whereas demand is currently for smaller properties. There are also more 'sheltered' properties in landward areas and a lack of such provision in the town. Work has been done on a pilot project to demonstrate that accessible conversions can be carried out to stock in a cost effective way.

Resources

Housing Adaptations General Fund	£355k
Housing Adaptations HRA	£104k
Total	£459k

There are no plans for any staff with responsibility for housing functions to be transferred to the health and care partnership. Close partnership working will be essential, both strategically and operationally to ensure that housing's contribution can be achieved.

The General Fund adaptations are delivered through an agreement with Hjaltland Housing Association through a 'one-stop-shop'. This model has successfully provided a range of adaptations. With projected increased demand for adaptations to enable people to stay in their own homes, resources for aids and adaptations are likely to require close monitoring and review.

Programmes of maintenance and investment in housing stock has ensured that tenants in social rented sector have homes that meet the Scottish Housing Quality Standard. Continued planned investment will focus on energy efficiency which makes a significant contribution to health inequalities.

The Council and Hjaltland Housing Association work in partnership to deliver the Strategic Housing Investment Plan which is the development of a new build programme to meet the needs and priorities identified through the LHS. The current new build plan contains provision for the proposed Homes for Life development at King Harald Street, Lerwick. HHA are also carrying out a masterplanning exercise on the large site at Staneyhill, Lerwick and there may be opportunities to include specialist provision in the planned development as that takes shape.

Monitoring and Review

This statement forms the link between the LHS and the SCP. Actions will be reviewed jointly through monitoring arrangements for both documents.

Anita M Jamieson
Executive Manager – Housing

March 2016

Part 1 – Background Information

Name of Responsible Authority	Shetland Integration Joint Board, NHS Shetland and Shetland Islands Council
Title of Plan, Programme or Strategy (PPS)	Joint Strategic Commissioning Plan 2017-2020
Contact Name, Job Title, Address, Telephone Number and email	Simon Bokor-Ingram Director of Community Health and Social Care NHS Shetland Board Headquarters Burgh Road Lerwick, Shetland ZE1 0LA Telephone: 01595 743087 Email: simon.bokor-ingram@nhs.net
Signature	
Date of Opinion	NN January 2017
Purpose of PPS. Please give a brief description of the policy, procedure, strategy, practice or service being assessed.	The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.
Why PPS was written What is the intended outcome of this policy, procedure, strategy, practice or service?	Joint Strategic planning document for Integrated Joint Board (IJB) business. Statutory requirement for IJB when planning services.
Period covered by PPS	3 financial years from 2017-18 to 2019-20.
Frequency of Updates	Annual
Area covered by PPS (geographically and/or population)	Shetland
The degree to which the PPS sets a framework for projects and other activities, either with regard to the location, nature, size and operating conditions or by allocating resources.	The Plan will set a framework for all service activities including planning change and delivery within localities and decisions on resource deployment.
The degree to which the PPS influences other PPS including those in a hierarchy.	Overarching strategic planning document for integrated health and care services, and for NHS Service Planning.
Summary of Content	It is a strategic commissioning plan which is structured around the client groups / services that are included within the delegated authority of the IJB. In addition, it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.
Objectives of PPS	To improve national health and wellbeing outcomes for people in Shetland through the joint commissioning of services that are included within the delegated authority of the IJB, and as a single system approach to health and care service planning through NHS Shetland.

Part 1 – Background Information (continued)

What are you trying to achieve?	Service change and redesign to improve health and wellbeing outcomes.
Is this a new or an existing policy, procedure, strategy, practice or service being assessed?	Existing strategic plan updated.
Please list any existing documents which have been used to inform this Integrated Impact Assessment.	Draft Ethnic Minorities Health Needs Assessment for Shetland 2017 The needs assessment and consultative elements of Older People's Strategy and Primary Care Strategy.
Has any consultation, involvement or research with people impacted upon by this change, in particular those from protected characteristics, informed this assessment? If yes, please give details.	Yes in relation to specific client groups. For example, a health needs assessment for Minority Ethnic People in Shetland is underway. Initial findings show an increase in numbers of people from ethnic minority backgrounds in Shetland. Health Improvement: ongoing consultation / dialogue with people with learning disabilities, lower paid men in mainly manual type work, people of ethnic minorities, people with mental health issues. Adult Services for Learning Disability and Autism – Progression of the Day Services New Build (Eric Gray Resource Centre) Stakeholder engagement has taken place in the form of regular meetings and consultation with the Eric Gray Users Group; the new Eric Gray Resource Centre Working Group which includes nominated family, carers and users. Occupational Therapy Informal feedback from clients and stakeholders has helped us to define areas for improvement. Primary Care Issues of importance to local communities have been identified through the round of locality planning meetings. Additional service specific information has been held by engagement with various groups eg patient satisfaction survey for Advance Nurse Practitioner service at Lerwick Health Centre. General satisfaction survey across all of District Nursing and Continence Service. Discussions with community councils on health issues. Podiatry Services produce annual patient satisfaction surveys for a% of caseload. Feedback from survey enables service to produce and implement action plans.
Is there a need to collect further evidence or to involve or consult people, including those from protected characteristics, on the impact of the proposed policy? (example: if the impact on a group is not known what will you do to gather the information needed and when will you do this?)	Ongoing process of needs assessment in Health Improvement. It is clear from the Ethnic Minority Health Needs Assessment that statutory services in Shetland do not routinely collect enough data on protected characteristics, such as ethnicity, to be able to judge the accessibility and appropriateness of current services, let alone proposed changes to services. The EMHNA will recommend further work to fill this gap in future. The proposed audit of Adult Service Learning Disability and Autism service is anticipated to include engagement with

	people with learning disability, autism spectrum disorder, families and carers through meetings and gathered feedback. It is anticipated that this will be undertaken between April and June 2017. Further engagement work will be undertaken with island communities to explore / discuss sustainable service models for the future. The PPF will be used to discuss changes in nursing services based on the outcome of the national review of District Nursing services and the local work being carried out by Meridian Productivity. Podiatry service will continue to use both formal and informal feedback from service users to redesign and develop service provision.

Part 2 – People and Communities

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Economic	No impact / positive. In Health Improvement all our programmes are adapted to suit individual circumstances as far as possible. For Primary Care; not known at this stage – potential negative impact if reduction of employment in small communities through changes in service provision.	Discussions with partner agencies / other stakeholders as part of service review. We will use the recommendations contained in 'On Da Level' (the report of the Shetland Inequalities Commission, 2016) in assessing the impact of proposed service changes.
Cultural	Primary Care – potentially negative; communities may perceive changes in service provision as having negative impact on their culture. It is possible that significant changes in service provision may encourage community activism and an increase in communities taking ownership of and responsibility for health and social care.	Discussions with stakeholders as part of service reviews and engagement with communities in any major service change. Support for community initiatives and 'capacity building' in conjunction with Community Development and Learning and the Third Sector.
Environmental	There may be an increase in travel required if services are delivered further away from local communities. However the programme to return services to Shetland from Grampian and elsewhere may counterbalance this.	We will ensure that all changes in service provision are considered with regard to impact on environment.

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Poverty	No impact / positive. Primary Care – not known, may have negative impact if changes in access to services rely on care ownership or availability of public transport. Podiatry – not known.	We will use the recommendations contained in 'On Da Level' (the report of the Shetland Inequalities Commission, 2016) in assessing the impact of proposed service changes. We recognise that services may need to be adapted to individual circumstances to ensure that fewer people in Shetland live in poverty. Engagement with communities in any major service change. Podiatry will seek service user feedback on this.
Health	No impact / positive. As services are more targeted in their approach to the provision of services to those in greatest need.	
Stakeholders	No impact / positive. Primary Care	Discussion with partner agencies / other stakeholders as part of service review.

Equalities

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Ethnic Minority Communities (consider different ethnic groups, nationalities, language barriers)	We are not aware of any impact – positive or negative – at present.	Completion of EMHNA may allow an assessment of impact. It is likely that more complete data recording and engagement with people from ethnic minorities will be required to properly assess the impact of changes to services
Gender	No impact / positive	
Gender reassignment (consider transgender and transsexual people. This can include issues such as privacy or data and harassment).	No impact / positive	
Religion or Belief (consider people with different religions, beliefs or no belief)	No impact / positive	
People with a disability (consider attitudinal, physical and social barriers)	No impact / positive	
Age (consider across age ranges. This can include safeguarding, consent and child welfare)	No impact / positive	
Lesbian, Gay and Bisexual	No impact / positive	
Pregnancy and Maternity (consider working arrangements, part-time working, infant caring responsibilities)	No impact / positive	
Other (please state)	No impact / positive	

Part 3 – Resources

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Staff	Positive / Negative. Staff in some services will have to spread themselves more thinly with few resources	
Finance	Positive / No impact. We will continue to deliver within current or available resources. Some services identify that savings still need to be identified.	Podiatry planning to investigate alternative methods of service delivery
Legal	Positive / No impact.	
Assets and Property	Not known currently but potentially opportunities for sharing assets and property through integration, especially at locality levels.	Consider as part of all developments being progressed.

