Shetland Islands Health and Social Care Partnership

Shetland NHS Board	Shetland Islands Council

Enquiries to Leisel Malcolmson
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6 July 2017

Dear Member

You are invited to attend the following meeting:

Integration Joint Board
Thursday 13 July 2017 at 10am
Bressay Room, NHS Shetland HQ, Burgh Road, Lerwick

Apologies for absence should be notified to SIC Committee Services on 01595 744599.

Yours sincerely

S. Bokor Ingram.

Simon Bokor-Ingram
Chief Officer

Chair: Ms Marjorie Williamson
Vice-Chair: Mr Allison Duncan

AGENDA

A	Welcome and Apologies
B	Declaration of interests - Members are asked to consider whether they have an interest to declare in relation to any item on the agenda for this meeting. Any member making a declaration of interest should indicate whether it is a financial or non-financial interest and include some information on the nature of the interest. Advice may be sought from Officers prior to the meeting taking place.
ITEM	
1	Use of Integrated Care Fund and Additionality for 2017/18 *CC-25*
2	Remit of Strategic Planning Group *CC-27*
3	Management Arrangements for Strategic Change Programmes *CC-28*
4	Local Delivery Plan (LDP) 2017-20 *CC-29*
5	Directions to Shetland Islands Council *CC-37*

Agenda Item

1

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	13 July 2017
Report Title:	Use of Integrated Care Fund and Additionality Funding for 2017/18
Reference Number:	CC-25-17 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1.0 Decisions / Action required:

1.1 That the IJB:

1. APPROVE the use of the Integrated Care Fund and use of Additionality Funding for 2017/18 (Appendix 1); and
2. AGREE the intention to continue seeking opportunities to pump-prime future initiatives

2.0 High Level Summary:

2.1 This report summarises how the Integrated Care Fund and Additionality Funding is proposed to be utilised for 2017/18 and how future initiatives can continue to be pump-primed.

2.2 The IJB asked at the 10 March 2017 meeting (Min. Ref. 11/17) for the Chief Officer to report back on significant issues arising from "Audit Scotland: Reshaping Care Impact Report" that required local action. A paper was presented on 25 May 2017 to the IJB meeting (CC-23-17) (Min.Ref. 23/17) on decision making structures. Clarification as to how a whole system approach to health and social care can underpin the ten strategic areas has been covered by the production of the Strategic Plan. This paper focuses on clarification on the balance of the current and future use of the Integrated Care Fund and Additionality Funding and the capacity to use it for pump priming for new and innovative solutions.

2.3 The Reshaping Care for Older People Change Fund came to an end in March 2015, with the new Integrated Care Fund available to partnerships to invest in initiatives for all adults from 2015/16. Shetland has made good use of this funding, and has targeted prevention and rehabilitative programmes, which have contributed to key performance and outcomes where Shetland is performing very well on a national basis.

2.4 The Scottish Government has made £100M available to Health & Social Care

Partnerships to support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention, and further strengthen our approach to tackling inequalities. The Shetland IJB has been allocated £410k of this funding in 2016/17 and 2017/18.

2.5 Whilst it is important that we can continue to innovate, it is equally important that initiatives are not confined to one year programmes only, and longer term initiatives are properly supported and allowed to be embedded. The extension of intermediate care is an example where having made the decision in earlier years to carry out small tests of change, we are now in a position to roll this out further and do a more fundamental test of change on a larger scale.

2.6 There will be a challenge with larger scale innovations to shift the funding of those schemes, should the IJB decide to continue with them, to mainstream funding, thus allowing the Integrated Care fund to be utilised again for further tests of change. Both of the key funders to the IJB, being Shetland Islands Council and NHS Shetland, have expectations that efficiencies will be generated year on year, so as the Integrated Care Fund projects deliver the intended consequences in terms of outcomes, some of which will emerge as efficiencies in other parts of the system, retaining some of those efficiencies will be key to being able to move spend away from the Integrated Care Fund.

2.7 Appendix 1 shows how the finances from the Integrated Care Fund and Additionality Funding will be utilised in 2017/18, and Appendix 2 shows how the initiatives will help to meet outcomes against the National Health and Wellbeing Outcomes.

3.0 Corporate Priorities and Joint Working:

3.1 The planned use of the funding supports and is integral to the priorities in the Joint Strategic Plan, and is aligned to the National Health and Wellbeing Outcomes.

4.0 Key Issues:

4.1 Shetland's Joint Strategic Plan 2017/18-20 is our plan for how services for all adults including older people will meet the 9 National Health and Wellbeing Outcomes. The Integrated Care Fund Plan is also aligned to meeting those outcomes.

4.2 The Integrated Care Fund guidance states that it is important that the fund is used to test and drive preventative approaches to reduce future demand. The plan for Shetland has been developed to continue the approach of shifting care from hospital to the community, and to support people to remain living in their own homes wherever possible.

5.0 Exempt and/or confidential information:

5.1 None

6.0 Implications :

6.1 Service Users, Patients and	The ongoing commissioning cycle and guidance on development of health and care plans, requires that customers

Communities:	and carers and third sector colleagues have full involvement. Engagement has taken place on an ongoing basis through a number of routes. This includes a number of planning groups involving third sector providers and service user and carer representatives and the Public Partnership Forum.
6.2 Human Resources and Organisational Development:	Recruiting to short term posts has proven to be challenging in the past, and this had led to a delayed start for a number of project areas. Permanent recruitment to posts with the flexibility to deploy staff to respond to service requirements will reduce the risk of not being able to take forward initiatives although this must take place through the agreed HR process of the designated employing organisation.
6.3 Equality, Diversity and Human Rights:	Shetlands Joint Strategic (Commissioning) Plan 2016-19 supports and promotes equalities, health and human rights.
6.4 Partnership Working:	There are well established processes in place to engage with the public; third sector and other statutory agencies. There are established forums for engagement with unions and staff. The Strategic Planning Group which reports to the IJB brings together key stakeholders and this group advises the IJB on changes to the Strategic Plan.
6.5 Legal:	Under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the IJB is responsible for the strategic planning of the functions delegated to it by the Shetland Islands Council and NHS Shetland and for the preparation of the Strategic Plan. The Strategic Plan specifies the services to be delivered by the parties.
6.6 Finance:	The Scottish Government settlement for 2017/18 allocated a further £250M for the NHS to Health & Social Care Partnerships to protect and grow social care services and to deliver our shared priorities. The Shetland IJB has been allocated £1.024M of this funding.
6.7 Assets and Property:	There are no implications for major assets and property.
6.8 Environmental:	There are no implications for major assets and property.
6.9 Risk Management:	The main risk is that of not using the Integrated Care Fund and the Additionality funding to develop and establish new service provision models. We know that traditional models of care that rely on institutional settings are resource intensive and unsustainable. Good progress has been made in recent years to shift the balance of care. We must continue to promote new ways of working and provide flexible, responsive health and care services in the community that make fullest use of new technologies. We must work in collaboration with third sector partners and communities to promote prevention, early intervention and health improvement programmes.

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.
6.11 Previously considered by:	This report has not been presented to any other formal meeting.

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5 July 2017

Appendices:
Appendix 1 – Use of Integrated Care Fund and Additionality Funding for 2017/18
Appendix 2 – Initiatives to Meet Health & Wellbeing Outcomes

APPENDIX 1

2017/18 Projects Requiring Funding

Project	2017/18 Cost
Extended Intermediate Care Team (EICT)	
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
Medical Input	30,000
Sub-Total for EICT	**631,337**
Provision of hearing impairment training to community staff so they can better support clients.	8,163
Third sector provided Independent Living Support at Home across seven localities to provide ongoing reablement and social engagement.	30,000
Provision of Post Diagnostic Support for People Living with Dementia	14,465
Total 2017/18 Projects Funding Required	**683,965**
Funded By :-	
Integrated Care Funding 2017/18	410,000
Additionality Funding agreed in 2016/17 for Reablement Posts	86,100
Health Board Funded Posts	64,152
SIC Funded Posts	36,747
Additionality Funding 2017/18	86,966
Total 2017/18 Funding Available	**683,965**

Total 2017/18 Additionality Funding available is £110,000; balance remaining £23,034

APPENDIX 2 – INITIATIVES TO MEET HEALTH AND WELLBEING OUTCOMES

	Intended Local Outcomes	Meeting the National Health and Wellbeing Outcomes
Extending intermediate care	Optimising people's ability to live independently or as independently as possible. Earlier discharge from hospital, thus increasing opportunity for regaining function and independence.	People are able to look after and improve their own health and wellbeing and live in good health for longer. 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.
Provision of hearing impairment training to community staff so they can better support clients	Staff can assist clients to maintain impairment equipment which promotes functionality and sense of well-being. Staff are better able to identify clients who may need more specialist intervention at an early stage.	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. Public services contribute to reducing health inequalities.
Third sector provided Independent Living Support at home across seven localities to provide ongoing re-ablement and social engagement	Supporting people to maintain their independence either on hospital discharge or where an admission has been avoided.	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. Public services, particularly Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use them.

APPENDIX 2 – INITIATIVES TO MEET HEALTH AND WELLBEING OUTCOMES

Provision of post diagnostic support for people living with dementia	Supports people and their carers to continue living in their communities and in their own home. Connect people to their communities which promotes wellbeing.	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 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.

Shetland Islands Health and Social Care Partnership

Agenda Item

2

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board (IJB)	23 June 2017
Report Title:	Remit of Strategic Planning Group	
Reference Number:	CC-27-17 F	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board APPROVES the revised remit of the Strategic Planning Group.

2.0 High Level Summary:

2.1 In November 2015, the IJB agreed to the establishment of the Strategic Planning Group, one of the legal requirements from the Public Bodies (Joint Working) (Scotland) Act 2014.

2.2 In May 2017, the IJB approved the request from the Strategic Planning Group to revisit their Terms of Reference to better clarify its role and purpose, especially with regard to involvement in strategic change management projects.

2.3 The proposal is to include a new section within the existing terms of reference, which concisely summarises the role of the group. This wording is based on Edinburgh's Health and Care Partnership.

2.4 The Strategic Planning Group has been consulted on this change and they are content with the proposal, so long as it does not dilute their overall commissioning role. It has been confirmed to them that the proposal does not remove any of their responsibilities; the change is more intended to clarify their role and purpose within the overall decision making structure.

2.5 The proposed addition to the Terms of Reference are:

- The role of the Strategic Planning Group is set out in the legislation and is to be consulted and provide feedback:
  - At each stage of the production of the Strategic Plan; and
  - In respect of any significant decision about the arrangements for carrying

out the 'integration functions' that the Board proposes to implement without revising the Strategic Plan.

- Review detailed business cases and change plans on behalf of the IJB to ensure they are robust and meet the aims of the strategic plan.
- Provide assurance to the IJB that there has been appropriate consultation and engagement in line with the statutory responsibilities for any service changes.
- Review the planning structures in place and provide assurance to the IJB that appropriate planning mechanisms exist within the partnership, and between the partnership and key stakeholders.
- Provide a forum for discussion and debate in relation to emerging themes and national or local initiatives which emerge following the finalisation of the Strategic Plan.
- Receive updated Joint Strategic Needs Assessment and performance information as this emerges to inform the annual review of the Strategic Plan.
- Collaborate on the production of future iterations of the Strategic Plan.
- Oversee delivery of the Strategic Plan on behalf of the IJB.

The complete Terms of Reference, as amended, are included at Appendix 1.

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.

4.0 Key Issues:

4.1 The decision making arrangements for the IJB are set out in the Integration Scheme and supporting documents; the Scheme of Administration and Delegations and the Standing Orders for Meetings.

4.2 Following a period of operation, many partnerships are updating the detail of the governance arrangements, to reflect the knowledge they have gained.

4.3 The Strategic Planning Group requested that their terms of reference be updated and the IJB were supportive of that approach at their meeting in May 2017.

4.4 The Strategic Planning Group met on 2 June 2017 to consider the proposed changes and they are supportive of the proposal before the IJB.

4.5 This change does not fundamentally alter the role and remit of the Strategic Planning Group, which is determined by legislation and guidance. It does, however, help to clarify the Group's role and remit and relationship to the overall decision making arrangements.

5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The Strategic Planning Group is set up to ensure appropriate participation of services users and communities, through locality planning and other mechanisms. The revised Terms of Reference help to strengthen and acknowledge that role, particularly with regard to the significant change projects.
6.2 Human Resources and Organisational Development:	If staff are not clear how and where decisions get taken, there is the potential for proposals to not be considered by all the relevant groups and committees, which could result in time delays. The change to the Terms of Reference helps to clarity the Group's place within the overall decision making arrangements. The Joint Staff Forum is in place to ensure consultation with staff representatives of the partner agencies.
6.3 Equality, Diversity and Human Rights:	There are no specific issues to consider.
6.4 Legal:	The Strategic Planning Group exists to comply with guidance issued in support of the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. The Terms of Reference, as amended, comply with the legislation and guidance.
6.5 Finance:	There are no specific financial issues to consider. Clarification on routes to decision making where strategic change projects have a financial savings target will strengthen the governance arrangements to ensure that options and proposals which come before the IJB for a decision have been robustly challenged to ensure that financial proposals are aligned to the Strategic Commissioning Plan.
6.6 Assets and Property:	There are no specific issues to consider.
6.7 ICT and new technologies:	There are no specific issues to consider.
6.8 Environmental:	There are no specific issues to consider.
6.9 Risk Management:	Clarification of the decision making arrangements is an action point on the Strategic Risk Register. Approving this report will contribute to mitigating the risks around 'Failure of Governance Arrangements'. If there is a lack of clarity around how and where decisions to changes to community health and social care service models are made, this could

	lead to conflicting decisions, confusion for service uses and the public, financial savings not being released and time wasted.	
6.10 Policy and Delegated Authority:	The Scheme of Administration and Delegations states that, "4.6 The Board shall approve the terms of reference and membership of the committees, sub-committees and working groups and shall review these as and when required". Approval to amend the Terms of Reference of the Strategic Planning Group therefore rests with the IJB.	
6.11 Previously considered by:	Strategic Planning Group	2 June 2017.

Contact Details:
Name: Hazel Sutherland
Title: Head of Planning and Modernisation, NHS Shetland
E'mail: hazelsutherland1@nhs.net

6 June 2017

Appendices:
Appendix 1 Strategic Planning Group: Amended Terms of Reference

Background Documents:
Shetland Islands Health and Social Care Partnership's Scheme of Administration and Delegations
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/IJBSchemeofAdmin-V2.0-19January2016.pdf

Health and Social Care Integration: Guidance for everyone involved in the commissioning of health and social care services.
http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

Appendix 1

Strategic Planning Group

TERMS OF REFERENCE

Purpose

All stakeholders must be fully engaged in the preparation, publication and review of the Strategic Commissioning Plan as part of an on-going, cyclical process. To ensure this, the Act requires each Integration Authority to establish a Strategic Planning Group.

Role

The role of the Strategic Planning Group (SPG) is to support the Integration Joint Board in the cyclical development and finalising of the Plan and the continuing review of the progress in its delivery against the agreed national and local outcomes. The Strategic Commissioning Plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.

The Strategic Planning Group will take account of the relevant legislation and national guidance specifically the Strategic Commissioning Plans Guidance http://www.gov.scot/Resource/0046/00466819.pdf and Localities Guidance http://www.gov.scot/Resource/0048/00481100.pdf.

It will be concerned with supporting and challenging those responsible for strategic commissioning in the development of the local plan, for instance through asking:

- What exactly are we trying to achieve, and for whom?
- How successful have we been?
- What do we need to do differently for a better result, and how are we going to resource that?