ENDS

Project	Expected Impact on Health and Wellbeing Outcomes								
	Live in Good Health Longer	Live Independently at Home	Positive Experience	Improved Quality of Life	Health Inequality	Unpaid Carers	Safe from Harm	Staff Engagement	Resources
Implementing an asset based approach to health care prevention									
Understanding Patients	√		√	√	√				√
Health Information and Self Directed Care	√	√	√	√	√				√
Health Literacy	√		√	√	√		√		√
Behaviour Change and Skills Development	√		√	√	√				√
Creating /Tackling the environment (positive health environment) and reducing health inequalities	√		√	√	√				√
Anticipatory Care	√	√	√	√	√	√	√		√
Self Management / Long Term Conditions Support Group	√	√	√	√	√	√	√		√
Involving Carers						√			
Realistic Medicine			√	√	√				√

Project	Expected Impact on Health and Wellbeing Outcomes								
	Live in Good Health Longer	Live Independently at Home	Positive Experience	Improved Quality of Life	Health Inequality	Unpaid Carers	Safe from Harm	Staff Engagement	Resources
Effective Prescribing- working with patients and prescribers to ensure that evidenced, best value, medicines are started and stopped appropriately									
Quality Assurance			√	√	√				√
Staff Development								√	
Prescribing			√	√	√				√
Medicines Management									√
Systems and Process									√
Developing a safe and effective model of unscheduled care									
Developing an Unscheduled Care Hub (for mainland Shetland)			√		√				√

Project	Expected Impact on Health and Wellbeing Outcomes								
	Live in Good Health Longer	Live Independently at Home	Positive Experience	Improved Quality of Life	Health Inequality	Unpaid Carers	Safe from Harm	Staff Engagement	Resources
Developing a sustainable hospital, acute and specialist services model for Shetland									
Scenario Planning for the rural district general hospital model			√		√				√
Sustainable planned care pathways		√	√	√	√				√
Enhancing the environment and capacity for day surgery and ambulatory care		√	√	√	√				√
Developing a Sustainable clinical workforce (with a particular emphasis on medical staffing)			√					√	√
Review of Diagnostic Services									√
Developing a sustainable primary care model for Shetland, with clear links to the 7 locality areas and the Gilbert Bain Hospital									
Developing sustainable out of hours models for the outer isles			√		√				√
Intermediate Care	√	√	√	√	√				√
Primary Care Redesign	√	√	√	√	√				√
Community Nursing Capacity / Demand	√	√	√	√	√				√

Project	Expected Impact on Health and Wellbeing Outcomes								
	Live in Good Health Longer	Live Independently at Home	Positive Experience	Improved Quality of Life	Health Inequality	Unpaid Carers	Safe from Harm	Staff Engagement	Resources
Developing a sustainable primary care model for Shetland, with clear links to the 7 locality areas and the Gilbert Bain Hospital									
Planning, designing and delivering services in multi-disciplinary area based teams within the seven locality areas, including management arrangements	√	√	√	√	√			√	√
Developing a sustainable model of social care resources									
Demand analysis for levels of care services, by locality.	√	√	√	√	√	√			√
Resources / Capacity to respond to changing demand	√	√	√	√	√	√			√
Developing a sustainable model for mental health services, including appropriate crisis and emergency arrangements									
Building capacity through redesign and integration of health and social care elements of mental health.	√	√	√	√	√	√	√		√
Developing a sustainable model for adults affected by learning disabilities and autism spectrum disorders									
Building a model to create sustainability that responds to changing demand.	√	√	√	√	√	√	√		√

Project	Expected Impact on Health and Wellbeing Outcomes								
	Live in Good Health Longer	Live Independently at Home	Positive Experience	Improved Quality of Life	Health Inequality	Unpaid Carers	Safe from Harm	Staff Engagement	Resources
Improving Business Performance and Efficiency									
Maximising eHealth, Telehealthcare and Telecare opportunities	√	√	√	√	√				√
Building staff and organisational resilience and capacity								√	
National Shared Services									√
Review of Decision Making Structures									√
Procurement / Commissioning									√

Strategic Programme / Project	Expected Timeline								
	2017-18				2018-19				2019-20
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Asset based approach to health care prevention									
Effective Prescribing									
Developing a safe and effective model of unscheduled care									
Developing a sustainable hospital, acute and specialist services model									
Developing a sustainable primary care model									
Developing a sustainable model of social care resources									
Developing a sustainable model for mental health services									
Developing a sustainable model for adults affected by learning disabilities									
Improving Business Performance and Efficiency									

Shetland Islands Health and Social Care Partnership

Agenda Item

9

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	10/03/2017
Report Title:	2017/18 Budget	
Reference Number:	CC-19-17 F	
Author / Job Title:	Karl Williamson / Chief Financial Officer	

1.0 Decisions / Action required:

That the IJB:

1.1 NOTES that the funding allocation from Shetland Islands Council for the 2017/18 financial year to the IJB in respect of the functions delegated to it and as expressed in the Joint Strategic Commissioning Plan, is equal to the cost of the current service model as explained in this report;

1.2 NOTES the funding allocation of £23.135M from NHS Shetland for the 2017/18 financial year to the IJB in respect of the functions delegated to it and as expressed in the Joint Strategic Commissioning Plan;

1.3 NOTES the gap between the current service models and the allocation of funding is £2.529M in respect of NHS Shetland functions delegated to the IJB;

1.4 DIRECTS NHS Shetland, to redesign services to deliver the Planned Savings and Efficiency Projects, to the value of £1.291M as set out in paragraph 4.7 subject to final decisions of the IJB on the implementation plans to be presented at future meetings of the IJB;

1.5 DIRECTS NHS Shetland to identify further service redesign that delivers the required savings and efficiencies to close the remaining funding gap of £1.208M as set out in paragraph 4.9 and to report proposals in this regard to the IJB for approval in early course; and

1.6 NOTES that the Chief Financial Officer will present monitoring reports on the financial situation and revised financial plans to each meeting of the IJB going forward.

2.0 High Level Summary:

2.1 The total budget for 2017/18 for the functions delegated to the IJB has been allocated to the IJB prior to the start of the financial year, including the budgets for

acute services advised as a set aside sum.

2.2 The 2017/18 budget setting process began in June 2016 and through an iterative process has been reviewed by the IJB on the following occasions:

26th September 2016 - IJB Meeting
18th November 2016 – IJB Finance Seminar
09th December 2016 – IJB Meeting
23rd January 2017 – IJB Finance Seminar
17th February 20017 – IJB Meeting

2.3 This report details the funding allocations from Shetland Islands Council (SIC) and NHS Shetland (NHSS) for 2017/18. The allocations have not changed from the figures reported to the IJB on 17th February 2017 (2017/18 Budget CC-08-17, link below) so the finer detail of that report will not be repeated here.

http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=20560

2.4 The total budget for the IJB for 2017/18 is £44.865m, which represents the SIC budget of £20.494m and NHSS budget of £24.371m (including set aside sum). Please see paragraph 4.3 for further detail.

2.5 Recommendations to the IJB with regard to the Directions to SIC and NHSS to deliver the Joint Strategic Commissioning Plan within the funding allocations for 2017/18 as set out in this report are included in a separate report on the Joint Strategic Commissioning Plan on today's agenda.

2.6 The payment from SIC to the IJB for 2017/18 in respect of the functions delegated to it by SIC, and as expressed in the Joint Strategic Commissioning Plan, makes assumptions with regard to the IJB's treatment of the funding allocations that are contained in the NHS allocation from the Scottish Government for social care functions, which is in accordance with the Scottish Government guidance in this regard. This balanced position means that the Directions issued to SIC will be to deliver the services as set out in the Service Plans.

2.7 The payment from NHSS to the IJB for 2017/18 shows a gap between the cost of services and the available funding of £2.529m.

2.8 To enable the IJB to approve the Joint Strategic Commissioning Plan at today's meeting, the approach detailed in paragraphs 4.6 to 4.12 with regard to the NHSS funding allocation is recommended. This will allow the Parties to deliver the services and progress with the service redesign projects as set out in the updated Strategic Commissioning Plan

2.9 As required as part of the Strategic Planning process, paragraph 4.13 shows the indicative IJB funding proposals for 2018/19 and 2019/20, which are subject to change during future budget setting cycles.

3.0 Corporate Priorities and Joint Working:

3.1 The proposals support the IJB's vision, aims and strategic objectives as set out in the Integration Scheme and the Joint Strategic Commissioning Plan 2017-20. The report recognises that there is further work to do in order to redesign the NHS services so that these can be provided within the resources available. Further reports will be

required to inform the IJB on progress with service redesign and, where appropriate, to seek decisions from the IJB with regard to any changes that may be required to services and the Strategic Plan in order to close the budget gap.

4.0 Key Issues:

2017/18 Funding

4.1 The funding allocations contained in this report are incorporated into the Joint Strategic Commissioning Plan 2017-2020.

4.2 To clarify certain terminology around the funding of the IJB see extract below from the IRAG financial guidance.

"2.0.3 The Health Board and Local Authority will delegate functions and make payments to the Integration Joint Board in respect of those functions. Additionally, the Health Board will also, where appropriate, set aside amounts in respect of large hospital functions for use by the Integration Joint Board.

2.0.4 The Integration Joint Board has responsibility for the planning, resourcing and operational delivery of all integrated services. Decisions on integrated services are made by the Integration Joint Board, which produces the Strategic Plan.

2.0.5 The Integration Joint Board gives direction and makes payment, where relevant, to the Health Board and Local Authority for delivery of the services in line with the Strategic Plan. The Integration Scheme sets out how the managerial arrangements across the integrated arrangements flow back to the Integration Joint Board and the Chief Officer.

2.0.6 The legislation uses the term payment for the transfer of resources by the Health Board and Local Authority to the Integration Joint Board and for the allocation back from the Integration Joint Board to the Health Board and Local Authority for operational delivery. This term does not necessitate cash transactions and it is recommended that the majority of the accounting for these should be via book entries within the ledgers of the Health Board and Local Authority, one of which should host the accounts of the Integration Joint Board."

4.3 The delegated functions are still managed and delivered by the partner organisations and they have each set a budget for the services they will deliver. The 2017/18 budgets, shown in the accounts of SIC and NHSS, are shown below.

Service Heading	SIC £000s	NHS Managed £000s	NHS Hospital (Set Aside) £000s	Total £000s
Mental Health	619	1,353	0	1,972
Substance Misuse	180	496	0	676
Oral Health	0	3,123	0	3,123
Pharmacy & Prescribing	0	5,914	479	6,393
Primary Care	0	4,571	0	4,571
Community Nursing	0	2,330	0	2,330
Directorate	441	94	0	535
Pensioners	78	0	0	78
Sexual Health	0	0	38	38

Adult Services	4,944	66	0	5,010
Adult Social Work	2,386	0	0	2,386
Community Care Resources	10,032	0	0	10,032
Criminal Justice	18	0	0	18
Speech & Language Therapy	0	83	0	83
Dietetics	0	112	0	112
Podiatry	0	225	0	225
Orthotics	0	143	0	143
Physiotherapy	0	603	0	603
Occupational Therapy	1,370	185	0	1,555
Health Improvement	0	0	310	310
Unscheduled Care	0	0	3,190	3,190
Renal	0	0	145	145
Integrated Care Fund	0	410	0	410
SG Additional Funding 1	426	86	0	512
SG Additional Funding 2	0	110	0	110
Pay Reserve (a)	0	212	93	305
Total	20,494	20,116	4,255	44,865

(a) Pay Reserve will be added to Service Headings following the completion of the NHS zero based budgeting process.

4.4 The funding allocation to the IJB by both partner organisations is shown below – this represents the payments made to the IJB that will appear in the accounts of the IJB. The table shows the movement of funds between the Parties via the IJB with regard to social care functions.

	SIC £000s	NHS £000s	Total £000s
Payment to IJB (IJB Income)	19,231	23,135	42,366
Movement of funds between Partners			
SG Additional funding for Social Care £250m	938	(938)	0
SG Additional funding for Social Care £107m	340	(340)	0
Payment after movement of funds between partners	**20,509**	**21,857**	**42,366**
Cost of Services (from 4.3 above)	(20,494)	(24,371)	(44,865)
IJB Admin Costs	(15)	(15)	(30)
Total Costs	**(20,509)**	**(24,386)**	**(44,895)**
Funding Gap	0	2,529	2,529

4.5 The NHSS funding gap above of £2.529m comprises of the following.

	NHS Managed £000s	NHS Hospital (Set Aside) £000s	Total £000s
Unachieved savings carried forward	1,264	257	1,521
2017/18 target	815	193	1,008
Total	2,079	450	2,529

Recommended approach for Bridging the Funding Gap

4.6 The report 'Financial Plan – Options for Bridging the Funding Gap CC-07-17-F' presented to the IJB on 17th February gave the IJB the opportunity to consider the extent to which it would be willing to change the current range of services that are delivered in order to fulfil the functions delegated to it by NHSS. The IJB members indicated they were keen to explore all services within their remit but also made it clear they would require detailed reports before informed responsible decisions around service redesign could be made.

4.7 NHSS has already identified the Planned Savings and Efficiency Projects below. It is recommended that the IJB agree these projects and Direct NHSS to progress them. The IJB will receive regular progress reports on these projects and will be able to seek further information as and when required. Further decisions of the IJB will be sought as required in order for these projects to be delivered. The proposals relating to these projects may result in significant changes to the current services or budgets contained in the Strategic Commissioning Plan 2017-20.

Service Area	**£**	**Risk Category (determined by NHSS)**
Shifting the balance of care for hospital to community: Rehabilitation	472,184	Medium
Community Nursing	240,000	Medium
GP Employed Practices	150,000	High
Out of Hours	100,000	High
Pharmacy Drugs	328,500	High
Total	**1,290,684**	

Further information about these projects can be seen in Appendix 1.

4.8 NHSS has also identified further temporary savings and efficiency proposals below which the Chief Officer considers will have manageable risk and consequence on the delivery and performance of the existing services. The IJB approved these further temporary savings on 17th February 2017.

Service Area	**£**	**Risk Category (determined by NHSS)**
Allied Health Professionals	30,000	Low
Total	**30,000**	

4.9 The approach recommended above will still leave a net funding gap of £1.208m as summarised below.

Service Area	**£**
Funding Gap	2,529,000
Less: Planned Savings & Efficiencies	(1,290,684)
= Funding Gap less Planned Projects	1,238,316
Less: Further Temporary Savings & Efficiencies	(30,000)
Net Funding Gap: Recovery Plan	**1,208,316**

4.10 To close the net funding gap of £1.208m above it is recommended that the IJB Directs NHSS to develop further redesign plans that would support the balancing of the budget. These will be the subject of a report to the next meeting of the IJB. Financial performance reports prepared by the Chief Financial Officer will be presented to all future meetings of the IJB due to the need for the IJB to be assured that progress is being made that will address the financial issues identified in this report

4.11 The financial risk to the IJB is minimised by the responsibility of NHSS to provide additional one-off support where this is required. The IJB should be mindful that if the NHSS was only able to provide additional one-off support as a result of "brokerage" from the Scottish Government that this may result in the level of future funding available from NHSS to the IJB being reduced to allow NHSS to repay the brokerage to the Scottish Government. It is therefore important that all Parties work together to achieve mutually beneficial service and financial outcomes.

4.12 The IJB is responsible for strategic oversight of all delegated functions and is therefore central in reshaping community health and social care services in Shetland. The IJB is also ideally placed to ensure redesign proposals from either SIC or NHSS are not considered in isolation and will therefore result in efficiencies across the Health and Social Care system as a whole.

2018/19 and 2019/20

4.13 The indicative funding proposals for 2018/19 and 2019/20 are based on the best information we have at this time. SIC Medium Tem Financial Plan assumes an annual 3.3% savings target over this period and NHSS Local Delivery Plan assumes a 4.0% target in 2018/19 and 3% in 2019/20. These indicative proposals will change during future year budget setting cycles but provide a reasonable estimate for planning purposes. The Scottish Government may issue similar guidance in future years which will aim to maintain IJB funding at current levels but that is unknown at present.

£000s	SIC	NHSS	Total
Payments to IJB 2017/18 (4.5 above)	19,231	23,135	42,366
2018/19	18,596	22,210	40,806
2019/20	17,983	21,544	39,527
Total 3 year indicative funding proposal	55,810	66,889	122,699

5.0 Exempt and/or confidential information:	
None	
6.0	
6.1 Service Users, Patients and Communities:	Consultation with service users, patients and communities will take place as required by NHSS, SIC and IJB policies as the various projects and service changes are developed and taken forward.
6.2 Human Resources and	Any service development proposals or changes affecting staff will be subject to full staff engagement and consultation with

Organisational Development:	staff and their representatives through the Joint Staff Forum and other consultation committees in line with the relevant agencies policies and procedures.
6.3 Equality, Diversity and Human Rights:	None arising directly from this report. Any equalities impacts will be assessed and considered as part of any proposals for change and schemes for efficiency savings.
6.4 Legal:	The proposals in this report are consistent with the Public Bodies (Joint Working) (Scotland) 2014 Act and the Integration Scheme for Shetland's IJB.
6.5 Finance:	This report presents the budgets for the functions that are delegated to the IJB and the funding allocations from SIC and NHSS for 2017/18, together with their indicative allocations for 2018/19 and 2019/20. These budgets and payments will form part of the Strategic Commission Plan 2017-2020. Based on the assumptions set out in paragraph 4.4, the funding allocation from the SIC to the IJB for 2017/18 will fully fund the cost of services, however the funding allocation from NHSS to the IJB for 2017/18 shows a gap between the allocation and the cost of services of £2.529m.
6.6 Assets and Property:	None arising directly from this report however, service redesign proposals may have implications for assets and property used to deliver health and social care services in the community. Any proposals in this regard will be referred to either the Council or the Health Board as required because the Parties retain the obligation to maintain and manage these assets in line with the Integration Scheme. Both Parties have policies and procedures in place which govern their assets and property.
6.7 ICT and new technologies:	None arising directly from this report.
6.8 Environmental:	None arising directly from this report.
6.9 Risk Management:	SIC – Any failure to meet the reductions in overall budget spending levels will result in using its reserves unsustainably. The main specific risks for functions delegated to the IJB are: • Increased demand for care services as a result of the changing demographics of Shetland's population. • Unexpected demand for care services which may be costly depending on the circumstances. • The level of charging income received can vary significantly, as it is dependent on the individual financial circumstances of those in care at any time. These risks are mitigated by the Directorate using a realistic approach and the latest data when setting the budget, and the inclusion in the overall SIC budget of a corporate contingency to support cost pressures which may arise during the year. SIC also has a strong balance sheet and available usable reserves which ensures SIC is prepared for significant unforeseen events. Any draw on reserves beyond sustainable levels would have an adverse impact on the level of returns from

	the long term investments and this situation would require to be addressed quickly to ensure no long term erosion of investments. NHS – Any failure to redesign services so that they are financially sustainable will result in NHSS needing to use under spends, as a result of both recurrent and non-recurrent savings schemes, from other Directorates to underwrite the position. If NHSS cannot reach a break even position it will have to seek brokerage from the Government which will have to be paid back in future years. NHSS has no reserves and must therefore deliver services within its funding allocation each year. The risk to NHSS will increase if service redesign proposals are not presented to and approved by the IJB in a timely manner. IJB – The main risk to the IJB arising from this report is that the mismatch between the funding allocation to the IJB and the services described in the Service Plans which are integral to the Strategic Plan, means that the Strategic Plan cannot be delivered and consequently the national health and well-being outcomes would not be delivered in Shetland. NHSS has indicated that if any additional payment to the IJB in 2017/18 requires NHSS to receive brokerage from the SG, then this would need to be paid back to the SG by NHSS. This would reduce the overall funds available to the NHSS with consequent risks to the funding allocations to the IJB in future years. This would mean the IJB having to address an increasing funding gap going forward.	
6.10 Policy and Delegated Authority:	The IJB has authority from SIC and NHSS for the functions delegated to it as per the Integration Scheme. The IJB must direct service delivery, within its funding allocation, to deliver the outcomes of the Strategic Commissioning Plan.	
6.11 Previously considered by:	The proposals in this report have not been presented to any other committee or organisation	

Contact Details:
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27th February 2017

Appendices:
Appendix 1 – Planned Savings and Efficiency Projects

Community Rehabilitation £472K

- Community Rehabilitation delivered in a community setting
- Project Resourced in-house
- Interim arrangements in place due to staffing shortages
- Review of bed numbers within the hospital
- Report to be presented 10 March 2017
- Implementation from mid-April 2017