Or using the series of questions included in the guidance based on work by Audit Scotland:

• How many people will need services and what type will they need?
• What is the current provision, is it the right level, quality and cost?
• How can these services improve people's lives?
• Which Services will best achieve this?
• How do we develop these services at an affordable cost?
• How do we procure and deliver these services to best effect?
• How do we monitor and review these services?

The views of localities must be taken into account so that the Strategic Commissioning Plan reflects closely the needs and plans articulated at locality level.

NEW SECTION:

The role of the Strategic Planning Group is set out in the legislation and is to be consulted and provide feedback:

  - At each stage of the production of the Strategic Plan; and
  - In respect of any significant decision about the arrangements for carrying out the 'integration functions' that the Board proposes to implement without revising the Strategic Plan.
- Review detailed business cases and change plans on behalf of the IJB to ensure they are robust and meet the aims of the strategic plan.
- Provide assurance to the IJB that there has been appropriate consultation and engagement in line with the statutory responsibilities for any service changes.
- Review the planning structures in place and provide assurance to the IJB that appropriate planning mechanisms exist within the partnership, and between the partnership and key stakeholders.
- Provide a forum for discussion and debate in relation to emerging themes and national or local initiatives which emerge following the finalisation of the Strategic Plan.
- Receive updated Joint Strategic Needs Assessment and performance information as this emerges to inform the annual review of the Strategic Plan.
- Collaborate on the production of future iterations of the Strategic Plan.
- Oversee delivery of the Strategic Plan on behalf of the IJB.

Support for meetings

The secretariat for the Strategic Planning Group will be provided by the NHS Head of Planning and Modernisation in line with Shetland's Integration Scheme.

Agendas for meetings will be issued no later than five working days before the date of the meeting. Papers will be issued electronically, but will be available as paper copies on request or by arrangement. Meetings will be formally minuted, and the minutes will be reported to the IJB on a regular basis.

Frequency of meetings

It is anticipated that the Strategic Planning Group will meet formally once a quarter. Additional meetings may be called to deal with particular items of business in agreement with the Chairman. A schedule of meetings in line with the planning cycle for developing the Joint Strategic Commissioning Plan will be drawn up once the IJB has approved the Terms of Reference and Membership.

Notice of meetings

All ordinary meetings of the Strategic Planning Group shall be called by notice in writing issued by or on behalf of the chairman at least five working days before the date of the meeting.

Conduct of meetings

The Strategic Planning Group is an advisory group to the IJB and therefore there will be no formal voting in meetings. Differences of opinion will be reported to the IJB to take into account in its decision making.

A meeting shall be considered quorate if a minimum of seven members are present.

Minutes shall be taken of the proceedings of the Strategic Planning Group. Draft Minutes shall be distributed for consideration and review to the Chairman of the Meeting and the draft Minutes shall be presented at the next Meeting of the Group for approval. Formally approved Minutes shall be included in Integration Joint Board Meeting papers for noting.

The meetings will not be held in public (minutes will be published via reporting to the IJB).

Membership
Membership is set out in Table 1.

Table 1

STATUTORY MEMBERSHIP	**LOCAL REPRESENTATION**
Users of health care	A health care user representative to be identified from the current PFPI arrangements
Users of social care	A social care user representative to be identified from the current PFPI arrangements
Carers of users of health care Carers of users of social care	A carers representative to be identified from the current Carers Support arrangements representing carers of health and social care users. A representative of carers' support via the Carers Support Team
Commercial providers of health care	A representative of local commercial providers to be sought (engagement with Boots, Freefield and Brae commercial pharmacy businesses; Independent dental and optometry businesses)[1]
Commercial providers of social care	N/A
Non-commercial providers of social care	Crossreach (Walter and Joan Gray Care Centre, Scalloway)
Non-commercial providers of social housing	Hjatland Housing Association
Non-commercial providers of health care	N/A
Health professionals[2]	A representative to be identified via Area Clinical Forum
Social care professionals[3]	A representative to be identified via Area Clinical Forum
Third sector bodies carrying out activities related to health or social care	A representative identified via Voluntary Action Shetland
Members[4] nominated by the Local Authority or the Health Board, or both	Director of Public Health & Planning (Chair) IJB Chief Officer / Director of Community Health & Social Care (Vice-Chair) Director of Nursing & Acute Services (NHS) Other officers as determined by the IJB Chief Officer
Representatives of the interests of each	TBC by IJB Chief Officer, Director of

[1] A meeting of local commercial providers will be held to seek representation

[2] As described in the legislation – see Strategic Commissioning Guidance

[3] As described in the legislation – see Strategic Commissioning Guidance

[4] The group must involve members nominated by the Local Authority or the Health Board, or both. In effect, this provides for the partners who prepared the Integration Scheme, and are party to the integrated arrangements, to be involved in the development of the strategic commissioning plan.

locality[5]	Community Health & Social Care
Other persons the Integration Authority considers appropriate, such as Local Authority housing colleagues	A representative of SIC Housing Dept

Chairman: The role of Chairman will be taken initially by the NHS Head of Planning and Modernisation who has responsibility to the IJB for supporting the development of the Joint Strategic Commissioning Plan as set out in Shetland's Integration Scheme.

The role of Vice-Chairman will be taken by the IJB Chief Officer, the Director of Community Health & Social Care.

Members Roles

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

- represent their sector or professional area (community of interest) see Table 1 and relevant Guidance;
- ensure the interests of the agreed localities are represented;
- develop and maintain the necessary links and networks with groups and individuals in their community of interest to enable views to be sought and represented over the development, review and renewal of the Strategic Commissioning Plan;
- take an active role in the development of the initial draft of the Strategic Commissioning Plan (as well as the subsequent drafts);
- help ensure the Plan reflects the needs and expectations (and that there has been an adequate assessment of those needs and expectations) both across Shetland and in the localities.

END

[5] The Integration Authority is required to identify the most appropriate person to represent each locality on the Strategic Planning Group. Local flexibility is allowed, so that an individual can represent more than one locality.

Shetland Islands Health and Social Care Partnership

Agenda Item

3

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board (IJB)	23 June 2017
Report Title:	Management Arrangements for Strategic Change Programmes	
Reference Number:	CC-28-17 D1	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board:

a) APPROVE the proposed arrangements for managing the Strategic Change Programmes; and
b) NOTES the intention to report quarterly on progress as part of the Annual Business Programme approved in May 2017.

2.0 High Level Summary:

2.1 In March and April 2017, NHS Shetland, the IJB and Shetland Islands Council approved the Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan. That Plan included some significant change management programmes and projects, as set out below.

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
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
Organisational Issues	
Improving Business Performance and Efficiency	

2.2 Formal project management arrangements have been developed to support the implementation of these programmes, following the 3 categories of: whole population; sustainable service models; and organisational issues.

2.3 A Transformational Change Programme Board has been established to direct and co-ordinate the work. This is a short term group with a specific remit to oversee the delivery of the strategic programme. It will be chaired by NHS Shetland's Chief Executive and the focus will be on developing a whole system approach to redesigning health and care services within the constraints of the financial plan. The membership of the Board is set out in the Table below.

Roles and Responsibilities

Name	**Roles and Responsibility**	
Decision Makers:		
Ralph Roberts (Chair)	Whole Systems Approach / Integration	Organisational Overview
Simon Bokor-Ingram	Whole Systems Approach / Integration	Organisational Overview and Joint Programme Executive Lead
Medical Director	Whole Systems Approach / Integration	Organisational Overview
Colin Marsland	Whole Systems Approach / Integration	Organisational Overview
Kathleen Carolan	Whole Systems Approach / Integration	Programme Executive Lead
Lorraine Hall	Whole Systems Approach / Integration	Programme Executive Lead
Susan Webb	Whole Systems Approach / Integration	Programme Executive Lead
Edna Mary Watson	Clinical Engagement assurance	Chair of Area Clinical Forum
Chris Nicolson	Whole Systems assurance	Director of Pharmacy
Ian Sandilands	Staff Engagement assurance	Employee Director

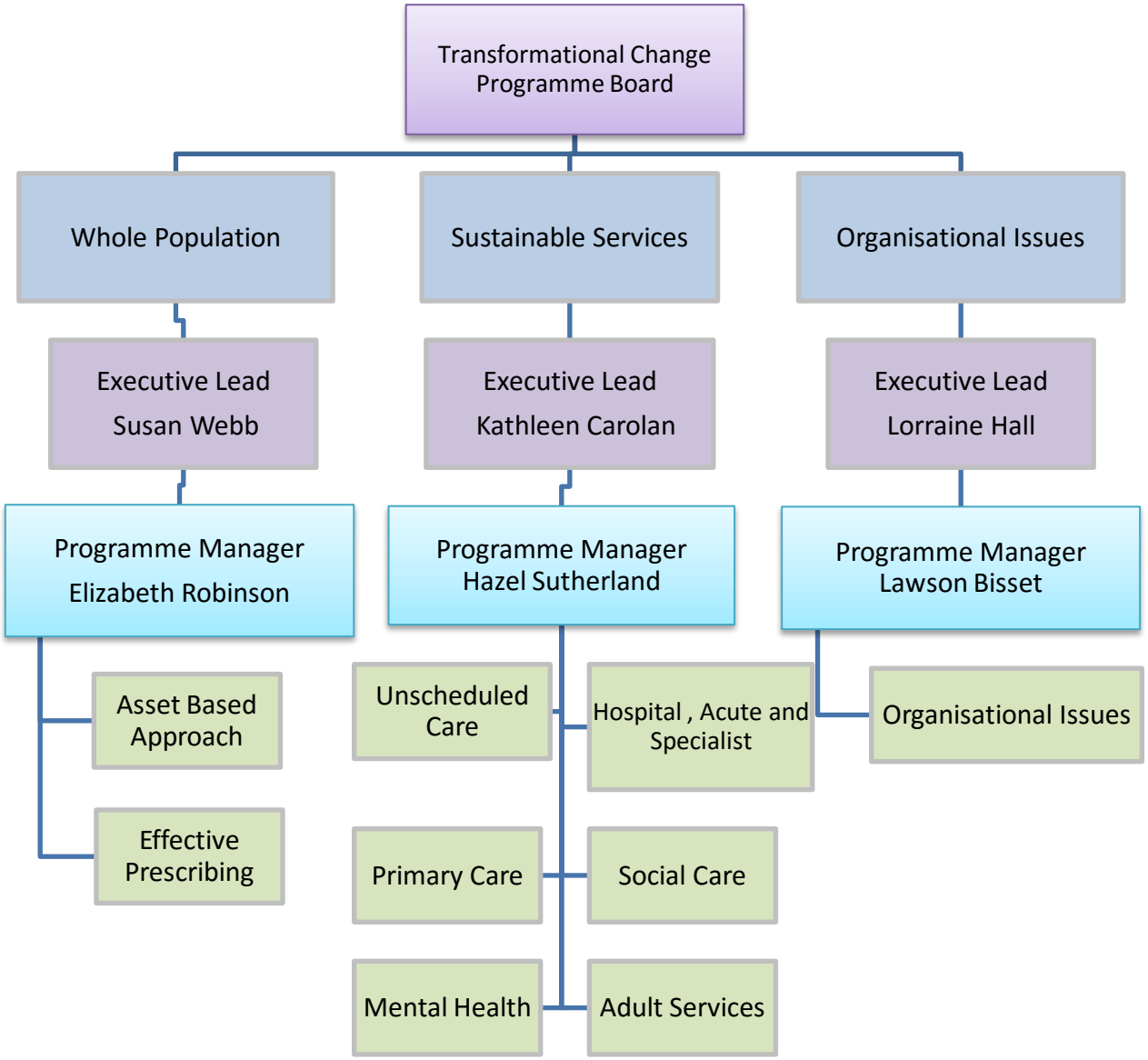
2.4 The Board will be supported by a number of advisers, including support for communications and information technology, systems and data.

2.5 A Director has been appointed to lead on each of the Strategic Programmes, a role known as 'Executive Lead' within the project management arrangements. The relevant Directors are:

Susan Webb	Whole Population
Kathleen Carolan	Sustainable Service Models
Lorraine Hall	Organisational Issues

2.6 Each of the Executive Leads will be supported by a programme manager, other Directors and project leads, to assist in co-ordinating the work and helping to deliver the overall objectives of the programme.

2.7 The Strategic programmes will be broken down into individual projects, which are project managed separately but linked together through the programme management arrangements. The diagram below outlines the arrangements.



Redesign Programme	Projects	Project Leads
Whole Population	Assets Based Approaches	Susan Webb
	Effective Prescribing	Chris Nicolson
Sustainable Services	Mental Health	Simon Bokor Ingram
	Adult Services	Simon Bokor Ingram
	Unscheduled Care (mainland OOHs provision)	Kathleen Carolan
	Primary Care	Simon Bokor Ingram
	Social Care	Simon Bokor Ingram
	Acute & Specialist Services	Kathleen Carolan
Organisational Development	Improving business efficiency	Lorraine Hall

2.8 The project leads will be responsible for ensuring that:

- The necessary project documentation is in place e.g. business cases, determination of goals and aims etc
- The individual project teams or working groups are convened to take forward scoping, options appraisal development and implementation plans
- Highlight reports are produced for review at the Programme Board meetings

2.9 The timetable for the Sustainable Service Models has been agreed and is set out below. This is broadly in line with the timetable agreed in the Strategic Commissioning Plan. For the developing projects, the dates indicate the point at which it is estimated that sustainable service models will have been modelled and the process of sharing the ideas through the decision making routes will have begun. The expected outputs from the Sustainable Service Models programme of work are set out in Appendix 1.

	June 2017	July 2017	August 2017	Sept 2017	Oct 2017	Progress
Extending Intermediate Care	√					Implementation Phase; on schedule
Unscheduled Care Hub	√	√	√	√		Options identified; on schedule
Primary Care		√				
North Isles Co-production		√				
Adult Services			√			
Community Nursing			√			
Medical Workforce			√			
Social Care				√		
Scenario Planning					√	

2.10 The timelines for the Whole Population and Organisational Issues programmes of work are being developed.

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 NHS Shetland has established programme and project management arrangements through the Transformational Change Programme Board for services directly delivered by the Board and for those services it has been "directed" to provide by the Integration Joint Board. Discussions are ongoing as to how the Transformational Change Programme Board might also provide a project management arrangement for redesign within services the Shetland Islands Council for services which it has been directed to provide by the Integration Joint Board (for example, social care resources and adults with learning disabilities and autistic spectrum disorder). Managing the change process in a single place will support whole system delivery. Where appropriate, the project management arrangements will also align with the wider Business Transformation programme for the SIC. The projects are inter-connected through the focus on a 'whole system' approach to health and care services through the integration principles and health and wellbeing outcomes.

4.0 Key Issues:

4.1 The Strategic Change Programmes are challenging in scope and intent. Shetland Islands Health and Social Care Partnership has implemented significant service redesign over a number of years and can demonstrate good outcomes, as evidenced through national performance indicators. The Strategic Programmes continue that process of successful partnership working, recognising the challenges around funding, staffing and increasing demand, and also acknowledging that health and care services needs to work together across all services to provide the best possible services for the community.

4.2 The NHS Shetland financial plan for 2017-18 is not yet in balance and will rely on one-off savings to secure a balanced position by the end of the year. There is not, as yet, an explicit link between the strategic change programmes and the financial plan, except for some specific service areas. There is also a key challenge between the pace of change in undertaking potentially significant service redesign projects using an evidence based, consultative approach and the speed within which NHS Shetland is expected to take significant money out of the system in order to achieve financial balance.