Community Nursing £240K

- Capacity and Demand Review
- 'Time and Motion' study being carried out by Meridian (commercial company)
- Variation and standardisation of services and systems
- Exploring potential for efficiencies

GP Employed Practices £150K

- Backroom Support Services
- Opportunities from further directly employed GP practices for shared systems and training
- Project resourced in-house

Out of Hours £100K

- Sustainability issues of current model which is reliant on GPs
- Alternative arrangements based on a mixed staffing model called an Unscheduled Care Hub, based at Gilbert Bain Hospital
- Trialling alternative models (e.g. Weekend clinics, triaged through NHS 24)

Pharmacy Drugs £328K

- Prescribing Culture
- Medicines Management
- Increasing demand
- Long term, quality based improvement programme

Shetland Islands Health and Social Care Partnership

Agenda Item
10

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	10 March 2017
Report Title:	Extending Intermediate Care in the Community - Update	
Reference Number:	CC-04-17 F	
Author / Job Title:	Simon Bokor-Ingram, Director Community Health and Social Care Kathleen Carolan, Director Nursing and Acute Services	

1.0 Decisions / Action required:

1.1 NOTE the information presented in this report and its appendices

1.2 CONFIRM the strategic direction of extending the availability and accessibility of intermediate care

1.3 APPROVE the proposal to extend Intermediate Care, NOTING that this will be funded in 2017/18 using Integrated Care Funding and Additionality Funding, combined with utilisation of existing employees who are to be funded within the proposed delegated budgets of the Shetland Islands Council and the NHS Shetland for 2017/18. The full IJB budget proposals will be presented as a separate report on today's agenda.

1.4 DIRECT NHS Shetland and the Shetland Islands Council to enact the changes required to extend and resource intermediate care in the community, and therefore support the shift in the balance of care;

1.5 DIRECT NHS Shetland to continue to deliver acute rehabilitation in the hospital and to support the shift in the balance of care through a disinvestment in Inpatient hospital services, in line with the proposed delegated budgets (see separate report on today's agenda)

1.6. NOTE that operational decisions on the distribution and use of Inpatient beds within the hospital rests with NHS Shetland

1.7 REQUEST a report evaluating the impact of the enhancement of community rehabilitation services in twelve months time.

2.0 High Level Summary:

2.1 On the 26 September 2016 the IJB were presented with a proposal to extend intermediate care and the community rehabilitation team. The IJB deferred a

decision on the proposal. Whilst the strategic direction was supported, the IJB sought assurance that where intermediate care packages were to be delivered, that they would be safe and effective and that access would not disadvantage individuals from the more remote parts of Shetland. The IJB also wanted more detail on affordability, and an indication on how intermediate care might be extended across Shetland, rather than being seen as Lerwick centric model.

2.2 This paper is brought to the IJB to advise of progress on developing the plan to extend intermediate care and to seek approval to implement the plan, so that we capitalise on the good outcomes we have already delivered, and do not slow the pace of change at a time when the population is ageing and financial resources are tightening.

3.0 Corporate Priorities and Joint Working:

3.1 The extension of intermediate care supports the following National Health and Well-being outcomes:

- People, including those with disabilities or with 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.
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm
- Resources are used effectively and efficiently in the provision of health and social care services

3.2 In addition, the Shetland Islands Council Corporate Plan includes:

- Older people and people who are living with disabilities (including learning disabilities) or long-term conditions will be getting the services they need to help them live as independently as possible.
- Our Integrated Health and Social Care services will be providing the services people need in a more efficient way, improving standards of care and keeping people healthier for longer.

3.3 and NHS Shetland's Board corporate objectives include:

- To provide quality, effective and safe services, delivered in the most appropriate setting for the patient
- To redesign services where appropriate, in partnership, to ensure a modern sustainable local health service

4.0 Key Issues:

<u>Current service provision</u>

4.1 The Intermediate Care Team (ICT) was set up in September 2014 using Reshaping Care for Older People Funding, followed by use of a portion of the Integrated Care Fund. The Reshaping Care for Older People agenda aimed to reduce unplanned admissions to hospital or long term care, enhance discharge planning, recovery and self-management. At this time, the intention was that it would include an overnight

nursing and care at home service, combined with intensive therapy input and enabling services.

4.2 There were several factors which limited the provision of a full range of services. A major factor was recruitment of healthcare practitioners (mainly Allied Health Professionals) to support the development of the team, along with an inability to recruit individuals to the rehab support worker positions on a fixed term basis (also impacted on by the local economic situation at the time). The community nursing 24/7 model has also had to revert to largely an on-call model overnight due to the number of vacancies that arose in the service over the last year. Therefore, the development of the ICT has focussed on provision of enabling services during core hours of 8am to 10pm. The current team also has geographical limitations due to its size, currently covering the central area of Shetland, extending south to Cunningsburgh, north to North Nesting, and west to Burra. It provides an in-reach service to the care centres within this area and when capacity has allowed, the service has reached further than this central area (e.g. to Yell).

4.3 Despite the staffing limitations, the service has achieved good outcomes, including assisting 22 individuals to return home from a residential care setting. Service performance data, along with examples of the work undertaken by the Intermediate Care Team are illustrated in Appendix 1. These summaries illustrate the range of settings which individuals have been discharged from, the complexity of individual's health and care needs, supportive measures put in place and progress made against the goal setting approach used in intermediate care. The summaries also reflect the level of detail and communication provided back to referrers, and other key stakeholders, at the end of an Intermediate Care Team intervention.

4.4 Shetland performs well against many measures across Scotland (Measuring Performance under Integration). There have been significant improvements in the reduction of delayed discharges and our ability to care for more complex care needs in the community. These improvements have been achieved by a combination of initiatives including Intermediate care, the new Understanding You (Single Shared assessment) implemented in April 2015 which promoted assessments focusing on strengths through an assets based approach, and a new duty/hospital liaison system in place since April 2015, which has streamlined processes around referrals/ allocation/ hospital discharges.

4.5 Hospital bed occupancy during 2016 has operated at a median of 64%, which is relatively low when compared to most health and care systems. The median has also reduced from 66% at the beginning of 2016 to 51% at the end of 2016. The reduction in hospital bed usage reflects the positive impact of the work already done within intermediate care. NHS Shetland continues to monitor the use of the hospital bed base to make the best use of the resources available.

4.6 With the current bed occupancy NHS Shetland has recently made an operational decision to reduce the number of beds in the hospital by six. This has been achieved by temporarily closing the Inpatient beds in Ronas Ward using the mechanisms in the jointly agreed winter plan. This has allowed NHS Shetland to temporarily redeploy staff into nursing vacancies in other wards and department in the hospital and therefore assist in sustaining these services. A small number of staff are also temporarily covering existing vacancies in the Intermediate Care team.

4.7 All patients who need hospital based treatment and care, including a period of acute rehabilitation, have and will continue to receive their care in the Gilbert Bain

hospital.

4.8 The Rural Care model, which the Shetland Charitable Trust supports, and the availability of locality based services has allowed health and care services to respond to need in a way that has supported the shift in the balance of care, from hospital to community.

4.9 The demographic changes predicted for Shetland are that the number of people over the age of 75 years will increase from 1,997 in 2017 to 3877 in 2037 (Shetland Older People's Strategy - Living Long, Living Well, 2015). We therefore have some way to go in reaching the peak for an aged population. So, building on current achievements is vital to creating sustainable services into the future.

Proposals for an extended intermediate care service

4.10 There is a need to continue to look at how we can shape local services in order to meet the predicted service demand. This requires us to develop care models that support community based services as an alternative to hospital care, including managing more people with complex needs in a safe and sustainable way and providing enhanced recovery in the community (e.g. shorter lengths of admission following illness or surgery) and promoting recovery (e.g. intensive rehabilitation).

4.11 A project board and team were set up in order to plan and deliver on the proposal to extend the Intermediate Care Service. The project team consists of a range of clinicians/practitioners from community health and social care and includes professionals working across community and acute services. The project team fully support the expansion of the ICT. The project board is being led by the Chief Officer with key Executive Managers/Service Managers and the Director for Nursing and Acute Services.

The 3 further stages of the project are:

Stage 1	An enhanced Intermediate Care Team
Stage 2	A sustainable Out of Hours response service
Stage 3	A Shetland wide "Intermediate Care" service

4.12 The overall objectives of the project are to provide:

- Intensive therapy (including rehabilitation) input into individuals at home, hospital or in residential care to prevent admission to hospital or care home and increase speed of discharge from care home or hospital
- An "enabling" service to prevent admission to hospital/residential care, and increase speed of discharge from hospital/ residential care
- Assistance with prevention of avoidable hospital admissions
- Better support and care in community settings, through the supporting of individuals and by supporting care staff within residential establishments on mainland Shetland providing ready access to advice/ support at night
- An enhanced level of service for individuals with nursing or support needs in the out of hours' period (5pm – 8am)

4.13 The planning for these stages is now complete, and this report covers the implementation of Stages 1 and 3. Stage 2 will be reported to the IJB separately, as the solution identified has the potential to meet a far wider need than that identified through this project, and is therefore deserving of separate consideration. A project timeline is attached in Appendix 5, which details the specific actions against planned timescales to implement the stages of this project.

4.14 The proposal for an enhanced intermediate care team is shown in Appendix 2. It is considered that this model, working in partnership with existing community resources (e.g. Care Centres, Care at Home, Occupational Therapy, Physiotherapy, Community Nursing, Social Work etc.) will have the potential to provide an enhanced Intermediate Care Service to the whole of Shetland. The associated pathways are shown in Appendix 3. The project team have worked across all service areas in order to determine any impact on other community services from this proposal to extend intermediate care. It is not anticipated that additional resources will be required in other service areas in order to continue the advancement of intermediate care. Whilst efficiencies are being sought from service areas to meet the financial challenge in 2017/18 and beyond, any proposed reduction in budget and/or staffing will be brought back to the IJB along with risks and potential impacts. Any proposed service redesign will take into account the support required for extending Intermediate Care to ensure its continued efficacy and capacity.