4.3 An important element of the successful delivery of the strategic change management projects will be good communication and engagement with staff,

service users and the community. The Transformational Change Programme Board is considering how best to support a robust communication plan.

4.4 The complexity of the decision making arrangements, through NHS Shetland and the IJB Board and their various committees and engagement forums, is recognised and it will be necessary to invest time in making sure that proposals are developed with input from all the necessary stakeholders prior to seeking formal decisions through the Board and Committee structures.

4.5 There is a local commitment to trying so far as possible to do things 'once for Shetland', supported by the IJB's Integration Scheme. The Scottish Government, through the Local Delivery Plan, is encouraging NHS Shetland to be explicit about plans for working on a regional (North of Scotland) basis. There is also in place a National Shared Services programme of work, which looks to develop expert service points to deliver services across Scotland. It is likely that, as the work progresses, these agendas will not always be aligned.

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. The programme of work is underpinned by a 'whole' system philosophy, to ensure that all the consequences of change are considered and addressed.
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. The concept of seeking solutions through multi-disciplinary teams, working together in localities, needs to be explained at a practical level in terms of how the tasks which people currently undertake may change from what they currently do. 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 and engaged in the process to help them to deal with questions and queries from our service users.
6.3 Equality, Diversity and Human Rights:	Each of the strategic change programmes will include a review of actual and potential impact on service users, including knowledge of and access to services.
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. Delivery of the Plan, including the strategic change programmes, rests with staff in NHS Shetland and Shetland Islands Council.
6.5 Finance:	There is a significant challenge in 2017/18 for both NHS Shetland and the IJB because of the recurrent funding levels that are affordable for NHS Shetland. The estimated gap between the cost of the current service delivery models and the funds available for NHS Shetland is £2.5m for NHS funded services. There is a legal requirement on NHS Shetland to achieve financial balance each year. While Shetland Islands Council have provided a balanced budget for 2017/18 their Medium Term Financial Plan details the challenge it faces in the future years as a result of reducing funding, set against rising costs and demographic change. The risk of the time taken to further evolve our models of health and care, towards integrated pathways, set against the speed within which the savings need to come out of the system is acknowledged and needs to be actively managed throughout the year.
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 Strategic Programmes set out the need to continue to modernise our working practices – 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:	Each strategic programme will carry and manage its own

	risks and the Transformational Change Programme Board will oversee the overall programme risks. The Transformational Change Programme Board have identified risks around: - Governance and accountability - The pace of change required to meet the financial challenges - Complex decision making arrangements - Potential conflicts of interest and dual roles - Complexity of programme of work and potential for unintended consequences from changes to service models - Challenging deadlines - Adequately resourcing projects and delivering change, whilst also having operational responsibility - Potential for local, regional and national requirements to not be aligned - Poor communication to all stakeholders on the need for and impact of any changes - Potential to destabilise services - Immediate operational services needs taking priority over planning the shape of future service models. The necessary control measures have been indentified and developed to help mitigate the risks identified and secure the successful delivery of the programme.	
6.10 Policy and Delegated Authority:	The IJB has been established to develop the Strategic Commissioning plan for the relevant (devolved) services in Shetland. Within the plan a key set of redesign areas have been agreed. This Transformational Change Programme Board will be responsible for delivering the proposed areas of redesign and ensuring that the options for sustainable service models are reported to the IJB for decisions in a timely manner. The IJB will want to be assured that the necessary management arrangements are in place to deliver the programme of work and be regularly informed of progress with redesign. This is a key element in implementing the strategic plan. The IJB will be required to make appropriate decisions as redesign proposals are developed	
6.11 Previously considered by:	Staff Governance Committee Joint Governance Group Strategy & Redesign Board Clinical Care and Professional Governance Committee	15 May 2017 16 May 2017 23 May 2017 7 June 2017

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6 June 2017

APPENDICES
Appendix 1 - Sustainable Service Models: Project Outputs

Sustainable Service Models: Project Outputs

Strategic Direction

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 Strategic Commissioning Plan sets out the arrangements 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 will include:

- 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; 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.

The health and care system is complex and inter-dependent. The Strategic Change Programme will therefore be undertaken using a whole systems approach to:

- understand the way in which interconnected parts relate to each other;
- avoid unintended consequences;
- fully understand all the parts in relation to the whole;
- promote a whole organisation approach and avoid 'silo' (or individual service) thinking.

The Plan determined that services should be 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

Purpose of Strategic Change Programme for Sustainable Service Models

The Aims of the Strategic Change Programme for Sustainable Service Models is:

To establish 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.

To establish a sustainable hospital model that addresses Shetland's current and future health and care needs.

To establish a sustainable primary care model that addresses current and future health and care needs across each area of Shetland including:

- GPs; and
- Community Nursing

To establish a sustainable social care model that addresses current and future care needs across each area of Shetland including:

- Shetland wide resources
- Area based / locality provision for
    - Permanent, respite and short breaks care
    - Day support
    - Rehabilitation and re-enablement services
    - Care at home / Personal care
    - Nutritional support
    - Domestic support

where provided directly or out-sourced to third sector providers or supported through unpaid carer arrangements; 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; and is in line with the Housing Contribution Statement set out in the Joint Strategic Commissioning Plan and the principles of Self Directed Support.

To establish a sustainable mental health service including:

- Specialist services, delivered outwith Shetland
- Shetland wide resources
- Community / locality resources

- Self care / self management

To establish sustainable services for adults living with learning disabilities or autistic spectrum disorder, including:

- Shetland wide resources
- Community / locality resources
- Self care / self management

To design a co-production exercise to develop options for health and care services across the north isles (Yell, Unst and Fetlar).

This programme will be based on a sound understanding of the needs of the Shetland population, and take into account the principles of the Chief Medical Officer's report on Realistic Medicine, working to support the development of realistic expectations of what medicine, health and social care can offer.

Outputs for Each of the Projects

The outputs from the Programme will be:

Unscheduled Care:

The establishment of a clinician led, multi-disciplinary team for out of hours services, called an Unscheduled Care Hub.

Savings from current levels of spend of £100,000 per annum (specific target set for 2017-18).

Hospital, Acute and Specialist

A costed options appraisal / scenarios evaluation, that critically reviews the scale and scope of services to be delivered from the Gilbert Bain Hospital and determines the appropriate services, staffing arrangements, bed base, clinical and other support services required to meet the general and potential emergency needs of a remote and rural community including:

- The balance of services to be delivered locally and those more appropriately delivered elsewhere through the regional planning arrangements;
- The balance of services to be delivered in a hospital setting and those which might be more appropriately be delivered through Primary Care;
- The extent to which reliance can be placed on technology enabled care;
- The extent to which the Gilbert Bain Hospital might become a Health and Care Hub for Lerwick / Shetland by co-locating hospital, acute, specialist and primary care through multi-disciplinary teams working within one setting;
- The size of the hospital bed base;
- The size and composition of a resilient medical workforce;
- The size and composition of the nursing staffing arrangements;
- The size and composition of the clinical / professional support arrangements;

- The size and composition of the support functions.

Primary Care

GP Practices

- Equitable, sustainable and affordable distribution of and access to GP services across Shetland
- shared back-room support functions
- capacity for shared premises / settings (linked to sustainable Social Care model)
- Specific savings target of £150,000 in 2017-18.

Community Nursing

- Equitable provision and access across Shetland;
- Specific savings target of £240,000 set for 2017-18.

Determine the extent to which each locality could be further developed into multi-disciplinary care hubs with the co-location of primary, social care and ill health prevention within one setting

The extent to which reliance can be placed on technology enabled care.

Social Care

Determine the type and location of care services required by locality, taking account of the policy focus to work to enabling people to live independently at home for as long as possible;

Determine the extent to which each locality could be further developed into multi-disciplinary care hubs with the co-location of primary, social care and ill health prevention within one setting;

Determine the extent to which back office support functions can be shared across health and care and with other partners in each locality;

Determine the appropriate use of generic worker posts; and

Investigate the extent to which the models can support more equitable financial charging arrangements.

Mental Health

Determines the appropriate services, staffing arrangements, bed base, clinical and other support services required to meet the health and care needs, including crisis intervention, of patients and services users living with a mental health condition including:

- The balance of services to be delivered locally and those more appropriately delivered elsewhere through the regional planning arrangements;
- The balance of services to be delivered in a hospital setting and those which might be more appropriately delivered through Primary and Social Care, including episodes of crisis.

Adults with Learning Disabilities or Autistic Spectrum Disorder

To establish a sustainable, equitable and affordable range of services for adults living with learning disabilities or autistic spectrum disorder, including:

- Health
- Housing
- Day Support
- Short Breaks and Respite
- Jobs and training
- Leisure opportunities
- Community / locality resources

North Isles Co-production

To explore, develop, pilot and implement with the North Isles communities (Unst, Yell, Fetlar) using a co-production methodology alternative models of health and care which are sustainable, equitable and affordable.

Timeline

	June 2017	**July 2017**	**August 2017**	**September 2017**	**October 2017**
Extending Intermediate Care	√				
Unscheduled Care Hub	√	√	√	√	
Primary Care		√			
North Isles Co-production		√			
Adult Services			√		
Community Nursing			√		
Medical Workforce			√		
Social Care				√	
Scenario Planning					√

ENDS

Shetland Islands Health and Social Care Partnership

Agenda Item

4

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Shetland NHS Board Integration Joint Board (IJB)	23 June 2017 13 July 2017
Report Title:	Local Delivery Plan (LDP) 2017-20	
Reference Number:	CC-29-17 F	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That Shetland NHS Board APPROVES the Local Delivery Plan (LDP) for 2017-20.

1.2 That the Integration Joint Board NOTES the Local Delivery Plan (LDP) for 2017-20.

2.0 High Level Summary:

2.1 NHS Shetland is required to annually prepare a LDP and submit it to the Scottish Government. In essence, it reflects the agreement between the Scottish Government and NHS Shetland for the delivery of key strategic priorities and ongoing service delivery. The Plan for 2017-18 is set out at Appendix 1.

2.2 It sets out the strategic priorities which NHS Shetland is committed to. In that respect, it is complementary to the recently approved Strategic Commissioning Plan for 2017-20. The LDP is more focused on the ongoing delivery of services and detailed service improvements, whereas the Strategic Commissioning Plan did not address any operational matters.

2.3 In a change to previous years, there was limited guidance from the Scottish Government on specific priorities to cover in the 2017-20 LDP. However, there was a specific focus on Regional Planning, to address the commitment in the National Health and Care Plan for collaboration on a regional basis. There was also a continuing focus on financial planning and securing a balanced budget.

2.4 The Draft LDP was prepared and submitted by the deadline of 31 March 2017. The Scottish Government has provided comments on the Draft. There are no specific changes to make to the Draft Plan but further supporting submissions will be required for workforce, financial and regional planning.

3.0 Corporate Priorities and Joint Working:

3.1 The Local Delivery Plan sets out the strategic overview and key delivery mechanisms for health and care in Shetland. It is therefore part of the core suite of planning documents which support the integration arrangements for health and care services.

4.0 Key Issues:

4.1 The key national planning documents from NHS Scotland are:

- The National Clinical Strategy
- The National Health and Care Plan and
- Realistic Medicine

4.2 The LDP sets out how NHS Shetland will respond to the challenges and commitments within those national plans.

4.3 The development of the IJB and the need to develop a Strategic Commissioning Plan has created a shift within the strategic planning framework to support local health and care services. The LDP should therefore be read alongside the Strategic Commissioning Plan to give a complete picture of strategic planning for health and care in Shetland.

4.4 The feedback from the Scottish Government is included in full at Appendix 2. The key themes within the feedback relate to: taking a whole system approach; responding to regional planning and collaboration; addressing the financial deficit; integration; and achieving waiting times targets.

4.5 The next stages will be:

- To submit the workforce plan, by spring 2017
- To resubmit the financial plan, by July 2017 and
- To collaborate with partners in the north of Scotland region, to submit a regional plan by the end of September 2017.

5.0 Exempt and/or confidential information:

5.1 None.

6.0 Implications :

6.1 Service Users, Patients and Communities:	The LDP is a key tool is describing to our service users our commitment to service delivery and service improvements.
6.2 Human Resources and Organisational Development:	The LDP contained a section that summaries the main workforce issues and there is complementary piece of work to submit a detailed Workforce Plan. The Joint Staff Forum is in place to ensure consultation with staff representatives of the partner agencies.

6.3 Equality, Diversity and Human Rights:	The public health section details how NHS Shetland will tackle health inequality in Shetland. The LDP includes a Rapid Impact Assessment; there are no specific issues to highlight.	
6.4 Legal:	NHS Shetland is required by the Scottish Government to prepare and submit an LDP.	
6.5 Finance:	There LDP includes a section which summarises the key financial issues facing NHS Shetland. This is then supported by detailed Financial Planning Templates, which form the basis of the financial performance reporting throughout 2017-18. NHS Shetland is required to re-submit the Financial Plan by July 2017, to demonstrate how it will address the financial deficit forecast for 2017-18.	
6.6 Assets and Property:	There are no specific issues to address with regard to assets and property.	
6.7 ICT and new technologies:	There are no specific issues to address for ICT and new technologies.	
6.8 Environmental:	There are no specific environmental implications to highlight.	
6.9 Risk Management:	The key risks to delivery of the LDP centre around the strategic organisational risks already recognised of: finance; recruitment and retention; delivering waiting times targets and delivering on the strategic change programmes.	
6.10 Policy and Delegated Authority:	NHS Shetland has responsibility for approving the LDP, as it is a record of its agreement with the Scottish Government to deliver on national strategic priorities and service performance. The LDP forms part of the suite of strategic documents that describe the arrangements for health and care planning in Shetland. As the IJB has responsibility for planning all local health and care services, it is appropriate that the Report is considered by the IJB and is for noting.	
6.11 Previously considered by:	Draft for review & comment at NHS Shetland Board	April 2017

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7 June 2017

Appendices
Appendix 1 : Draft Local Delivery Plan 2017-18
Appendix 2: Scottish Government Response to NHS Shetland's LDP, May 2017

Local Delivery Plan (LDP)

2017- 2020

March 2017

Contents:

Reference:
Shetland Islands Health and Social Care Strategic Commissioning Plan 2017-2020:
http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=20744

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Introduction

This Local Delivery Plan (LDP) supports our ambition to deliver:

> "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".

A separate Plan has been prepared to support the Shetland Health and Social Care Partnership's Strategic Commissioning Plan. This covers the whole of Shetland's health and care system. Where possible, the Strategic Commissioning Plan (SCP) and the Local Delivery Plan (LDP) have been aligned and the SCP clearly sets out the strategic context within which the LDP is set.

Along with other Boards, it is recognised that NHS Shetland is working in a challenging context in which there is a need to balance delivery of quality services with ambitious improvement targets and standards, while also living within the financial realities facing public sector. The need for transformational change is recognised, alongside continuing to delivery safe and effective services of the best quality possible. Shetland faces particular challenges associated with the sustainability of services and the recruitment and retention of staff, who often work in small teams or single-handed and often in remote and rural areas.

The Strategic Commissioning Plan has put in place a challenging programme of strategic projects to fundamentally review how best to develop and deliver sustainable models of service across the whole of health and care.

The Scottish Government's Health and Care Delivery plan also sets out a renewed focus on the development of regional working. To support this, over the next 6 months, the North of Scotland will develop a Regional Health and Care delivery plan and our Local Delivery plan will link to this.