4.15 The emphasis will be on the person receiving their input in the most appropriate place, as close to home as possible. Montfield Support Services may be used as an interim measure, as it is currently by people resident anywhere in Shetland, for those who require rehabilitation or reablement, whilst waiting for a setting closer to home. Montfield Support Services already support a number of people at any one time with interim placements, and will continue to provide a focal point for reablement and rehabilitation. It will be important that capacity is maintained through timely and appropriate discharge from the care centre in order that we can maintain the capacity required to meet demand.

4.16 All residential care centres already successfully provide step up and step down facilities in each locality and the Intermediate Care Team, working in conjunction with locality based staff (including care at home), will continue to direct programmes for people who move outwith Lerwick, or who require input from the team where they have needs either at home or in a residential care setting in a locality. Occupational Therapy already have in place a mechanism whereby each locality receives regular input including those in residential care centres and where people are at home.

4.17 As the Intermediate Care Team gears up through the recruitment process, the opportunity for providing more reablement and intensive therapy in the community setting increases. The anticipated outcome of the extended intermediate care service is that it will reduce the reliance on the use of hospital beds. However, where an individual requires a period of acute rehabilitation and has ongoing medical needs necessitating a stay in hospital, this service will continue to be provided in the Gilbert Bain Hospital. As part of the proposal to extend intermediate care, the IJB is asked to direct NHS Shetland to continue to provide acute rehabilitation in the hospital while also taking the opportunity this creates to support the shift in the balance of care by disinvesting in hospital beds.

4.18 It will then be the responsibility of NHS Shetland to determine on an operational basis where and how this is provided within the hospital and to make formal decisions on the future use of space created in the hospital.

4.19 The proposals do not impact on the ongoing use of space within Ronas ward to provide Oncology & Haematology services (i.e. Chemotherapy) and ambulatory care that are planned to continue from their current locations.

Finance

4.20 The proposed method of funding the enhanced service is shown in Appendix 2. The sources of funding are described below.

Integrated Care Fund

- Shetland's share of the £100million national resource for the Integrated Care Fund amounts to £410,000 for 2016/17, and this allocation is based on the national allocation formula for the distribution of funding to health boards. From 2016/17 it is no longer a separate allocation but has been added to NHS Shetland's baseline funding allocation.

- 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.

- On 28 June 2016 the IJB endorsed the use, in 2016/17 of £443k funding for the Intermediate Care Team. This was from the overall budget for the Integrated Care Fund in 2016/17 of £582k (£410k for 2016/17 plus an agreed carry-forward of unspent Integrated Care Funding from 2015/16 of £172k). For 2017/18 it is proposed that £380k of the overall £410k Integrated Care Funding available is used as part of the package of funding for an Enhanced ICT.

Scottish Government Additionality Funding (first issued in 2016/17, recurrent in nature)

- In 2016/17 the Scottish Government provided Additionality Funding for Adult Social Care from the central NHS budget. NHS Shetland was allocated £1.024m of this funding with the expectation that this was passed to IJBs. The IJB agreed the use of this additionality for 2016/17 (Integration Joint Board on 28 June 2016 (Min Ref 32/16). From 2017/18 this allocation has been added to the NHS core funding allocation (on a recurrent basis). The Scottish Government has also increased Additionality Funding in 2017/18 by a further £450k, (of which £420k is funded from within NHS Shetland's core budget uplift).

- There is specific guidance from the Scottish Government on how the funding may be applied. The guidance allows for £852k (£512k 2016/17 and £340k 2017/18) of the funding to be applied directly against SIC budgets to support cost pressures faced by local authorities in the delivery of effective and high quality health and social care services. Budget proposals have been made for 2017/18 which agree with funding guidance for the use of the remaining £622k funding, with the exception of £110k funding yet to be allocated and available to support transformational change projects.

- The proposals include £86k of this funding being applied to cover the cost of two therapist posts (1 Physiotherapist and 1 Occupational Therapist) for community rehabilitation and that a further £26k of the unallocated funding be used to ensure the Enhanced Intermediate Care Team proposal can be fully funded.

4.21 The Chief Officer will bring a full report in due course to the IJB, on proposals for the longer-term use of Integrated Care Funds and Additionality. This will give clarity on

the strategic direction of travel for the IJB on the use of these funds and to allow the IJB to comment on the principle of the way this funding allocation is being administered nationally as well as determining local usage.

Funding from within SIC & NHSS Budget

It is proposed that some staff who have been budgeted for within the delegated budgets of SIC and NHSS be utilised as part of the Enhanced Intermediate Care Team. As per Appendix 2 a total of £109k (£72k NHSS & £37k SIC) will be funded via these means.

Waiving of charges for reablement period

4.22 A six week reablement period (free of charge) for all new service users and those who have had an acute episode (social as well as medical) was introduced as part of Council's Self-directed Support Policy presented 29 January, 2015 to Social Services Committee (Min Ref 03/15) and through Chairs Report to Policy & Resources Committee on 9 February 2015 (Min Ref 03/15) and is included in the Council's Charging Policy presented 27 April 2016 to Policy & Resources Committee (Min Ref 29/16). The aim of this six week period is to enable people to rebuild their skills. Individuals requiring reablement or rehabilitation under the Intermediate Care Team or through standard services are entitled to this period free of charge. All NHS care remains free at the point of delivery.

4.23 The detailed allocation of funding is an integral part of the Strategic Plan and the Service Plans which will form the basis of the Directions from the IJB to the Council and the Health Board for 2017/18, which is the subject of a separate report on today's agenda. The ongoing use of the Integrated Care Fund and Additionality Fund will be the subject of future reports to the IJB.

5.0 Exempt and/or confidential information:

5.1 None

Implications :	
Service Users, Patients and Communities:	An Equality Impact Assessment has been carried out as part of the development of this proposal. No specific risks/negative impacts identified. Patients who require hospital care, including acute rehabilitation will continue to receive this in the Gilbert Bain Hospital.
Human Resources and Organisational Development:	Any change in the way services are delivered will involve engagement with affected staff. The Council and NHS have a range of policies that will apply to any staff affected by an organisational change. There is also regular consultation with Trade Unions through the consultative mechanisms in place in both organisations and through the Joint Staff Forum. Human Resources Representatives from NHS Shetland and the Council are part of the project team and continue to provide advice as required. More detailed discussions will take place with staff affected by short-term secondments and their representatives on the impact

	of these changes to their terms and conditions.
Equality, Diversity and Human Rights:	Shetlands Joint Strategic (Commissioning) Plan 2016/17-19 supports and promotes equalities, health and human rights.
Legal:	Under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the IJB is responsible for the strategic planning of the functions delegated to it by the Shetland Islands Council and NHS Shetland and for the preparation of the Strategic Plan. The Strategic Plan (in which this proposal is positioned) specifies the services to be delivered by the parties.
Finance:	The proposed cost of providing an Enhanced Intermediate Care Team in 2017/18 has been costed at £601,337. Funding to cover this full cost has been identified as detailed in Appendix 2, but will be subject to approval of the overall IJB Budget proposals for 2017/18. The IJB faces significant challenges with its 2017/18 budget, as reported to the IJB in January 2017 (Report CRP-02-17-F), where a continuing deficit in the NHS budget persists. The most expensive location for service delivery is the hospital, with community locations (including residential care) costing less, and home the lowest cost per patient / client day. This is a result of the economy of scale and infrastructure costs associated with hospital care. Research also shows that community based models of care support services that achieve better outcomes for people and are cost efficient. The anticipated outcome of extending intermediate care is that this will reduce reliance on the use of care centre and hospital beds over a sustained period of time. This is shown in the IJB Strategic Commissioning Plan for 2017/18 and in the 2017/18 IJB Financial Plans, which are the subject of separate reports on today's agenda. The extended intermediate care service will cover people requiring rehabilitation in the community, either at home or in a residential care setting, thereby utilising resources much more effectively.
Assets and Property:	There are no implications for major assets and property. However the proposals in this report rely on the continuing availability of a range of services in the community including the services currently provided by and from all existing adult social care settings. Any proposals for change in this pattern of care would be the subject of extensive consultation and future reports to the IJB. The outcome of the recommendations from this report will allow plans for the alternative use of space freed up in the hospital to be developed and to support the provision of clinical services.
ICT and new	There will be a need for additional ICT resources for new staff

technologies:	members. The service also currently makes use of relevant telecare devices such as "Just Checking" to assist in delivering its service. These costs are included in the total cost of delivering the service presented in Appendix 2.	
Environmental:	There are no environmental issues associated with this report.	
Risk Management:	There are a number of risks to the delivery of this project. These are detailed in full in the project risk register at Appendix 4. The key risks are as follows: • Failure to obtain funding to support the development of an enhanced therapy service/ overnight service. These enhancements will enable the shift from hospital to community settings for more care. • Failure to recruit staff in a timely manner thus compromising the implementation of the project. HR staff are working in conjunction with the project team to advise on best practice in successful recruitment exercises. It is recognised that fixed term contracts are unlikely to result in successful recruitment. • Lack of capacity of staff to develop service models in addition to existing roles means inability to keep to deadlines in the action plan. An action plan has been drawn up with relevant timescales, and the senior management are aware of the limited staff resources available to enact this plan within the required timescale. The other key risk results from a failure to progress these proposals. This would result in alternative service redesign being required to balance the delivery of the IJBs budget.	
Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. The IJB's primary role is to develop strategic plans for the functions delegated by the Shetland Islands Council and NHS Shetland and commission services directing service delivery through the Council and the Health Board. This proposal fits with the current Strategic Plan for 2016/17-19, and is described in the updated Strategic Plan for 2017/18-20, which is the subject of a separate report on today's agenda. The Strategic Plan can be updated through the year if required.	
Previously considered by:	Integration Joint Board	26 September 2016

Contact Details:

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24 February 2017

Appendices:
Appendix 1 - Performance data and case studies
Appendix 2 - Funding proposal
Appendix 3 - Proposed pathway for enhanced service
Appendix 4 - Risk register
Appendix 5 – Project Timeline, Intermediate Care

Background Documents:

Proposal to Develop an Extended Intermediate Care and Community Rehab Team- paper to 26th September 2016 IJB meeting
http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=19882

Older People's Health and Wellbeing Strategy
http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=18449

Intermediate Care Framework for Scotland http://www.jitscotland.org.uk/wp-content/uploads/2014/07/Intermediate_care_framework1.pdf

Integrated Care Fund http://www.gov.scot/Resource/0046/00460952.pdf

Reshaping care for Older People http://www.gov.scot/Resource/0039/00398295.pdf

Measuring Performance under Integration, Health and Social Care Integration Directorate Jan 2017 (see Performance Report Q3)

Self Directed Support Policy
http://www.shetland.gov.uk/community_care/documents/SDSPolicy.pdf

Charging Policy
http://www.shetland.gov.uk/community_care/documents/SICPolicyCareandSupportCharge2016-19FINAL.pdf

Intermediate Care Team Service Performance
Update – February 2017

Introduction

The Intermediate Care Team was established in June 2014 and received the first individuals into the service as of 8 September 2014.

"The function of intermediate care – inherent in its name – is to integrate, link and provide a transition (bridge) between locations (home/hospital and vice versa); between different sectors (acute/primary/social care/housing); and between different states (illness and recovery, or management of acquired or chronic disability)."
Ref An Evaluation of Intermediate Care for Older People, Institute of Health Sciences and Public Health Research, University of Leeds, 2005

The local Intermediate Care Team was established in line with the guidance in Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland (Scottish Government, 2012). The core principles of Intermediate Care as outlined in this guidance can be seen in Section B of this appendix.

Staffing

The proposed staffing of the Intermediate Care Team was as follows:

Staffing	
Team Leader (Nurse)	1 wte
Occupational Therapists	2 wte
Physiotherapist	1 wte
Rehabilitation Support Workers	7 wte
Admin support provided via Community Nursing Service	Nominally 0.2 wte

Due to recruitment challenges faced locally the Rehabilitation Support Worker posts were recruited to on a substantive basis. However, to date only 4.8wte Rehab Support Workers have been in post.

Intermediate Care Team Performance (up to 31 January 2017)

Referrals
Total referrals since service commenced – **179**

Of the 179 individuals,

- Discharged from service following ICT intervention – 119
- Current caseload – 7
- Declined support - 37
- Supported – 10 (data only recorded since January 2016 – this category of referral is where Intermediate Care Team staff have supported delivery of other services eg support at home package, palliative care package)
- Falls Assessment undertaken by ICT staff – 6 (data only recorded since June 2016)

Current Caseload
The Intermediate Care Team predominantly support Early Discharge from Hospital or Care Home or provide additional support into the individual's home to prevent an unnecessary admission to Hospital.

Of the current 7 patients on the caseload – 6 for Early Supported Discharge, 1 for Admission Avoidance

Area	**Number**
Lerwick	7 (includes 1 whose home address is on outer island but in LK based facility)

Ages	**Numbers**
< 80 years	2
< 85 years	2
< 90 years	2
<100 years	1

Discharged from Caseload
Up to 31 January 2017, 119 individuals have been discharged following input from the Intermediate Care Team. 84 of these individuals were for Early Supported Discharge, 35 for Admissions Alternatives.

The home geographical areas of the individuals are noted below.

Area	**Number**
Lerwick	84
Scalloway	12
Burra	10
Tingwall	5
Nesting / Girlsta	3
Quarff	1
Sandwick	2
Yell	2

Ages of Individuals accepted into Intermediate Care Service

Ages	Numbers
< 50 years	5
< 60 years	1
< 70 years	7
< 75 years	13
< 80 years	20
< 85 years	30
< 90 years	28
< 95 years	12
99 years	3

As can be seen from the table above 78% of the individuals whom the Intermediate Care Team have supported have been aged 75 years or over with 36% of the individuals being aged over 85 years.

Duration of Time on the Caseload

The table below outlines the detail of individuals who have been discharged from the caseload. As can be seen approx. two thirds (64%) of the individuals have been discharged by the end of the standard Intermediate Care time period of 6-8 weeks.

Where additional support has been provided 85% of individuals are discharged by 3 months, with 9 individuals having required a very individualised package for particularly complex needs and thus have required an extended period of support until approx. 4 months.

Weeks on Caseload	Number of Individuals
< 1 week	8
< 2 weeks	8
< 3 weeks	9
< 4 weeks	11
< 5 weeks	11
< 6 weeks	9
TOTAL – 6 weeks	**56 (47%)**
< 7 weeks	9
< 8 weeks	11
TOTAL – 8 weeks	**76 (64%)**
< 9 weeks	6
< 10 weeks	5
< 11 weeks	4
< 12 weeks	9
TOTAL – 3 months	**100 (85%)**
< 13 weeks	4
< 14 weeks	4
> 14 weeks	9
TOTAL – 4 months	**117 (98%)**
Deceased	2 (2%)

Outcomes

In terms of Outcomes for the Individuals who have received Intermediate Care Team Intervention this can be demonstrated by reviewing individuals Dependency scores.

For a positive intervention, and thus an enhanced outcome for the individual in terms of an increased level of independence, this can be seen by a reduction in their Dependency score. As noted below 77% of individuals achieved a reduction in their Dependency score through the period of intervention with a further 8% maintaining their level of independence but not managing to increase it.

Dependency Scores	**Total – 119 Discharges**
Reduction in score post ICT intervention	92 (77%)
Remained the same post ICT intervention	9 (8%)
Increased post ICT intervention	2 – 1 x 99 year old patient (2%)
Not Recorded	12 (10%)
Deceased	4 (3%)

Readmission to Hospital or Care Setting post Intermediate Care Team Intervention

There were 9 (7.5%) readmissions in total, reasons as noted below.

Readmissions within 28 days	**Number / reason – 9 in Total**
6	3 medically unwell – Chest Infection
	1 – Follow up post surgery
	1 - Sepsis
	1 – Pain in Joint
3 “Real” readmissions	1 – Unable to support at home due to level of support visits required from Support at Home in addition to IC Team
	2 – Admissions Alternative – 1 x input delayed timing of re-admission

Declined Admission to Intermediate Care

The tables below indicate the number of individuals who were declined admission to the Intermediate Care Team service since it’s introduction and the reasons for this.

The high number of declined admissions in 2014 when the service was first established reflects the challenges posed in recruiting Rehab support workers to the Team and therefore the team’s ability to only support a limited number of clients at a time.

Declined Admission to Caseload	**Numbers**
2014	10
2015	17
2016	9
Total since service established	**36 individuals**

Appendix 1

Reasons for being Declined Admission to ICT	**Numbers**
No goals / ICT potential	13
Out of Area	5
Lack of Staff	4
Medically unwell	2
Lack of out of hours support	2
Patient / Carer Declined	8 (7 pt / 1 wife)
Died	2
Total	**36 individuals**

The core principles of Intermediate Care are:.

The purpose of Intermediate Care is to provide **time-limited interventions** at points in a person's life where this will **restore or avoid a loss of independence** and **confidence**, or **reduce the risk of hospital admission** (or a longer stay in hospital).

Experience suggests that Intermediate Care should **extend for up to 6-8 weeks**. After this period of time, the pace of recovery tends to slow and the person no longer receives the same level of benefit from the intensive interventions associated with Intermediate Care.

However the **period of time during which Intermediate Care should be provided should reflect the needs of the individual** and be shorter, or longer, as appropriate.

Intermediate Care is one form of rehabilitation targeted at those who will benefit from **short term, intensive, and multi professional interventions**: other rehabilitation services may well continue (as may the period of recovery) well beyond this 6-8 week period.

Intermediate Care should be provided, **free of charge, to people in their own homes** where possible: this reflects the clear priorities of older people. Free and effective Intermediate Care has the potential to pay its own way, when commissioned as part of a wider suite of integrated resources.
Intermediate Care in these circumstances is additional, and **should be complementary, to any existing services that the person receives**. It should not displace existing care and support arrangements, but seek to enhance and keep these in place.

This **continuity is of particular importance** for older people who are confused, and where maintaining routine is a key component of retaining their independence. In other circumstances, this will not be possible and a move to another setting, such as a care home or community hospital, may be required.

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

Level of acute need

Individual becomes unwell.
Primary care; District Nurse; Social Work; Home Care; NHS24; Ambulance practitioner; A&E attendance.

Contact Single Point of Access

Assessment

Intervention as required:
- Nursing
- Therapy
- Support Worker
- Telecare

Timely diagnosis by GP

Specialist input by:
- Geriatrician
- Community diagnostics
- Rapid Response Team

If too unwell to be cared for at home, step up to a care home, community hospital or other residential setting.

History / Examination / Diagnostics.

GP, Nurse practitioner or Consultant review within 24 hours.

MDT input with principle of care delivery at home when appropriate (as it may be in a care home).

If too unwell to be cared for in a community facility, admit to acute hospital for comprehensive assessment.

Transfer to community facility or home when medically stable and fit for transfer.

Level of need during recovery

Timely comprehensive multidisciplinary and multi-agency assessment :

Rehabilitative need identified.

Referral to Intermediate Care Single Point of Access.

Individual is medically stable and fit for transfer.

Individual transferred to the appropriate setting:
- Own home
- Community based facility (such as a care home or community hospital)

If the individual requires more care than can be delivered at home, step down from acute hospital to a care home, community hospital or other residential setting.

Regular MDT and GP / Nurse / Consultant review with principle of care at home to continue rehabilitation when appropriate

Majority of users of Intermediate Care to receive their episode of care at home.

MDT driven re-ablement to optimise recovery and promote independence.