Within the North of Scotland region Regional working and joint collaboration will remain an important element of the planning for the future and we are committed to supporting the development of the Regional Delivery Plan by 30 September. The plan will take account of the key actions in the Health and Social Care Delivery Plan, for example

- Planning for the delivery of some clinical services on a regional basis so that specialist expertise can deliver better outcomes for individuals and create greater

service sustainability and resilience. This will ensure that the services provided to people are high quality and the expertise remains as effective as possible. A number of regional opportunities have already been progressing and we look forward to the planning of the major trauma arrangements within the North as part of the national network.

- The redesign of elective care to address the demand for planned surgery, particularly from an ageing population.
- We will build on existing regional approaches to service delivery with many arrangements already in place and working well including where appropriate shared senior staff (Director of Public Health) and payroll accounts payable and accounts receivable support services.

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 to 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. While the NHS continues to see 'real term' growth this is at historically low levels and social care in Shetland will see further budget reductions, all be it from a comparatively high level of spend per head of population. It is therefore important to recognise that we need to find a way, collectively, to develop a mix of hospital, primary and community care services that best meet the needs of our population.

The Shetland Islands Health and Social Care Strategic Commissioning 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. This will be under-pinned by the evolving relationships at a regional level, which will be supported by the Regional Strategy for the North of Scotland;
- the primary care model, to determine an equitable distribution of primary care resources across Shetland, recognising the particular recruitment challenges in this area set alongside the Government's commitment to secure investment at 11% of front line services by 2020; 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. This is under-pinned by the Older People's Strategy and Shifting the Balance of Care from hospital to community settings.

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, recording 'first in Scotland' on some key performance indicators. 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 NHS Shetland and 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.

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 described in more detail within the Strategic Commissioning plan.

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

<table>
<tr><td colspan="2">(A) Whole Population</td></tr>
<tr><td>Implementing an asset based approach to health care prevention</td><td>Effective Prescribing- working with patients and prescribers to ensure that evidenced, best value, medicines are started and stopped appropriately</td></tr>
<tr><td colspan="2">(B) Sustainable Service Models</td></tr>
<tr><td>Developing a safe and effective model of unscheduled care</td><td>Developing a sustainable hospital, acute and specialist services model for Shetland</td></tr>
<tr><td>Developing a sustainable primary care model for Shetland, with clear links to the 7 locality areas and the Gilbert Bain Hospital</td><td>Developing a sustainable model of social care resources</td></tr>
<tr><td>Developing a sustainable model for mental health services, including appropriate crisis and emergency arrangements</td><td>Developing a sustainable model for adults affected by learning disabilities and autism spectrum disorders</td></tr>
<tr><td colspan="2">(C) Organisational Issues</td></tr>
<tr><td>Improving Business Performance and Efficiency</td><td>Improving the Quality and Safety of our services</td></tr>
<tr><td colspan="2">Achieving Financial Balance</td></tr>
</table>

LDP Standards

LDP Standards are priorities that are set and agreed between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance.

The 2015-16 Local Delivery Plan (LDP) Standards are retained and analysed in this updated Plan:

- Accident and Emergency Waiting Times
- Alcohol Brief Interventions
- CAMHS Waiting Times
- Cancer Waiting Times
- Clostridium Difficile Infections
- Dementia Post Diagnostic Support
- Detect Cancer Early
- Drug and Alcohol Treatment Waiting Times
- Early Access to Antenatal Services
- Financial Performance
- GP Access
- IVF Waiting Times
- Psychological Therapies Waiting Times
- SAB (MRSA/MSSA)
- Sickness Absence
- Smoking Cessation
- Treatment Time Guarantee
- 12 Weeks Outpatient Appointment
- 18 Weeks Referral to Treatment (RTT)

Accident and Emergency Waiting Times

95% of all A&E patients should be admitted, discharged or transferred within four hours of arrival at an A&E department across NHS Scotland to ensure that all patients receive the most appropriate treatment, intervention, support and services at the right time, in the right place by the right person.

At the end of December 2016, 97.7% of patients **waited less than 4 hours at A&E,** meeting the target of 95%.

Alcohol Brief Interventions

This standard helps tackle hazardous and harmful drinking, which contributes significantly to Scotland's morbidity, mortality and social harm. Brief interventions have been proven to be a highly effective and evidenced-based early intervention for those individuals (for those

currently over the age of 16) who are drinking at hazardous and harmful levels to moderate their level of drinking and thereby reducing their risk of developing more serious alcohol-related problems.

The standard is that NHS Boards and their Alcohol and Drug Partnership (ADP) partners should maintain the same total level of target delivery of ABIs as under the HEAT H4 target for 2011-12 and it is expected that at least 80% of delivery will continue to be in the priority settings.

During 2015-16, 360 **Alcohol Brief Interventions** were delivered in the 3 priority settings (Primary Care, A&E, antenatal), exceeding our target of 261.

CAMHS Waiting Times

Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services. Early action is more likely to result in full recovery and in the case of children and young people will also minimise the impact on other aspects of their development such as their education, so improving their wider social development outcomes.

For the quarter from October to December 2016, 100**% of patients waited less than 18 weeks** from referral to treatment for specialist **Child and Adolescent Mental Health Services (CAMHS) services**, which more than achieved the target of 90%.

Cancer Waiting Times

Two standards are in place to support diagnostics and treatments are delivered efficiently.

In the quarter ending December 2016, 100% of patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral, so achieving the target of 95%.

In the quarter ending December 2016, 100% of patients diagnosed with cancer started treatment within 31 days of their decision to treat.

Clostridium Difficile Infections

Tackling and reducing Health Associated Infections (HAIs) is a key priority in terms of the safety and well-being of patients, staff and the public.

In April 2016, we had one case of **C Diff infection**, which was community acquired.

Dementia Post Diagnostic Support

People with dementia benefit from early diagnosis and access to a range of post-diagnostic services, which enable the person and their family to understand and adjust to a diagnosis as well as connect better and navigate through services and plans for their future care.

The standard is to deliver expected rates of dementia diagnosis and that all people newly diagnosed with dementia receive a minimum of one year of post-diagnostic support and to have a person-centred plan in place at the end of that support period.

In December 2016, 174 people with a diagnosis of dementia were registered on the dementia register against a target of 184.

100% of patients diagnosed were offered the opportunity for post diagnostic support.

Detect Cancer Early

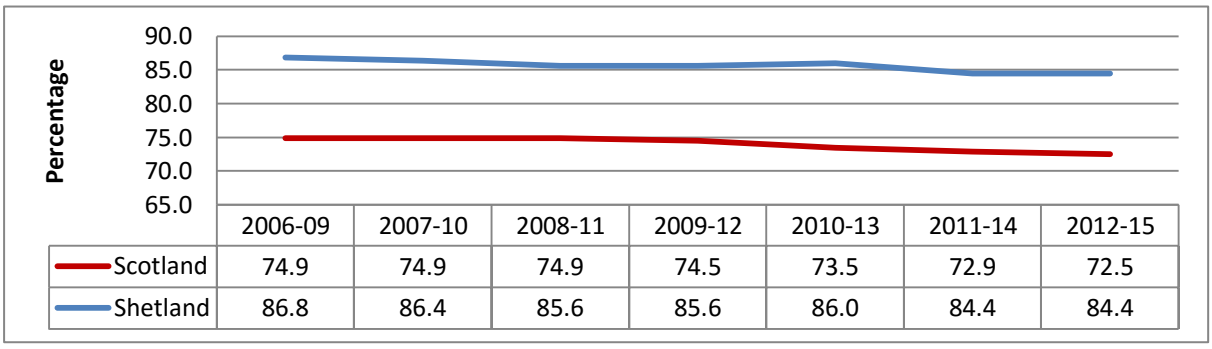
Cancer survival is a key measure of the effectiveness of health care systems. The earlier that cancer is diagnosed and treated, the better the survival outcomes.

Cancer staging is the process of determining the extent to which a cancer has developed and spread, on a scale from 1 to 4. 'Stage 1' represents the earliest stage of detection, and patients diagnosed at this stage have better associated outcomes.

In 2015, 16.9**%** of people were **diagnosed and treated in the first stage** of breast, colorectal and lung cancer, which missed our target of 29%.

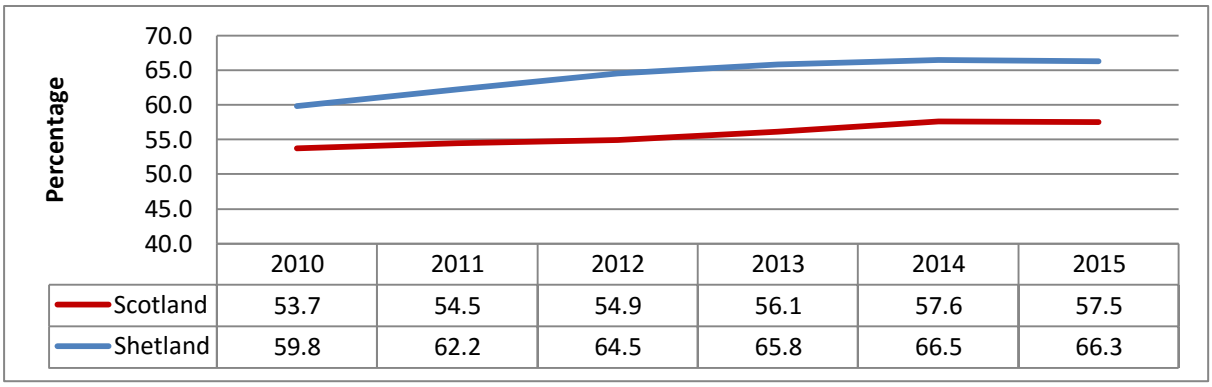
However, breast and bowel screening uptake remains above the national average.

Breast screening uptake



	2006-09	2007-10	2008-11	2009-12	2010-13	2011-14	2012-15
Scotland	74.9	74.9	74.9	74.5	73.5	72.9	72.5
Shetland	86.8	86.4	85.6	85.6	86.0	84.4	84.4

Bowel screening uptake



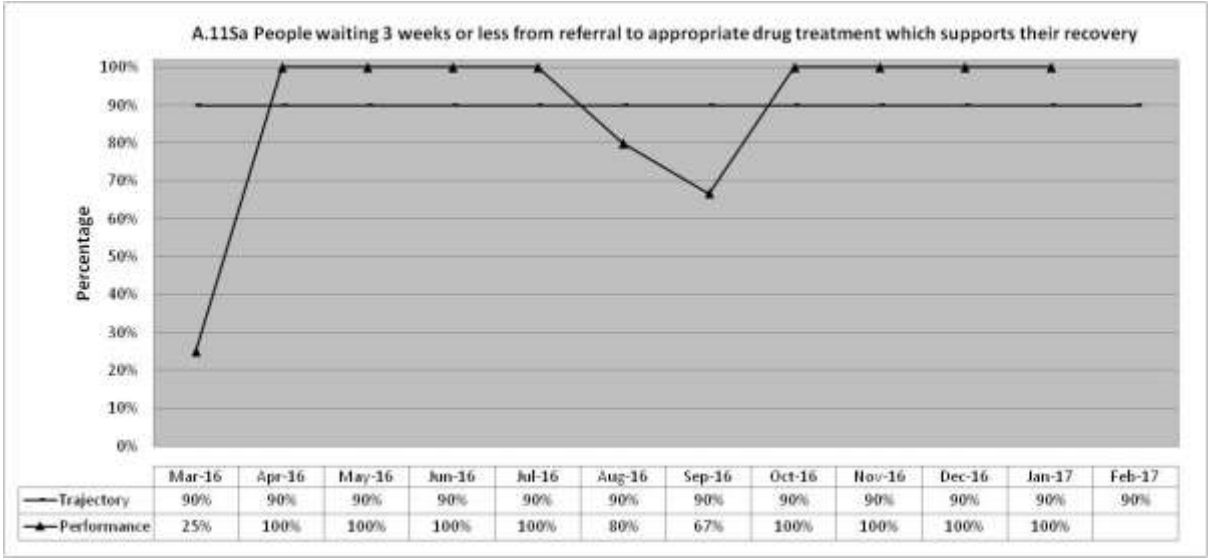
	2010	2011	2012	2013	2014	2015
Scotland	53.7	54.5	54.9	56.1	57.6	57.5
Shetland	59.8	62.2	64.5	65.8	66.5	66.3

Drug and Alcohol Treatment Waiting Times

The original Drug & Alcohol Treatment Waiting Times HEAT Target was established to ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy.

The month on month trend data shows that NHS Shetland regularly achieves the target for 90% of patients being seen within 3 weeks of referral.

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Performance	75%	33%	100%	100%	100%	100%	100%	100%	100%	100%		



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Performance	25%	100%	100%	100%	100%	80%	67%	100%	100%	100%	100%	

Early Access to Antenatal Services

There is evidence that those women at highest risk of poor pregnancy outcomes are less likely to access antenatal care early and/or have a poorer experience of that care. Access to high quality, relationship based antenatal care with a strong focus on prevention, promotion of health, early intervention and support as early as possible in pregnancy is vitally important.

The national standard is for at least 80% of pregnant woman in each SIMD quintile to have booked for antenatal care by the 12th week of gestation.

According to national figures for the year ending December 2016, the overall rate was 73.1%. This equates to 177 of 242 pregnant women having booked for antenatal care by the 12th week of gestation. A local audit from maternity records puts the compliance with early booking at a much higher figure and we have now moved to a shared electronic record with NHS Grampian which should ensure that data recording is valid and accurate. Figures for January to February 2017 from the NSS Discovery system show us to be at 93.8% - 15 of 16 pregnant women having booked for antenatal care by the 12th week. Our lowest SIMD quintile was 83.3% - 5 of 6 women booking within the 12th week, which suggests our data accuracy and performance are improving.

GP Access

Often a patient's first contact with the NHS is through their GP practice. It is vital, therefore, that every member of the public has fast and convenient access to their local primary medical services to ensure better outcomes and experiences for patients.

The performance measure for this standard is measured by the Health and Care Experience Survey and says that at least 90% of people should have 48-hour access to the appropriate healthcare professional.

During 2015/16, 93.6% of patients accessed an **appropriate member of the GP Team within 48 hours,** meeting the target of 90%.

IVF Waiting Times

Eligible patients should be able to access IVF treatment equitably. Longer waiting times for patients leads to poorer outcomes, as the effectiveness of IVF reduces with age.

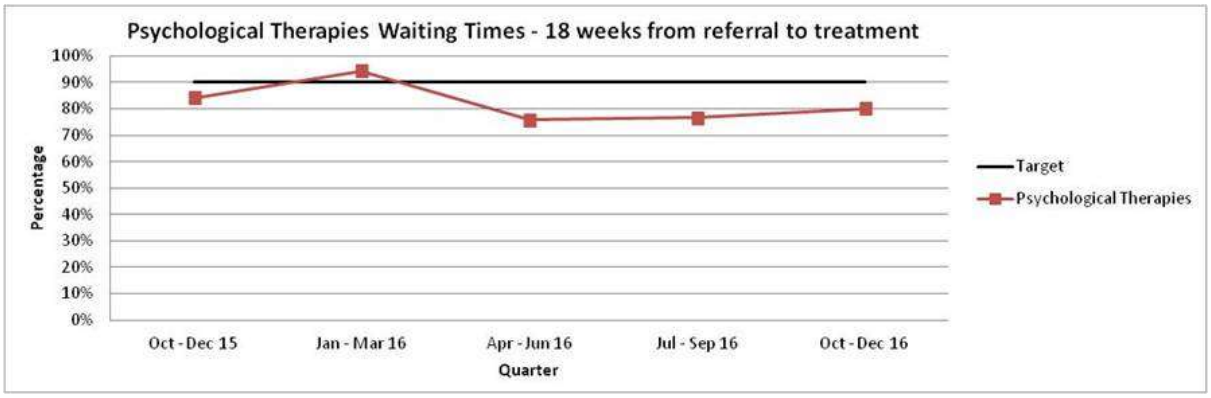
At the end of September 2016, 100% of **eligible patients have commenced IVF treatment within 12 months**, meeting the target.