6

Shetland Islands Council

NHS Shetland

Intermediate Care Team (ICT)
Discharge Summary – Case 1

All summaries have been anonymised from actual patient Discharge Summaries

NAME:…Patient Y

Category of client - supported home from hospital
- supported home from care home
- prevented admission

ADDRESS:
DOB: X

Date of initial assessment: XX
Date of discharge from ICT:XX

Reason for admission to ICT: Patient Y was admitted to a care home as emergency respite due to reduced mobility. There were also concerns regarding deteriorating cognitive abilities due to a diagnosis of dementia

Origin of referral: Social Work Assistant

Prior level of ability/care provision: Following a recent fall and admission to hospital Patient Y had received dementia support services upon discharge

Level of ability/care provision upon discharge: Patient Y made a good physical recovery and walks with no walking aid and is independent on stairs again.

Number of interventions from ICT: Occupational Therapy- 68
Rehab support worker- 62

Modified Dependency rating scale (Supplementary Scale)
Overall score on assessment: 24 indep / low / mod / **med** / high / max.
Overall score on discharge: 16 indep / low / **mod** / med / high / max.

Summary of ICT intervention
Patient Y participated in a period of intensive rehabilitation at the care home, with ICT, to promote their ability to walk without an aid again and to independently walk up and down stairs. Risks were identified and discussed at a case conference and how these could be managed. It was Patient Y's wish to return home and the GP noted that they had capacity to make this decision. It was agreed that the dementia team would lead on reinstating service provision and ICT would support the transition from the care home to back home.

Liaison with other agencies
Very close joint working with dementia team.

Review plan
Staff member X is Patient Y's care coordinator and will continue to monitor and review their needs in conjunction with the dementia support team.

Signed:… OT Date:…XX

Intermediate Care Team (ICT)
Discharge Summary – Case 2

NAME: Patient Z

Category of client - **supported home from hospital**
- supported home from care home
- prevented admission

ADDRESS:
DOB: XX

Date of initial assessment: XX
Date of discharge from ICT:XX

Reason for admission to ICT: Patient Z was admitted to hospital following a fall which resulted in a fractured hip. Due to complications Patient Z was required to follow full hip precautions for 6 week post op. Upon discharge home Patient Z was to be partially weight bearing.

Prior level of ability/care provision: Fully independent with all aspects of personal care, domestic tasks, housework. No formal services.

Level of ability/care provision upon discharge: Patient Z made great progress during our interventions and regained independence with all personal care, showering and light domestic tasks

Number of interventions from ICT:
Nursing - 1
Occupational Therapy - 30
Physiotherapy - 3
Rehab support worker - 45

Modified Dependency rating scale
Overall score on assessment: 20
high / max.
Overall score on discharge: 10
/high / max.

(Supplementary Scale)
indep / low / **mod** / med /

indep / **low** / mod / med

Summary of ICT intervention
Patient Z was assessed by the ICT whilst in hospital and supported in their transition home. Patient Z had specific goals that we agreed to and made very good progress in achieving these. Adaptations were made to make the stairs and shower more accessible.

Equipment supplied
Bathboard- returned
Commode - returned
Community alarm
Chair raisers
Dressing aids
Wheeled Zimmer Frame
Walking sticks

Elbow crutches

Referrals to other agencies
Hjaltland OSS
Support@home

Review plan
Patient Z has Senior Social Care Worker as key worker and is aware how to contact if future assistance is required.

Signed:… OT Date:…XX
Occupational Therapist

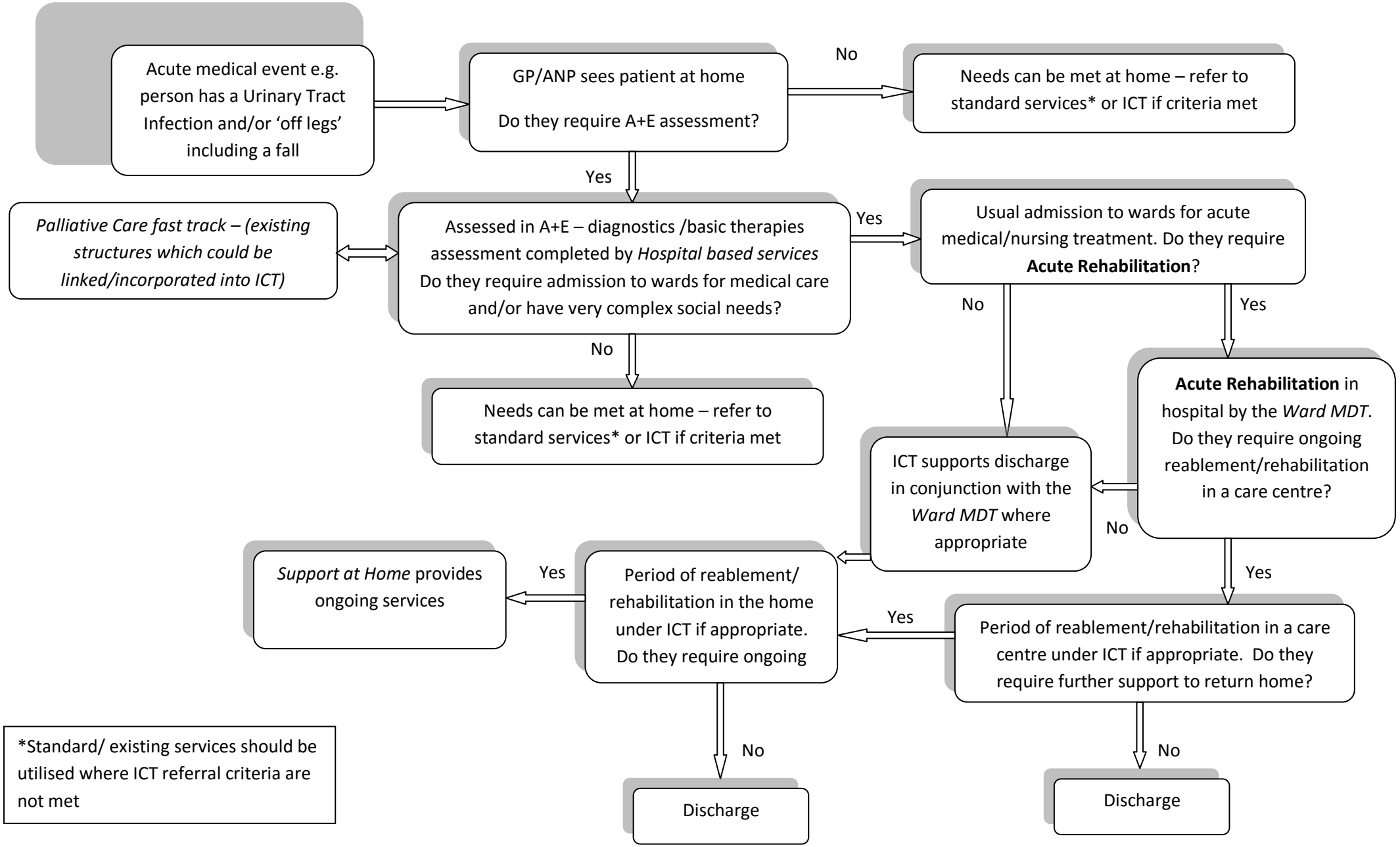
cc:
GP Practice
Medical records, GBH
Support@home

Intermediate Care Team 2017/18

Proposed Staffing Structure and costs

Required	2017/18 Cost	
1.0 WTE Team Leader Band 7 Nurse	55,380	
2.76 WTE Occupational Therapists (1WTE Band 6, 1WTE Band 7, 0.76FTE K2 plus ECU / mileage)	139,685	
7.6 FTE Rehab Support Workers includes mileage	280,384	
0.4 WTE Advanced Nurse Practitioner (ANP) Band 7 Nurse	22,152	
1.0 WTE Physiotherapist (Community Rehab Therapist) - Band 6; 0.67 WTE Band 4 Physio; 1WTE Band 5 Physio	90,626	
Training for ICT	3,000	
Transport - car lease; tyres; fuel costs; vehicle insurance.	3,000	
Recruitment costs	5,000	
Extension to Multi Person Just Checking System Warranty	1,110	
Furniture / Equipment / Uniforms	1,000	
Total Cost	**601,337**	
Funded By :-		
Integrated Fund	380,000	£30k required for 3rd sector initiatives, leaving £380,000 for Intermediate Care
Additionality Funding agreed 16/17 for Reablement Posts	86,100	Agreed by IJB for 17/18
Health Board Funded Posts	72,152	
SIC Funded Posts	36,747	
Additionality Funding 17/18	26,338	Total of £110k available which would leave £83,662 available for other projects.
Total Funding	**601,337**	

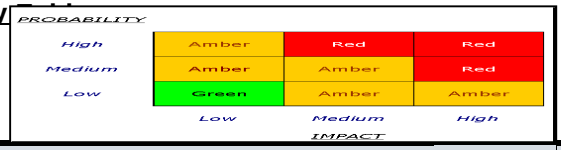
Appendix C Proposed Rehabilitation / Enhanced Intermediate Care Service Pathway