Psychological Therapies Waiting Times

Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services.

For the quarter from October to December 2016, 80**% of patients waited less than 18 weeks** from referral to treatment for **Psychological Therapies,** which missed the target of 90%.

The trend over time is shown below.

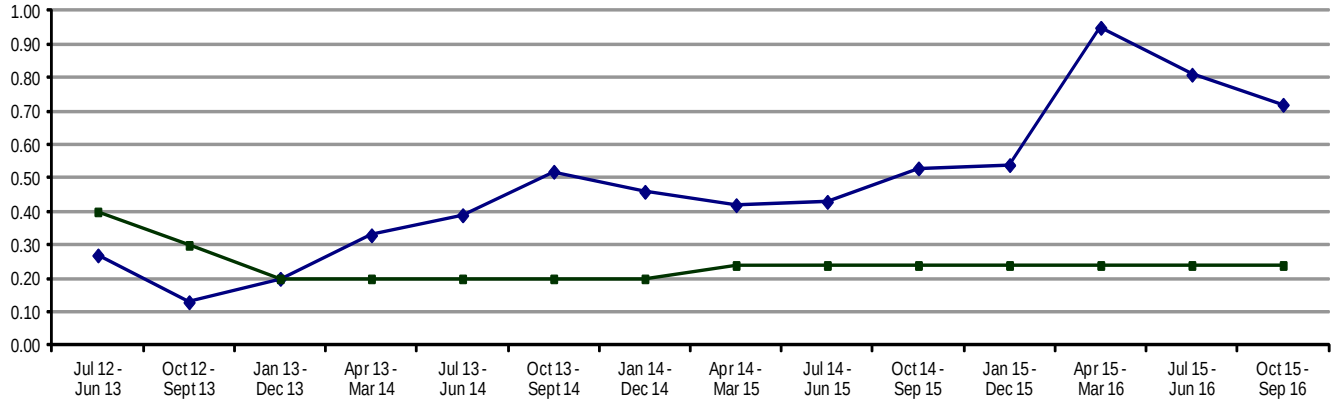


Staphylococcus aureus bacteraemia SAB (MRSA/MSSA)

Tackling and reducing HAIs is a key priority in terms of the safety and well-being of patients, staff and the public.

During the period July to September 2016, we had eight **Staphylococcus aureus bacteraemia (including MRSA)** infections, one of which was MRSA. This gave us a rate of 0.72 cases per 1000 acute occupied bed days. This missed our target of 0.24. This relates to very small numbers.

Quarterly rolling year *Staphylococcus aureus* Bacteraemia Rates per 1000 Acute Occupied Bed Days for HEAT Target Measurement



	Jul 12 - Jun 13	Oct 12 - Sept 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sept 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Actual Performance	0.27	0.13	0.20	0.33	0.39	0.52	0.46	0.42	0.43	0.53	0.54	0.95	0.81	0.72
Target	0.40	0.30	0.20	0.20	0.2	0.2	0.2	0.24	0.24	0.24	0.24	0.24	0.24	0.24

Sickness Absence

Sickness absence can result in cancelled appointments and procedures. It can also lead to increased pressure on staff and patients, increased costs of employing bank and agency staff, and reduced efficiency.

During 2015-16, we had a **Sickness Absence rate** of 5.2%, missing the target of 4%.

At November 2016, the rate had decreased to 3.88% which is below the Scottish average for the month. The rolling 12 month period 1 December 2015 to 30 November 2016 is 5.13%, again below the Scottish average.

Smoking Cessation

Smoking has long been recognised as the biggest single cause of preventable ill-health and premature death. The emphasis is on supporting people who want to quit smoking by delivering effective cessation services and preventing smoking uptake amongst young people.

Within **smoking cessation services**, at the end of March 2016 we had helped **51 people** to successfully quit at 12 weeks. This met our target of 33.

Treatment Time Guarantees

The treatment time guarantee places a legal requirement on health boards that once planned inpatient and day case treatment has been agreed with the patient the patient must receive that treatment within 12 weeks.

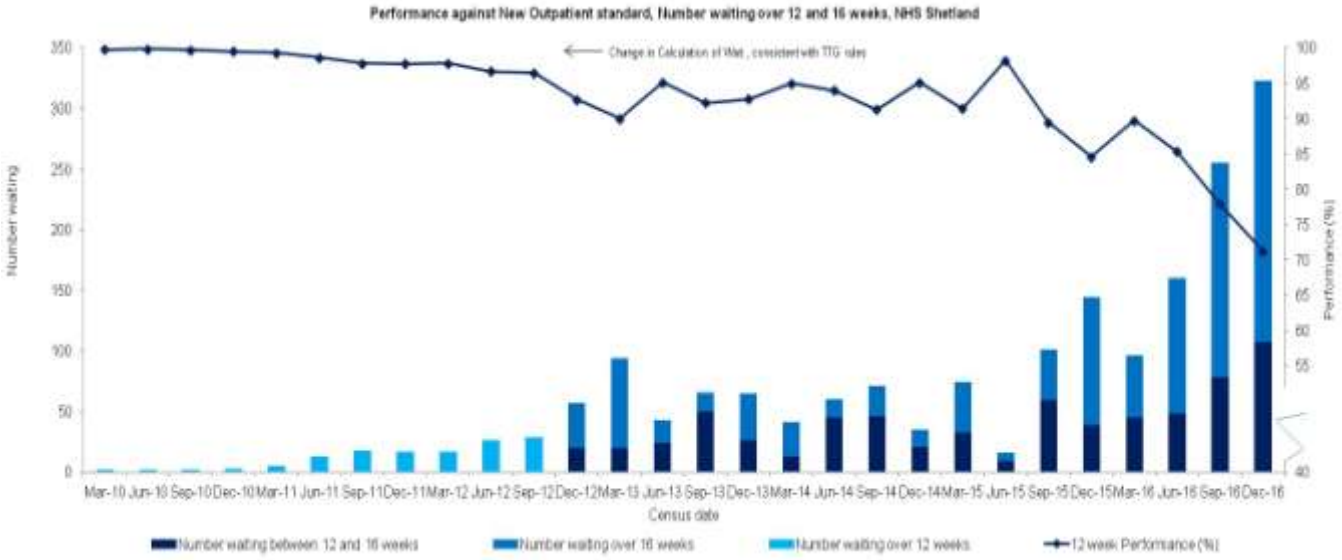
The standard is for 100% of patients to be seen within 12 weeks of agreeing inpatient/day case treatment.

During the quarter ending December 2016, 100% of patient of patients were reported as commencing inpatient/day case treatment within 12 weeks.

12 Week Outpatient Appointments

Shorter waits can lead to earlier diagnosis and better outcomes for many patients as well as reducing unnecessary worry and uncertainty for patients and their relatives.

At the end of December 2016, 71.2% of **patients waited less than 12 weeks from referral to a first outpatient appointment,** missing the 95% target. The trend is shown below.



18 Weeks Referral to Treatment (RTT)

Shorter waits can lead to earlier diagnosis and better outcomes for many patients as well as reducing unnecessary worry and uncertainty for patients and their relatives.

At the end of December 2016, 91.8**%** of **planned/elective patients commenced treatment within 18 weeks of referral**, meeting the 90% target.

Hospital, Acute and Specialist Services

Scheduled Care

We have set out the high level aims to support the delivery of planned care services in our Joint Strategic Commissioning Plan (2017-20). The aims include:

- Active management and redesign of outpatient services (e.g. developing multi-disciplinary models, introducing tele-health to support remote access etc) to promote pre-admission assessment and follow up in localities
- Creating pathways to support day surgery and ambulatory care as the norm for planned procedures (reducing reliance/pressure on inpatient services)
- Streamlining referral and diagnostic pathways
- Active management of admissions so that only patients who need specialist care are admitted to hospital (implementing alternative models, reducing length of stay)

We have clear and robust arrangements in place for monitoring all patient pathways i.e. those that are directly provided by NHS Shetland and those which are shared with specialist providers e.g. NHS Grampian.

Where we have shared pathways we have developed a quality assurance framework for all of the sub specialities which are delivered in whole or in part by NHS Grampian.

The quality assurance frameworks set out:

- The indicative demand and capacity required to ensure that each sub specialty service is provided within the national waiting times targets;
- The additional capacity required non recurrently to manage peaks in demand (over the forecast activity levels which are set on a rolling three year average);
- The governance arrangements to support shared pathways (e.g. clear roles and responsibilities);
- We continue to perform well against the national waiting times targets for access to outpatient services and the treatment time guarantee (TTG).

Whilst we continue to perform well against the national waiting times access targets for outpatient services and the treatment time guarantee (TTG); some of the key challenges in the delivery of planned care services for NHS Shetland are associated with the regional capacity to deliver shared care pathways which include access to: dermatology, ENT, ophthalmology, oral surgery, gynaecology and orthopaedic services in Shetland.

We have seen a mismatch in the demand for these services and capacity available to deliver ‘visiting services’ for a variety of reasons but these include as significant factors an increase in the referral rates for all specialities along with challenges in recruiting key clinicians. This means that a number of the shared services with NHS Grampian are not performing consistently within the national waiting times targets and we are developing a recovery plan

to ensure that we address short term (non recurrent) access issues as well as using the 'Getting Ahead' methodology to understand the opportunities to redesign pathways taking a whole systems approach. During 2016-17, we received very limited gynaecology and dermatology services and we expect that to continue into 2017-18 whilst we look for mutual aid from other Health Boards.

We have also seen the impact of the shift towards increasing clinical sub specialisation on service sustainability where the historical model was that clinicians with 'generalist' skills supported remote and rural services - this is no longer possible and so we are starting to explore alternative models such as increasing access through telemedicine and telecare approaches. In 2016-17, we delivered over 600 appointments using technology enabled approaches (ranging from emails and phone calls, to complex multi-site video conferencing).

We have been working with NHS Grampian and National Waiting Times Hospital (Golden Jubilee National Hospital) to look at how we can maximise the potential for technology enabled orthopaedic pathways. We intend to build on this work to look at the potential for embedding telemedicine into pathways (particularly for routine patient follow up).

In order to ensure that we have the right size and shape for planned care services, the Gilbert Bain Hospital is being examined as part of shifting the balance of care and changing patterns of usage of inpatient beds. We have worked with health care planners for the last four years and we have developed a plan that describes short, medium and long term plans for the optimal configuration of the hospital to support clinical services. This includes identifying ways of providing medical assessment and ambulatory care services as 'non admitted' planned care services as well as developing a better understanding of the positioning of services that can be delivered out with the hospital setting.

We also continue to work with NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) who play a critical role in the co-ordination of planned care, including the provision of technology enabled services to support long term conditions and self management as well as transporting patients between health and social care settings.

Plans for 2017-18 include

All of these plans as appropriate will include joint plan development with NHS Grampian and GJNH as well as the Integration Joint Board (IJB) and are a continuation of the plan developed in 2016-17:

- We will continue to review pathways to increase efficiency and reduce waste e.g. ensure that pathways conform to best evidence and clinical standards; optimise available capacity by setting clear parameters for referral into specialist services and renew approach for managing DNA rates within sub specialities

- We will maximise the potential for technology enabled decision making e.g. electronic vetting, pre-referral advice and optimising systems for sharing clinical information effectively such as SCI Store and PMS Trak
- Putting in place the technology and infrastructure to support telemedicine in outpatient and primary care settings in Shetland
- Identify opportunities for repatriating planned care services (e.g. shared delivery with local clinicians)
- Identify opportunities to change the skill mix to create more sustainable pathways across local, regional and national services e.g. increasing the number of GPwSI and Specialist Nurse led clinics and pathways
- Progress the business case to enhance the day surgery and ambulatory care facilities at the Gilbert Bain Hospital

Risks/Challenges

- We will need to agree a clear and joint strategic intent with NHS Grampian to deliver sustainable services within the national waiting times targets and the mechanism by which we will take an integrated and whole system approach to implement changes as described in the Modern Outpatient Programme (2016).
- There is a considerable mismatch between the capacity required to ensure that services are delivered within the national waiting times target (as set out in the quality assurance frameworks) and the capacity available from regional and specialist services. Some of the potential solutions (e.g. regional or national pathways) will increase the cost of planned care services because of the need for patients to travel to regional and national centres – this need to be factored into the whole systems activity profiling and cost/benefit analysis as part of the Regional Delivery Planning process.
- The mismatch between the capacity and demand for outpatient services has been met with non recurrent funding e.g. additional resources provided to support increasing activity out with the service level agreement with NHS Grampian. This is not a sustainable way of managing growing demand and we will need to review the impact on our performance against access standards as we move to delivering services in line with core budgets.
- There needs to be a clear e-health strategy at a regional level, which focuses on technology enabled care – to support decision making and create opportunities for connecting locality based services with secondary and specialist care services. This is not something that individual Health Boards can achieve alone.
- We need to ensure that we provide equity of access to services, which are person centred – we need to look at how we can use technology to maintain access for remote communities as well as shifting the approach to planned care away from episodic management to an assets based approach e.g. co-production, self directed

care and management of long term conditions and increased access to patient education programmes

Cancer Waiting Times

In the quarter ending December 2016, 100% of patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral, meeting the target of 95%

In the quarter ending December 2016, 100% of patients diagnosed with cancer started treatment within 31 days of their decision to treat.

Working in conjunction with NHS Grampian, we seek to maintain this good position in delivering cancer care promptly in 2017-18 and will prioritise the use of resources to provide appointments and diagnostic tests that facilitate cancer diagnosis and treatment.

12 Week Outpatient Appointments

At the end of December 2016, 71.2% of patients waited less than 12 weeks from referral to a first outpatient appointment, missing the 95% target.

This is due to the continued pressure and lack of capacity available to deliver key specialities which are part of shared clinical pathways with NHS Grampian (e.g. ENT, orthopaedics, ophthalmology, dermatology, and Max Fax) and this has resulted in a number of patients who waited longer than 12 weeks to their first appointment.

Despite fully embracing the Modernising Outpatient Programme, we expect that going into 2017-18 we will not meet the 12 week Outpatient appointment standard in the following specialism's because the core capacity available from NHS Grampian does not meet the demand for these services.

Based on current capacity and demand forecasts, the estimated shortfall is:

- ENT - 458 appointments
- Dermatology – 444 appointments (we do not currently have access to a service from NHS Grampian, who is our usual provider and we are looking at alternative options for 2017-18)
- Ophthalmology – 149 appointments
- Max Fax – 170 appointments

- Gynaecology – 438 appointments (we do not currently have access to a service from NHS Grampian, who is our usual provider and we are looking at alternative options for 2017-18)

- Orthopaedics – 132 appointments. Whilst the service delivered by GJNH is largely supported by a tele-health approach, a small mismatch in demand and capacity still remains. In addition to this, the service model is not established as core provision by GJNH so a significant proportion of the clinical activity is attributed to 'non core' capacity which is reflected in the overall cost of the model which we estimate is £300,000 greater than the visiting service previously provided by NHS Grampian.

The risks are that even with the comprehensive redesign programme, we will not be able to sustain the 12 week access standard for approximately 30% of the patients who are referred to secondary care services.

The estimated cost of providing additional capacity through direct engagement with clinicians from NHS Grampian (outside our SLA) and/or using capacity from other sectors is £167,000 (not including the model for orthopaedics). Within the Board's current financial plan these resources are not available and it should be noted that the Board's plan is currently not financially sustainable.

The table below shows in more detail the breakdown of capacity and demand for the specialties which have a significant mismatch in capacity and demand.

	Specialty Name				
	Oral Surgery	ENT	Ophthalmology	Dermatology	Gynaecology
Access to OutPatients					
Number of new OP appointments available in Q1 (core capacity)	50	90	75	0	0
Number of new OP referrals per week (average)	6	12	8	6	8
Number of predicted new OP referrals in Q1 (demand)	72	144	104	72	96
Number of OP appointments in current waiting list (backlog)	42	242	33	156	54
Mismatch in demand and capacity for new patients in Q1	64	54	29	228	96
Mismatch in demand and capacity for new patients in 2017-18	128	216	116	288	384
Mismatch in demand and capacity for all new OP in 2017-18 (with backlog)	170	458	149	444	438
Additional OP sessions required to maintain steady state in 2017-18	14	35	15	34	34

Treatment Time Guarantee (TTG)

The treatment time guarantee places a legal requirement on health boards that once planned inpatient and day case treatment has been agreed with the patient the patient must receive that treatment within 12 weeks.

The standard is for 100% of patients to be seen within 12 weeks of agreeing inpatient/day case treatment.

For the first three quarters of 2016-17, we reported that 100% of patient commenced inpatient/day case treatment within 12 weeks.

However, due to the lack of gynaecology service provision during 2016-17, a number of patients (12) waited longer than the 12 week TTG and we have put in place a recovery plan to ensure that these procedures are completed by the end of March 2017.

In order to reduce the risk of not meeting the TTG, we have prioritised clinical capacity to ensure that where interventions are indicated; we can deliver them within 12 weeks of the decision to treat. This has been achieved by using additional capacity to maintain waiting lists and meet demand for a number of visiting specialities. However, this is not a financially sustainable option in 2017-18.

The table below shows the number of interventions (520) that might not be delivered within the TTG in 2017-18, because the core clinical capacity available does not match the predicted demand for treatment.

	Specialty Name				
	Oral Surgery	ENT	Ophthalmology	Dermatology	Gynaecology
InPatient TTG					
Planned procedures per quarter (core capacity)	15	24	15	N/A	0
Demand for procedures per quarter	59	30	60		35
Mismatch in demand and capacity per quarter	44	6	45		35
Mismatch in demand and capacity for 2017-18	176	24	180		140
Additional theatre sessions required to maintain steady state in 2017-18	18	6	18		14

Unscheduled Care

Shetland consistently meets the 95% target for 4 hour maximum A&E waits. However, achieving the target has been more challenging at times during 2016-17, because we have seen an increase in the clinical complexity and frailty of patients presenting at A&E and this has had a wider impact on patients across the hospital system. As part of the winter planning review process and actions to support unscheduled care services, we have made good progress in the development of community mental health services in 2016-17 and this has meant that we have been able to offer improved access to mental health services as an alternative to the A&E or emergency care setting (reducing the number of patient presentations to A&E, particularly out of hours). We have also seen the positive impact of the development of community based services, which has reduced A&E attendances and inpatient admissions by increasing the range and availability of anticipatory care in localities.

There are a number of ongoing initiatives which are described in our Joint Strategic Commissioning Plan (2017-20) which focus on appropriate models of service provision to support alternatives to hospital and reduce unnecessary emergency episodes and A&E attendances (which are aligned to the '6 Essential Actions for Unscheduled Care' programme). Progress on the strategic plan is evaluated through the joint management arrangements for health and social care (and summarised in the quarterly unscheduled care action plans) and a whole system approach continues to be undertaken.

One of our local objectives, as described in the Joint Strategic Commissioning Plan (2017-20) is to provide services to people in their own homes or as close as home as possible. This requires an integrated approach between hospital and community, as well as the integrated approach between community health and care services as we have a number of work streams reviewing primary and secondary care interfaces as well as development of locality based services. We offer a high degree of choice for place of death and end of life care, but we continue to develop services to support this in the community.

The Integration Fund is being utilised to test initiatives which are focused on caring for more people in the community, and during the out of hours periods e.g. community nursing and social care 'rapid response' models and 'hospital at home' to increase access to services in the community to provide alternatives to hospital admission for example investment in primary care pharmacy services. Intermediate care models have been developed which include multi-disciplinary teams and are an important aspect of our wider plans to ensure we have effective services to support emergency/unscheduled care pathways and reduce the number of patients who are medically fit and delayed in their discharge from hospital. We have sustained a good position throughout 2016-17 by continuing to reduce the number of people who are delayed and the length of delay in hospital (by streamlining joint assessment processes and increasing resources to support rapid response services) but maintaining this position is one of our key challenges.

The third sector is fully involved in the development of initiatives through Voluntary Action Shetland, and we continue to seek opportunities for third sector involvement in helping to deliver services in the community e.g. independent living support through mobility aids and transport services, assistance at home and caring and befriending support services.

We continue to align our unscheduled care plans with work streams focussing on safety and prevention e.g. community based falls assessment and physiotherapy led education programmes, hip fracture management and early supported discharge.

More use is being made of Care Centres for unscheduled admissions, with GPs and Specialist Nurses having admitting rights along with Social Workers so hospital admissions can be avoided wherever possible and appropriate e.g. supporting end of life care. Community care provision has been reviewed as part of the development of an Older Peoples Strategy for Shetland which includes a focus on reducing unscheduled admissions (to hospital), along with more care in people's own homes (including access to re-enablement and rehabilitation at home) as an alternative to long term care centre placement.

We have worked with the SAS (Scottish Ambulance Service) on creating a Strategic Options Framework. During 2017-18 we will continue to work with SAS on initiatives to deliver community based care through enhanced paramedic 'see and treat' pathways as well as continuing to support Community First Responder schemes. In line with the national falls management/improvement programme, we continue to work closely with SAS to develop a more robust community response to support people when they fall at home, thus reducing the number of people who need conveyance to hospital.

We have also worked with the oil and gas industry to ensure that we provide appropriate access to emergency care services for contractors acknowledging the increase in temporary residents associated with these major projects.

The A&E service in the Gilbert Bain Hospital is well supported by 24/7 consultant cover (on call out of hours) and a range of disciplines that can help to manage emergency cases. One of the outputs from a Clinical Staffing review undertaken in 2014 was the development of an advanced nurse practitioner (ANP) model to support primary care, which has also helped to change the profile of attendances at A&E. In 2016-17, that model has been further developed to provide primary care clinics at the weekend.

More work is needed to look at the sustainability of emergency services, including during the 'out of hours' models and a redesign programme has commenced to review our OOHs models, in particular overnight care and the interface between primary and secondary care services. This work is also aligned to the local primary care strategy and the national Primary Care Outcomes (2016).

Further work is also being undertaken to review the medical staffing model, so that we have a strategic plan for our medical workforce, which recognises the need for timely succession planning and the skill mix necessary to deliver sustainable hospital and primary care services. Service models (which include the necessary skill mix to deliver them) are being

developed to describe sustainable medical staffing models, including a particular focus primary care in the very remote parts of Shetland and doctors in training (in both primary and secondary care settings).

The size and shape of the Gilbert Bain Hospital is being examined as part of shifting the balance of care and changing patterns of usage of inpatient beds. We have worked with health care planners for the last four years and we have developed a plan that describes short, medium and long term plans for the optimal configuration of the hospital to support clinical services. This includes identifying ways of providing medical assessment and ambulatory care services as 'non admitted' planned care services as well as developing a better understanding of the positioning of services that can be delivered out with the hospital setting. This work will also inform the development of the regional delivery plan as we intend to describe a range of models/scenarios for sustainable Acute, Rural General Hospitals as part of this work.

The hospital management structure has been reviewed to strengthening the clinical leadership and management of services. In 2016-17, we reviewed the clinical, care and professional governance (CCPG) arrangements for health and social care to ensure that there is effective leadership and senior clinicians involved in decision making and redesign programmes, through the Integrated Joint Board, Joint Management Team arrangements and the CCPG Committee.

Plans for 2017-18 include

- Using the Integration Fund to ensure that there are robust and responsive community services and hospital admissions only happen where appropriate. Focus on reducing lengths of stay in hospital and better liaison between community and hospital.
- Clear pathways for further/specialist assessment of conditions of old age in the community setting e.g. dementia through Community Mental Health/Dementia Liaison Services.
- Further develop the advanced practitioner model to support primary care settings (including remoter localities in Shetland).
- Undertake an options appraisal to determine how best to deliver healthcare services OOHs and overnight – with greater integration of hospital and primary care teams.
- Further developing locality based services (multi-agency) where 24/7 care is delivered, including support if a person has escalating care needs.
- Using the pilots for locality working to redefine the care at home services, using integration as the driver for improving capacity and responsiveness.
- Further developing intermediate care pathways to enhance the availability of community based rehabilitation.

- Further developing early supported discharge from hospital (e.g. in conjunction with the intermediate care team in the community) and co-ordination of the discharge planning process to reduce patient flow pressures.
- Further developing the model for anticipatory care planning to support locality based decision making and consistent delivery of care plans already agreed.
- Putting a local emphasis on developing shared information systems, records and assessments to reduce duplication and support decision making.
- Continuing to work with the Scottish Ambulance Service to put into place the actions agreed in the Strategic Options Framework.

Risks/Challenges

- Our workforce is made up of many small teams and that means some services remain fragile – we will need to reconsider some of the models that we have in place e.g. where we have single handed practitioners to ensure that we can continue to deliver safe services. This is an issue across health and social care, but is a particular challenge when considering services in the community including those supporting very remote communities.
- Affordability of the current models is a key challenge because of the diseconomies of scale across services. For example, there is a reliance on locums to cover key GP and hospital doctor posts that are critical for the provision of safe services; however this is not a financially sustainable option.
- We will need to determine at a strategic level what the balance of locality based services and centralised services we need to deliver services safely and affordably – our overnight care services (social care, community and primary care) are largely based on models using 'on call' staffing. Developing hub and spoke models to increase and enhance overnight care will need to be considered in order to deliver sustainable services for the future along with a change in the skill mix.
- We will need to develop a clear e-health strategy which focuses on technology enabled care – to support decision making and create opportunities for connecting locality based services with secondary and specialist care services.
- We will need to develop a clear approach and strategic plan to support self directed care and self management. The ANP model has helped to support increased capacity and access to primary care services; we need to look at how we can develop the model across Shetland.
- There is more work to do in developing our signposting, redirection and health education/awareness services to ensure that the public know what services are available, when they are available and how to access them appropriately.

Child and Adolescent Mental Health Services (CAMHS)

During 2015-16 the CAMHS team worked on developing clearer pathways for access to tier 2, 3 and 4 services which include working with regional teams and clarifying the interface/transitional arrangements between adult and CAMHS services.

Key findings from the evaluative work so far are that there are some specific gaps in:

- Interfaces between specialist services – regional network and specialism's such as Learning Disabilities
- Capacity to provide an acceptable level of access to CAMHS services, particularly psychological therapies
- Skills and skill mix of the team – we are reviewing training requirements across the multi-disciplinary team
- Supporting the provision/awareness of universal services e.g. multi-agency approach providing general advice and support to promote resilience and wellbeing

Throughout 2016-17, we have been working on an improvement plan to address the identified gaps. Specifically in response to the actions to review the skill mix and improve access to psychological therapies; we have developed a new model to increase the clinical capacity available for psychiatric and psychology input which is where the CAMHS service had the greatest deficit.

The changes to the skill mix have been funded from the £45,278 that is available to CAMHS from the Transforming Mental Health (2016) allocation to develop CAMHS capacity, as well as through a redistribution of core resources.

We have been working closely with NHS Grampian to develop clear, joint pathways between NHS Shetland and the specialist services in Aberdeen where a child may have complex needs and a learning disability so that an appropriate and coherent plan can be put in place quickly.

A transitional pathway/model for young people transitioning into adult services has also been developed and is in draft.

A plan to support practitioners in new roles has also been developed in conjunction with NHS Education Scotland (NES). Staff have made links with specialist services (e.g. tier 4) in Dundee to fully understand the clinical pathways, governance arrangements and role that local services need to play in supporting children in the Island context. Clear clinical supervision and management arrangements are also in place for the whole, multi-disciplinary team.

Priority has also been given to support the development of the capability and capacity of generalist practitioners working across health, social care and schools to provide

appropriate support and advice to young people, who would otherwise have been referred to CAMHS (i.e. tier 1).

The service has recently moved into new premises, which will enable closer working with inter-agency partners and includes space that can be used for group work facilitated by the CAMHS team or partner organisations (e.g. youth groups, schools and the voluntary sector).

As a result in changes in our skill mix and the introduction of new pre-assessment clinics, facilitated group sessions and new pathways, we have improved access to the service considerably in the last six months.

In April 2016, 22% of patients waited less than 18 weeks from referral to treatment for specialist Child and Adolescent Mental Health Services. By October 2016, 100% of the children referred to the service were seen within the access target and the waiting list has reduced considerably with better triage arrangements.

Progress and performance of CAMHS is reported to the Integrated Children & Young Peoples Strategic Group as well as through NHS Shetland governance and management structures.

Plans for 2017-18 include

- Working with partners to develop services to support psychological wellbeing and resilience (e.g. early intervention)
- Completing and implementing the transitional pathway with adult Mental Health Services
- Continuing to develop local capacity and capability to support young people with complex needs e.g. working with local and specialist Learning Disabilities services
- Providing training and support to generalist practitioners, particularly developing close working with GPs, Child Health and Schools

Risks/Challenges

- The CAMHS team is small and therefore fragile, only a small shift in capacity would reduce access to specialist services and change our performance against the access standard for psychological therapies
- Capacity of specialist, mainland services remains a key risk for young people who need inpatient care or a higher level of clinical input that cannot be easily maintained in Shetland

Community Health and Social Care Services

Primary care

Shetland NHS Board has a Primary Care department, which works primarily with General Practice and Optometry, alongside separate Dental and Pharmacy departments, both of which have a Director.

General Practice

Aims:

- To ensure any person in Shetland with primary care health needs has access to a local GP Practice.
- To develop a range of high quality primary care services in Shetland, which are sustainable in the long term.
- To enhance the services available and facilitate shifting the balance of care from institutional settings to the community.
- To increase the number of anticipatory care plans for patients most in need of this level of care, to ensure that healthcare needs are met and unnecessary hospital admissions prevented where possible.

Plans for change:

- Develop and implement Primary Care Strategy – this document was presented to the Shetland IJB in April 2016; an initial action plan on the recommendations was subsequently agreed by the IJB and implemented during 2016/17. The plan will be augmented once the detail of the new Scottish GP contract is available (see comment below).
- The new Scottish GP contract comes into effect during 2017. As yet, detailed information on the new contract has not been issued but once this information is received, implementation of the new contract will become one of the largest pieces of work undertaken in Primary Care during 2017/18.
- The work to replace the GP I.T system, EMIS (used by all Shetland practices), will commence in 2017, following the national framework solution. We are also undertaking a proof of concept to explore a potential electronic solution to record keeping across Health & Social Care with interface to GP records, social care and secondary care information. This will develop in Spring 2017.
- The removal of QOF led to the introduction of Practice Clusters. The local LMC agreed that there would be one cluster in Shetland and all practices nominated a designated Practice Quality Lead. The Cluster has met regularly and will continue to develop.