Appendix A
PROJECT RISK LOG
Project name

Risk Level Summary

Red	0
Amber	5
Green	8
Closed	0

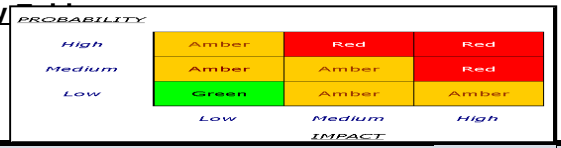


				Current			RISK RESPONSE		Controlled		
Risk Ref	Risk	Date	Ownership	Probability (L/M/H)	Impact (L/M/H)	Level (R/A/G/C)	Action Plans / Control Measures	Risk Owner	Probability (L/M/H)	Impact (L/M/H)	Level (R/A/G/C)
1	Failure to agree models	Oct-16	All partners	M	M	Green	Ongoing discussion/ work through issues at Project team and Board meetings	Project Board	L	L	Green
2	Failure to obtain funding to support the development of an overnight service/ enhanced therapy service	Jul-16	All Partners	M	M	Amber	Already some recognition of the need to provide overnight care to enable a 24/7 service to be provided in the community setting	Project Board	L	L	Green
3	Failure to recruit staff in a timely manner, thus compromising the implementation of the project. Failure to recruit to temporary/ fixed term posts.	Jul-16	All Partners	M	M	Amber	HR advisors are part of project team and will provide advice on most effective methods of recruitment. Substantive posts are most likely to be successful.	Project Board	L	L	Green
4	Lack of understanding of criteria for the any or the services resulting in either inappropriate referrals or saturation of staffing resource in a short period of time and thus inability to support any new patients	Jul-16	All Partners	M	M	Green	Develop service criteria which is publicised across health and social care. Team to monitor and actively manage referrals and admissions/discharges to the team.	Project Board	L	L	Green
5	Failure to agree on joint systems of work, e.g. recording of patient/ service users notes	Jul-16	All Partners	M	M	Green	Discussion with Data sharing partnership, e-health services required	Project Board	L	L	Green
6	Failure to secure long term funding to support the service going forward	Jul-16	All Partners	M	H	Amber	Discussion with Director and finance required	Project Board	L	L	Green
7	Knock on negative impact of removal of emergency provision from Montfield on delayed discharges	Oct-16	All partners	H	H	Green	Need to work on increasing access to other care centres to free up resources in Montfield so that this service can be maintained	Project Board	L	L	Green
8	Lack of capacity of staff to develop service models in addition to existing roles means inability to keep to deadlines in action plan	Oct-16	All partners	H	H	Amber	Senior managers to be clear about limited staff resources - need to agree to acheiveable action plan	Project Board	L	L	Green

Appendix A
PROJECT RISK LOG
Project name

Risk Level Summary

Red	0
Amber	5
Green	8
Closed	0



				Current			RISK RESPONSE		Controlled		
Risk Ref	Risk	Date	Ownership	Probability (L/M/H)	Impact (L/M/H)	Level (R/A/G/C)	Action Plans / Control Measures	Risk Owner	Probability (L/M/H)	Impact (L/M/H)	Level (R/A/G/C)
9	Differing advice from respective HR services following own PINS meaning that staffing issues cannot be resolved	Oct-16	All partners	M	M	Green	It is recognised that each service has a responsibility to their employer and it is not always possible to resolve issues but HR to resolve issues where possible. To be resolved once agreement is made which body they sit under	Project Board	L	L	Green
10	Unable to engage staff sufficiently to ensure smooth implementation of service/s	Oct-16	All partners	L	M	Green	Ensure time is taken to effectively engage staff during the project.	Project Board	L	L	Green
11	ICT issues, causing difficulty with implementation	Oct-16	All partners	M	M	Green	Identify issues at an early stage to highlight to IT where relevant	Project Board	L	L	Green
12	Lack of patients/ clients who have capacity to be reabled/ rehabilitated	Oct-16	All partners	L	M	Green	Ensure early idenitification of potential is undertaken	Project Board	L	L	Green
13	Risk around bed availability in the hospital, increased delayed discharges, possible transfer to ARI	Oct-16	All partners	M	M	Green	If project proceeds to plan, the risk of this happening as a result of this project will be minimised	Project Board	L	L	Green
14	Failure to provide expanded service to service users	Oct-16	All partners	M	M	Amber	Ensure implementation of project proceeds according to plan	Project Board	L	L	Green

Action	Action by:	Action Tracker R/A/G	24/10/16	25/10/16	26/10/16	27/10/16	28/10/16	31/10/2016 - 4/11/2016	07/11/2016 - 11/11/2016	14/11/2016 - 18/11/2016	21/11/2016 - 22/11/2016	23/11/16	24/11/2016 - 25/11/2016	28/11/2016 - 01/12/2016	02/12/16	05/12/2016 - 06/12/2016	07/12/16	08/12/2016 - 09/12/2016	12/12/2016 - 16/12/2016	19/12/2016 - 23/11/2016	26/12/2016 - 30/12/2016	02/01/2017 - 06/01/2017	09/01/2017 - 13/01/2017	16/01/2017 - 20/01/2017	23/01/2017 - 24/01/2017	25/01/17	26/01/17	27/01/17	30/01/2017 - 03/02/2017	06/02/2017 - 07/02/2017	08/02/17	09/02/2017 - 10/02/2017	13/02/2017 - 17/02/2017	20/02/2017 - 24/02/2017	27/02/2017 - 03/03/17
Update PID	JR	G																															
Review and agree action plan in principl	All/ PT	G			PT																												
Review and sign off action plan at Project Boar	**PB**	G				PB																											
Sign off PID at Project Board	**PB**	G				PB																											
Distribute NAIC definitions	JR	G																															
Define model of Intermediate Care using NAIC definitions and definition of Rehabilitation	All/ PT	G			PT																												
Invite HR and Finance to be part of Project tear	JR	G																															
Agree model/s to be recommended to Project Boar	All	G			PT							PT																					
Aprove model/s to be implemente	**PB**	G				PB																											
Identify extra staff required to provide model/	All	G										PT																					
Obtain Job Descriptions for SIC/ NHS posts	JR/ HR	G										PT																					
Obtain staffing costs from finance	JR	G										PT																					
Identify where funds will come fron	All/ HR	G										PT																					
Obtain HR advice re holding posts for NHS staf	JR	G										PT																					
Recommendation to project board as to whether posts ar SIC or NHS	PT	G										PT																					
Recommendation to project board re. ability to hold posts fo NHS staff	PT	G										PT																					
PB makes decision re SIC or NHS	**PB**	G													PB																		
PB makes decision re. holding posts	**PB**	G													PB																		
Identify what needs to be done to obtain funds e.g. report to IJB? If so, add in actions/ timescale required for this	**PB**	G													PB																		
Review Physio input to ICT	JR/ FS/ EC	G																															
Recruit to posts if no decision required	ICT	A													PB				For 3 months... end date														
Make decision as to where reablement/ rehab will take place depending on model	All	G										PT																					
Recommend venue to Project Boar	**PB**	G										PT																					
Assess need for physical resources, desks/ computers etc	JB/ IS	G										PT																					
Assess need for Physical resources at Montfield for PT and OT	JB/ EC/ AR/ LB	G										PT																					
Organise provision of physical resources	JR, JB, LB	R															PT																
Agree funding stream for physical resources	JR/ EMW/ **PB**	R													PB																		
Obtain clarification re. where community nurses role crosses over/ interfaces with ICT nurse role	IS/ EMW	G										PT																					
Review staff travel within ICT team, including insurance issue	JR/ EMW	A																															
Review/ organise provision of mobile phones for team/s	JR/ EMW	R																															
Review access of teams to computer systems/ EMIS SWIFT/ ELMS/ Sharepoint	JR/ EMW	R																															
Once new staff recruited to ILC carry out induction	Team leader/s	R																															
Review access criteria for Montfield to ensure they mee need	AR/ RB	G										PT																					
Review bed allocation criteria for Monfield, update if required	AR/ RB	G										PT																					
Publicise access criteria for Montfield to ensure all referrers are clear about who can authorise admission, and to ensure appropriate placement	AR	A										PT																					
Review impact of changes on potential social admissions t hospital	RB/ AR/ SM/ DM	G										PT																					
Prepare and present proposal for out of hours service, including definition of emergency/ unplanned visit at night	EMW	G															PT																
Decise how out of hours team will be contacted, access protocol	EMW	A															PT																
Decide where out of hours team will sit, ? Extension of current community nursing service, or part of ICT team, recommend to project board	EMW/ All	A															PT																

Calculate no of staff required to cover shifts for out of hours service	EMW	G
Obtain costs for out of hours service	EMW	G
Present proposal to PB for approva	EMW	A
PB approve proposal for out of hours workin	PB	A
Identify source of funds for out of hours service	EMW/ Finance	A
Obtain approval for recruitment via NHS	EMW	A
Recruit to posts once decision is obtaine	EMW	R
Obtain H&S advice for out of hours working/ lone working policy		R
Write/ update procedures for out of hours working	EMW/ Team lead	R
Decision/ recommendation about where staff will be sited ou of hours	All	R
Check registration if out of hours service is sited in Care home	AR	R
Check insurance if out of hours including if SCW's are sited in GBH	ICT Team leader	R
Ongoing.. Identify suitable patients/ clients for more intensive support and make referrals	All	G
Identify method of transport for patients from hospital	EMW	A
Identify staff transport, for out of hours	EMW	A
Once new out of hours staff recruited carry out induction	Team leader/s	R
Inform Care Inspectorate of plans if require	AR	R
Clarify processes around designating some one a delayed discharge if in hospital - if needing acute rehab, they are not a delayed disharge	RB/ SM/ KC	G
Clarify line management/ professional line managemer responsibilities for the services	JR/ EMW	G
Identify plans for ICT covering whole of Shetland	JR/ EMW/ DM/ All	G
Make recommendation to project board	JR/ EMW/ DM/ All	G
Identify additional resources required	JR/ EMW/ DM/ All	G
Identify funding source for additional resources - does it need further investment	JR/ EMW/ Finance	G
Identify route for obtaining additional funds	JR/ EMW, Finance/ **PB**	G
Obtain approval for recruitment via appropriate body	JR/ EMW/ DM	A
Undertake recruitment (date to be inserted)	Delegate to team leaders	G
Review information for the publi	All	A
Transfer funds to appropriate budget code	Finance	R
Check signatory rights for staff members	Team leader/s	A
Cascade info on new services to acute and CH&SC staff	Team leader/s	A
Identify publicity and service identity resources	Team leader/s	A
Plan B, if recruitment fails first time…. Locums, agency staff, trainees, add in additional time scale	All	R
Attend HRGP and JSF with new staffing models	JR/ SBI	A
If staff redeployment required, identify process and add i actions to action plan	All	A
Draft report for IJB	SBI	G
IJB seminar	JR/ SBI	G
Clearance process for IJE	SBI	G
Present report at IJE	SBI	R
Review action plan to ensure all components are covere update if necessary	All	R
Go live		R