- Further develop implementation of eKIS Anticipatory Care Planning across services including new polypharmacy reviews for patients at risk of readmission (as per SPARRA data). This will involve working with colleagues in mental health and social care, to standardise information collected and to share ACPs in place (with appropriate consent). The Transitional arrangements for 2016/17 had an emphasis on Anticipatory Care Planning, which will continue during 2017/18. In addition, practices now have access to Primary Care Indicator Information from ISD, although this information is not currently accessible to the Primary Care Management team.
- Our largest practice commenced on line prescription ordering and although uptake has been slow, this has been steady with good patient feedback.

During 2016-2017 the Primary Care service has experienced significant challenges with recruitment, particularly with regards to GPs, across Shetland. Five out of ten practices in Shetland have GP vacancies and we will continue to work creatively on recruitment, which has included working with Promote Shetland to actively promote GP recruitment. We have also introduced a new service model for the North Isles of Shetland, with posts being advertised in March 2017. As part of the Primary Care Strategy implementation, new service models are being investigated, which will include looking at the use of Advanced Nurse Practitioners more generally in Primary Care (for example, one of the larger health centres is considering the use of ANPs as part of a service redesign).

During 2016/17 two more practices have become salaried and in February 2017 a further two practices have intimated a notice to become salaried. This will give Shetland 7 out of 10 practices salaried and during the course of 2017/18 a review will take place of demand and capacity across the service.

The Primary Care and Mental Health teams in Shetland have submitted a bid to become an innovation site for post-diagnostic support in primary care for people with dementia, as well as working with other remote & rural Boards on a joint bid with a view to promoting the roles and opportunities of remote working and we will continue to seek innovative ways to attract staff to Shetland. Nonetheless, recruitment and retention of staff at all grades remains the greatest risk to delivery.

Out of Hours Services

Four of the ten health Centres provide their own OOH services (three are on islands and the fourth is very remote in Shetland). The other six practices have cover provided through an out of hours co-operative, with the rota being managed by the Primary Care Manager. GP numbers for the rota remain low and with the imminent departure of several GPs to other roles, the service is becoming increasingly fragile. This in turn has led to a review of existing out of hours provision which is expected to propose a new system of working by June 2017.

We have worked with Community Nursing colleagues and NHS24 to trial new unscheduled care processes, involving Saturday and Sunday Primary Care clinics and this will be evaluated towards end of March 2017. The aim is to continue offering this additional service provision, within existing resources and thereby extending the access to Primary Care clinicians.

Risks to Delivery

- Ability to recruit and retain suitably skilled GPs, ANPs and practice nurses
- Ability to deliver a comprehensive out of hours service across a disbursed rural population
- Ability of practices to remain sustainable and independent which limits the attractiveness for recruitment
- Community acceptance of alternative primary care configuration

Nursing in Community Settings

The Community Nursing Service comprises a range of services which provide nursing care, treatment and support within a community setting. These include:

- District Nursing;
- Practice Nursing;
- Advanced Nurse Practitioner service at Lerwick Health Centre;
- Specialist Nurses, eg Continence Nurse Advisor;
- Non-Doctor Island Nursing – there are 5 islands where the only resident healthcare provider is a nurse.
- Intermediate Care Team – this multi-disciplinary, partnership team provides 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 6-8 weeks.

Whilst the current Community Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16years and are housebound, the services endeavour to meet the needs of any individual across the lifespan from birth to death, within the community setting, who has a nursing and/or health need.

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.

In the next year, with the increase in the number of directly provided Board practices meaning that 7 out of the 10 practices locally will have the Practice Nursing service delivered via the Community Nursing service there will be opportunities to review the interface between Practice and District nursing and to consider the future model of nursing services within the community.

Plans for Change:

A review of the Community Nursing service will be completed in 2017/18 with the following aims:

- To ensure that the nursing service remains focussed on caring for unwell and frail older people;
- To enhance individual's independence through the promotion of self care and undertaking anticipatory care and rehabilitation support where necessary.
- To identify efficiencies that are cash releasing where the service continues to have adequate capacity to meet needs.

The local review of nursing services will take into account the work carried out into defining the roles of the Band 6 District Nurse, the wider Community Nursing team and Advanced Nursing Practice which is being led by the Chief Nursing Officer under the banner of Transforming Nursing Roles. The work will also explore the sustainability of community nursing in our most remote and isolated communities, and particularly the islands, and how we can ensure that the skills of the wider team can best support those communities.

This review will ensure that the 7 core elements of the District Nurse role are reflected in the leadership provided by District Nurses, namely public health/health improvement/ addressing inequalities, anticipatory care, assessment, care/case management, complexity/frailty, intermediate care and palliative and end of life care.

Through the review, consideration will be given to the following areas of practice

- Developing an overnight nursing and care service (links to the out of hours review);
- Enhancing the rapid response service provided to acutely unwell individuals in the community setting;
- Reviewing of the nursing and care skill set to better support working in Integrated teams;
- Establishing an Advanced Nurse Practitioner "Academy model" to support the development and ongoing support and supervision of nurses working at this level in remote and rural practice;

- Development of a "Nursing in the Community" Strategy which will set the strategic direction for nursing in Community settings locally, providing a career framework from initial registration through to advanced practice thus ensuring that the nursing workforce has the appropriate skills and competencies to support working in, and providing leadership to, integrated teams as well as being able to support the implementation of the new GP Contract from 2017.

Risks to Delivery

- Ability to recruit and retain suitably skilled community nurses
- Sustainability of service in very small remote and rural settings, including small islands
- Ability to deliver a sustainable out of hours service across a disbursed rural population

Optometry

NHS Shetland has close links with NHS Grampian and receives Optometric advice on the basis of one session per month. Staff based in Shetland are also part of the NHS Grampian Eye Health Network and take part in regular VC training.

Grampian's Eye Health network will continue to deliver further service improvements and continue to implement recommendations from the HIS review from 2014. There are also plans to continue to improve planned care pathways in eye care and join up contractor/stakeholder collaboration in key long term condition management work. In line with Strategy Outcome 2 of the Scottish Visions strategy (SVS) 2013-2018, NHS Grampian continues to emphasise optometry as first point of call for eye problems and has rolled out the integrated electronic referral system, which NHS Grampian are continuing to support. We have also formed an eye advice email line so that unnecessary referrals are minimised.

Actions for 2017/18 include:

- Continued use of CDU and helpline
- Support Optometrists using LES in Shetland, which all three practices are signed up to. This includes teach and treat session training.
- Utilising the new SIGN guidelines coming for Glaucoma but with more integrated care for stable patients in the community
- Use of technology – utilising OCT machines in Shetland to manage macula patients locally
- Shared learning – through VC links for EHN and NES and Shared learning notices. Quarterly Significant Incident review meetings held with EHN Board pull together any Shared Learning and on occasion Optometrists invited to use Reflective Learning exercises as method of continual learning.

Oral Health Care

The LDP for 2017-18 uses the term 'Oral Health Care' to recognise that Oral Health Care extends beyond Primary Care into Secondary Care provision, as well as into community via health promotion. This is reflected in the following Vision statements:

The Vision for Oral Health in Shetland is:

- 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 (periodontal) disease.
- All adults can maintain a healthy natural dentition through to later life with minimal need for artificial replacement.
- 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 the onset of oral health disease.
- 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.
- All the population can access high quality, affordable, safe, and effective NHS oral health care services.
- The vast majority of people requiring specialist oral health care can receive this in Shetland.

Priorities for Change in 2016-17 included:

- Taking measures to reduce the Public Dental Service (PDS) waiting list of adults wanting to register for dental care in Lerwick.
- Encouraging independent NHS dental practices to open in Shetland, in order to increase the capacity for NHS primary dental care.

Outcomes:

- Lerwick Dental Practice, an independent NHS dental practice, opened in Lerwick in January 2016 with the capacity to register in excess of 6000 people.
- The PDS waiting list has reduced by 30% - people who have been happy for their names to be passed on to the new Practice for priority registration.

Priorities for Change for 2017-18 to help achieve the Oral Health Vision:

- Work to eliminate the PDS registration waiting list altogether.
- Encourage more local independent NHS dental practices to open, to further increase local NHS capacity, and to reduce the reliance on the PDS to provide general dental services.
- Further align with the PDS remit, as defined by Scottish Government, to provide a range of specialist dental services that are complementary to those provided by the local independent practices, and reduce the need for people to need to be referred to Grampian for specialist oral health care.
- To draft an NHS Shetland PDS Oral Health Promotion framework aligned from 2017-2020 to include:
  - A review of the use of fluoride.
  - A review on the use of fissure sealants.
  - Direct engagement with schools and community regarding healthy eating.
  - Alignment with overarching NHS Shetland Health Improvement demonstrations.
- To implement an annual training programme for all care home staff and older person carers in accordance with the Caring for Smiles Programme.
- To review the role of skill mix and up skill within the dental team to enhance oral health promotion and clinical effectiveness within the dental team.

Risks to Delivery:

- The shortfall in primary dental care capacity – reconfiguration of the PDS is predicated on adequate growth of the independent 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 independent 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.

Pharmacy Service

NHS Shetland continues to use the opportunities available through the introduction of Prescription for Excellence in ensuring that Pharmaceutical Care is delivered to a high standard, regardless of where a patient lives. A new strategic direction for pharmacy has been introduced in recent years, with support from NHS Shetland and the Scottish government which envisaged a much greater role for pharmacists within general practices.

A key challenge in Shetland is in recruiting pharmacists with the balance of specialist and generalist skills to allow them to work effectively and safely in remote and rural areas. Progress has been made in supporting pharmacists and technicians as they develop the range of skills required to implement Prescription for Excellence. This has been facilitated through the deployment of Primary Care funding in recruiting an additional pharmacist.

A Pharmacist now works full time in the Lerwick Health centre. This is the largest GP practice in the northern isles and the first to benefit from this work. Steps to improve patient safety, through medicines reconciliation and some innovative working on discharge arrangements; alongside better management of repeat prescriptions and drug monitoring arrangements, have helped to bring about safer and more efficient practice. Meantime remote GP practices, many of whom already have strong links to community pharmacies, including former dispensing practices, continue to be supported by a clinical pharmacist, who undertakes medicine and polypharmacy reviews according to identified need.

The role of pharmacists in most specialist settings, for example within the management of rheumatology and in supporting the Shetland diabetes clinic continues to be explored and developed, as does the specialist technician role within the hospital, procurement and homecare settings.

Plans for change

Plans continue to develop the role of pharmacy in an incremental way as outlined in the pharmacy work plan; “creating pharmacy capacity” is required to ensure that Prescription for Excellence is delivered locally. Delivery of the plan will involve recruiting a sustainable workforce; this additional staffing commitment will ensure that polypharmacy work will increase, and that the GP workforce will be supported to ensure a more efficient use of GP time and resource. Full integration of the clinical pharmacists into the clinical skill mix in Primary Care remains a priority in 2017-18 The use of video conferencing is being explored, to link clinical pharmacists, perhaps based in pharmacies, to care homes and very remote GP surgeries.

Supporting Social Care Workers and patients in their own homes will help to reduce medicine waste, and supporting GP practices in improving repeat prescribing should also help to contain medicine cost. Both these interventions will also reduce the potential for harm from these medicines. The intention is to tackle both these activities through

recruitment of an additional pharmacy technician in primary care, and plans are now in place to put this into effect. There are still efficiencies which can be made through better prescribing and a comprehensive prescribing action plan is in place, the speed of change will depend very much on the staffing resource available.

A further area which will need to be looked at is the in hours and out of hours service in the hospital. There may be a need, with changing legislation, to manage the procurement of hospital medicines from Shetland, rather than in Grampian. Additionally there is now an expressed need for a formal out of hours pharmacy service, these potential developments will be explored in 2017.

These developments all incur additional staffing resource, particularly for fixed term posts a range of funding options will be explored.

These include. Specific allocations for pharmacy development from Scottish government. Potential availability of funding from National Education for Scotland. Joint funding through the Health and Community Care Directorate. Spend to save projects. Multidisciplinary skill mix exploration, and utilising project enabler funding.

Risks to delivery:

- That bids to secure funding are unsuccessful.
- Multidisciplinary skill mix considerations and joint working arrangements are not implemented quickly enough.
- That the difficulties in recruiting and retaining permanent pharmacy staff increase.

In summary the plans for 2017-18 are to:

- Recruit additional pharmacy staff to ensure the department is adequately resourced to continue to provide core services, improve safety and drive efficiency.
- Increase the availability of support to patients in their own homes and in care homes
- Increase the use of technology to bring pharmacists closer to their patients
- Increase the roll out of the effective prescribing plan in particular the number of polypharmacy reviews by 20%
- Continue to develop a training and support programme for Remote and Rural pharmacists and the development of technicians.
- Explore the need and options for an out of hours pharmacy service.

Mental Health

The 2014 review of Shetland's mental health services identified a number of areas in need of redesign and improvement and we are making some progress in achieving these objectives. In 2015 we strengthened our community based provision of mental health care by appointing a Clinical Director for Mental Health (Consultant Psychiatrist) and supported this with an enhanced level of psychiatry provision and an increased number of CPNs, and 2016 appointed a Consultant Clinical Psychologist. These developments have enabled changes in how local services are delivered and we have already seen a significant reduction in admissions to off-island psychiatric in-patient facilities in NHS Grampian. Capital has been allocated for 2017 to develop an area within the hospital to help support those in mental health crises. These developments, together with an updated psychiatric emergency plan, will result in an overall improvement in the quality of Shetland's mental health provision.

Our progress in improving the quality of local services is being achieved against a backdrop of a national increase in the demand for, and changing public expectations of, mental health services. Mainland services can, and have, resourced the development of community provision by disinvesting from psychiatric inpatient facilities. In the absence of such facilities in Shetland, our challenge is to continue to identify the resources required to meet changing expectations and develop the necessary capacity to deliver safe, person centred and sustainable services that will reduce waiting times and improve access to the mental health services needed by the people of Shetland.

PT Waiting Times, Access and Workforce

Shetland's adult psychological therapy provision is delivered by 3.5 WTE staff, of which 2.5 WTE are Primary Care Counsellors, and 1 WTE is the Consultant Clinical Psychologist.

The provision of services for those with complex needs has been enhanced following the appointment of a Clinical Psychologist in November 2016. There has also been a reduction in the number of staff absences and these changes have contributed to a steady improvement in the waiting times target for those referred for a psychological therapy. We expect this to continue through 2017 as we progress our plans to increase the number of front-line staff trained to deliver evidence based interventions (e.g. Behavioural Activation for Depression).

Provision of PT services for mild to moderate presentations is being strengthened by the development of the primary care based Talking Therapies Service and we continue to work on identifying the most effective skill mix to meet the needs of the Shetland population.

Timely access to a relevant range of evidence-based psychological therapies continues to present significant challenges in the remote and rural island setting. There are service level agreements with NHS Grampian for Adult Neuropsychology, Adult Eating Disorders and

Adult Learning Disabilities. We are reviewing these agreements to ensure Shetland has sufficient capacity and resilience in the provision of these services.

Risks/Challenges

Whilst we have growing confidence in our ability to meet the needs of those with mild to moderate presentations, there continue to be significant challenges in responding effectively to the diverse needs of those with complex conditions. With a small team any period of unplanned leave will have a disproportionate impact on our ability to meet and maintain waiting time standards.

In addition, increased economic and social uncertainty can increase the demand placed on mental health services and we will need to monitor this closely to ensure that we have sufficient capacity to meet any such challenge.

Mental Health Plans for 2017-18 include

- An Organisational Development intervention covering:-
    - Mental Health management arrangements
    - Management and Leadership Skills development
    - Culture and behaviours
    - Clinical Governance arrangements
    - Accommodation
    - Administrative services
    - Service development
        - Psychiatric Emergency Plan / Crisis service arrangements
        - Creation of Psychiatric Emergency room – project agreed and should be progressing anyway
        - Developing SMRS
        - Clinical Psychology
        - Psychological Therapies

- Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
- Establish and increase access to Clinical/Counselling Psychology Services
- Redesign psychological therapy services and increase local capacity by training a wider range of existing staff
- Progress the 2015-18 Dementia Strategy Action Plan
- Establish the local service to provide training, formal diagnosis and support for adult ASD

- Introduce “Triangle of Care“ or Equal Partners in Care” (EPiC) training for a wide range of Health & Social Care staff
- Improve the support to people in crises out of hours, working with other statutory partners and the third sector
- Manage the transition between childhood and adulthood so that individual patients receive a seamless service

Risks/Challenges

- The mental health workforce is made up of small teams and that means some services remain fragile. We need to explore innovative solutions to the provision of specialist mental health services to remote and rural communities and we have had preliminary discussions with QuEST regarding the feasibility of VC services and specialist regional hubs to support generic island services.
- Risks to delivery will be managed by the strategic allocation of available resources and the redesign of services to achieve maximum efficiency and effectiveness. This will be achieved by working in partnership with patients, carers, staff and the Third Sector.

Telehealthcare/ Technology Enabled Care

There will be increased focus on supporting the use of telehealthcare to deliver services in a more effective manner. This will be achieved by both increasing the quantity of available video conferencing infrastructure, improving network links to/from GP surgeries (national project) and implementing a national tool to support desktop-based consultations between patients and healthcare across the internet.

Use of video conferencing from GP practices will require increased bandwidth and this is scheduled to be delivered as part of the national SWAN programme.

<u>Implementation of GP Patient Portals.</u>

This would provide online services for patients of GP practices, using EMIS Access. Such services include appointment booking, repeat prescription requests, access to self-help resources, and in the near future digital access to clinicians and own medical records. This would improve access to services, reduce pressure on physical appointments, reduce DNA’s and empower patients to self-manage own conditions. It would reduce administrative overhead required to managed appointment and repeat prescription times. It would also help to deliver safer medicines and medicine reconciliation. As detailed above, our largest practice has implemented on line prescription ordering and this is working well.

<u>National resources for self-management of conditions</u>

This will involve supporting patients and clients to access existing and planned national resources including websites for self-management of LTC’s including renal and diabetes.

Increasing uptake of these services would improve patient care through remote monitoring, reduce number of acute episodes, reduce pressure on services and enable localities to target care resources closer to point of need whilst maintaining efficiencies.

Implementation of a Management Information System for Community Nursing, Community Allied Health Professionals

Specific focus will be given to this project during 2017/18. This will involve ensuring a fit for purpose system to enable above cohorts to deliver care in a community setting. This would include integration in real or near-real time to existing acute, GP and social care systems, mobile access to patient and client records and alert messaging. (although not directly primary care focussed, enables a holistic approach to managing people at home in the community). In addition, focus will also be given to a Health & Social Care integrated clinical portal.

Health and Social Care Portal

A regional approach to implementing a H&SC Clinical Portal is being developed with other North of Scotland Boards. A proof of concept has been commissioned commencing April 2017 to explore a hosted model for delivery. This will maximise economies of scale by hosting in secure specifically built datacentres, simplifies inter-agency sharing and provides a platform for increased regional integration.

Clinicians and Care providers will have access to data from a single 'presentation layer' including that provides appropriate role-based access to various datasets including Acute and GP Electronic Patient Records, GP Emergency Care Summary data, and Social Care data.

H&SC Portal technology will also be the platform that will enable national delivery of patient access to, and engagement in, their own health record, as well as the access to services described above in the GP Patient Portals section.

GIRFEC

An information system to support GIRFEC messaging will be implemented in 2017/18. This system has been proven in the Ayrshire and Arran data sharing region, and may also be suitable for Adult messaging applications.

Order Communications System (Order Comms)

An Order Comms system will be implemented in both Acute and GP services. This will enable GP Practices and acute services to securely order tests from Radiology and Labs providers, and for results to be securely and safely work-flowed back to the requestor. This will provide a much more efficient and safe system for diagnostic services.

Health Intelligence

eHealth have invested locally in Health Intelligence technology and are in the process of training staff and developing 'dashboards' to provide visual insights into existing information resources. A suite of support has been established including formal training, peer working with Grampian colleagues and a support package from the National Services Scotland Health Intelligence team.

With this capability, staff responsible for service planning and monitoring will have greater access to information, and more scope to 'self-serve' information needs. This will also allow support staff with an informatics brief to support the increased requirement for an analytical and insightful approach to information services.

All of the above projects form part of the tactical delivery of the NHS Shetland eHealth Plan.

Integration

Shetland's Integration Joint Board (IJB) adopted a refreshed Strategic Commissioning Plan in February 2017 for the period 2017-2020. The Plan will be updated on an ongoing basis as part of a dynamic commissioning process. The Strategic Plan process has involved taking views from the Strategic Planning Group.

The Strategic Commissioning Plan and the Integration Scheme sets out the arrangements for carrying out the integration functions in the Local Authority area over the period of the plan. This includes key local actions to ensure effective involvement of clinical and care professionals in the Strategic Planning Group, through the clinical, care and professional governance framework, and through locality arrangements.

The Clinical, Care and Professional Governance Framework has been revised for the Integration Scheme to include care services.

Local and national standards are monitored through the joint reporting to the Integration Joint Board, and the reporting to the NHS Board. For completeness, and to ensure that inter-dependencies are captured, there are some standards that are reported to both boards, with the NHS Board retaining oversight of services it delivers. The joint Directorate has developed a yearly plan, with individual service plans supporting the Directorate plan. These plans detail the operational delivery of services, and the priorities that are reflected in the Strategic Commissioning Plan and the LDP. The Health Board's Corporate Action Plan supports the Health and Social Care Partnership's objectives with actions that are health's contribution to the Partnership in it meeting the nine health and well-being outcomes.

Integrated work with the Hospital, Acute and Specialist Services Directorate is maintained through joint strategic groups, which supports the shifting of the balance of care through policy development as well as through the Strategic Planning Group.

The Integration Joint Board has met regularly throughout 2016-17 and has received a broad range of reports to enable it to fulfil the functions delegated to it through the Integration Scheme on: strategic policy; service needs assessment; policy developments; options appraisal; financial planning; management accounts; performance; and risk management. The IJB has a focus on maintaining and improving performance in the areas which support the Health and Wellbeing Outcomes.

The decision making arrangements for NHS Shetland will be reviewed in light of a full year of operation of the IJB to reflect the new arrangements and avoid duplication on an underpinning principle of 'once for Shetland'.

Better Health

Health Inequalities and Prevention

Aims

The overall aim of health improvement and health inequalities work in Shetland is to help people live longer, healthier lives. To do this we aim to:

- reduce the key risk factors for poor health outcomes: substance misuse (smoking, alcohol, drugs); lack of physical activity and obesity.
- tackle health inequalities by identifying and meeting the needs of the most vulnerable and hard to reach groups, and targeting services (including services related to the key risk factors above) at those that are most in need.
- support people to reach their full potential at all life-stages – from birth and early years through working lives to old age.
- work through a range of other health and care activity such as re-ablement, support for people with disabilities and mental health problems, and early years work.

Priorities for change

Tackling Inequality, especially health inequality

Deprivation and inequalities in Shetland are not readily defined through geographical targeting. We have considerable understanding of inequalities in remote and rural areas from local research and interagency working.

In 2015/16, 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 that a variety of influences, including changes in welfare policies, are making their position steadily more precarious."

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

Health Inequalities are differences in the health experiences and outcomes between people and groups because of their life circumstances, particularly thinking about poverty and socio-economic deprivation or disadvantage, but also age, gender, ethnicity, sexuality, having a disability and physical environment.

Health inequalities are influenced by a wide range of factors including access to education, employment and good housing; equitable access to healthcare; individuals' circumstances and behaviours, such as their diet and how much they drink, smoke or exercise; and income levels.

Poverty and socio-economic disadvantage are probably the most important risk factor for poorer health outcomes. They impact on an individuals and communities abilities to make 'healthier choices' and to access services and information. Many health issues, and underlying risk factors such as smoking, are strongly associated with poverty, deprivation and social exclusion.

Although Shetland is a relatively prosperous community, and we have, for the most part, a good quality of life, there are still people living in Shetland in poverty, families who are not able to access services, or get the help and support they need, and people who suffer from discrimination and exclusion. For some people who have mental health problems (because of the stigma still attached to mental illness), and for many who live with long term conditions and disabilities or have problems with addiction, particularly the consequences of alcohol misuse, exclusion can be painful and can worsen health and limit access to services.

An Action Plan has been developed to implement the Recommendations of the Commission and is supported through a range of multi-agency partnerships reporting through the Shetland Partnership. Tackling inequalities, poverty, isolation and stigma can only be achieved through working in partnership utilising structures such as the Community Justice; Drug & Alcohol; Mental Health; Domestic Abuse; and Community Learning and Development Partnerships and associate groups and networks. NHS Shetland will play a direct role in the following agreed action points:

Target resources to break negative cycles within families

- Enable targeting and preventative actions to happen at any age where there is an opportunity to break negative cycles and support individuals and households to move on.

Building on one of Shetland's best assets; as individuals and as a community do all we can to reduce stigma and loneliness?

- Promote a culture of participation, equality and fairness, based on open communication and inclusion.

Use frameworks such as Health and Safety Executive management standards for work-related stress to promote and protect employee mental wellbeing.

Target resources to make sure actions to tackle drug and alcohol misuse are effective.

- Alcohol Brief interventions are among the most cost effective and effective interventions in reducing harmful and hazardous drinking.

Use the evidence to improve the targeting of resources and ensure inequalities do not widen as local financial resources diminish.

Implementing an asset based approach to health improvement and ill health prevention

NHS Shetland's Public Health Directorate (including the Public Health and the Health Improvement Teams) is responsible for three main strands of work: promoting, improving and protecting the health of people in Shetland; preventing disease and ill health; and reducing inequalities. The focus for the health improvement work continues to 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).

A new area of work this year within Public Health is the development of a specific project to implement an asset approach to health improvement and ill health prevention; broadly focused around self management.

This will promote an approach that is 'person centred'.[2] 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
- reducing health inequalities
- anticipatory care
- self management / long term conditions support group
- involving carers
- realistic medicine

[2] Healthcare Quality Strategy for NHS Scotland

When analysing service trends and demand, some services have highlighted an issue around repeat attendees 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 patients feeling the need to access statutory services, for no long term benefit.

The performance Indicators for this project will include:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of people with positive experience of care at their GP practice
- Rate of emergency admissions for adults
- Falls rate per 1,000 population in over 65s.

Further indicators will be developed to support each element of the programme. These may include.

- Reduced social isolation
- Increase in health literacy – understanding of health information, health issues and ability to take control.
- Reduction in secondary and tertiary care
- Reduced waiting times and DNAs
- Increased staff and patient satisfaction
- Fewer re-registrations
- Increased compliance with treatment
- Increased awareness of where to do for appropriate help and support

Transforming the delivery of core health Improvement work

We will continue to change the way we deliver the core health improvement services through further developing working in localities, integration with primary care, using community and asset based approaches and developing the generic workforce to identify health improvement opportunities and take appropriate action. However there are limitations to the progress we can make given the cuts to our funding and reduction in staff.

Specific objectives include:

Increase proportion of adults in Shetland who exercise at recommended levels through improving access to physical activity at a local community level, and supporting the most inactive.

Reduce percentage of adults who smoke through targeted smoking cessation, smoking prevention and tobacco control work; recognising that the relatively small number of people who continue to smoke tend to be in the hardest to reach and more vulnerable groups; and find it the hardest to quit.

Reduce number of people admitted to hospital with alcohol related conditions through Drink Better Campaign and further development of substance misuse services.

Reduce prevalence of mental health problems and suicides (and drug related sudden deaths) through Choose Life Action Plan and implementation of a new Mental Health Strategy, based on a comprehensive needs assessment.

Reduce obesity through preventative work, including locality based working with the most disadvantaged groups and work through the Early Years Collaborative.

Continue to deliver outcomes Focussed Action Plan to militate against effects of Welfare Reform.

Continued roll out of Keep Well inequalities programme - targeted health checks to vulnerable, socially excluded and disadvantaged groups to identify and help people with risk factors (including alcohol, smoking, obesity, inactivity) and health issues. There is a specific emphasis on male dominated workplaces and minority ethnic groups; building on the findings of a BME Health Needs Assessment.

The key indicators are:

- 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

The challenge on NHS procurement policies supporting employment and income for people and communities with fewer economic levers is less relevant to Shetland which has high employment levels and a buoyant but fragile economy, but local suppliers are included in the list of national contracts to allow access to local business and resultant benefits for the

local economy, and NHS Shetland contributes to the Local Outcome Improvement Plan objective on maintaining financial sustainability in the local economy.

Actions relating to employment policies that support people to gain employment or ensure fair terms and conditions for all staff include compliance with national PIN policies, targeted support for staff in recruitment and professional development for instance for those who may have difficulty accessing web-based recruitment methods or IT based learning opportunities, and a good record of employment for people with disabilities or additional support needs.

Financial Planning

Background and context

NHS Shetland recognises the importance of a sustainable and balanced financial plan and the impact this can have on the ability of the Health Board to sustain the quality of services offered to the local population.

NHS Shetland has, for a number of years, needed to make efficiency improvements over and above the National 3% target to achieve financial balance, provide investment to sustain local services and to address ongoing pressures such as the requirement of short term locums in both primary and secondary care. Achieving these efficiency improvements on a recurrent basis continues to be a significant challenge especially in clinical areas where a number of services operate on de minimis staffing levels.

As the Board is in recurring financial deficit it continues to focus upon an Efficiency and Productivity agenda over a five year period rather than the minimum three year period. The current projections include a significant efficiency savings target of £12.5m over the next five years. This figure includes £2.1m brought forward from 2016-17 plus £10.4m in new savings over the next 5 years. To achieve our aim of recurrent financial balance over this period table 1 below summaries the level of efficiency savings required.

Table1: Indicative Savings Target Requiring to be Delivered over the period 2017-18 to 2021-22

	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	Total £000's
Brought Forward balance	2,101.0					2,101.0
New Target 3% Target	1,308.0	1,337.9	1,365.2	1,508.0	1,562.0	7,081.1
New Target to meet 2016-17 funded developments	330.0	0.0	0.0	0.0	0.0	330.0
New Target Additional 1% Target for 2017-18 and 2018-19	443.0	450.0	0.0	0.0	0.0	893.0
New Target to meet Scottish Government Social Care Fund	420.0	420.0	420.0	420.0	420.0	2,100.0
Plan for actual achieved in-year recurrently	-3,386.4	-1,000.0	-1,000.0	-473.8	-478.9	**12,505.1**
Balance Carried Forward:	1,215.6	2,421.1	3,206.3	4,660.5	6,637.4	

The Board's immediate focus has been on developing recurrent proposals for 2017-18 to bridge the in year gap. As a consequence, proposals for years three to five include high levels of unidentified savings.

The achievement of financial balance over this period will require the Board to deliver non-recurrent savings alongside the recurrent plans. The current proposal assumes that non-recurrent savings and technical financial issues can generate around £1.0m in 2017-18. This includes an assumption that a small surplus is brought forward from 2016-17.

Significant recurring savings schemes have been identified with a projected full year effect value of just under £3.4m (7.3% of the Board's core baseline allocation). These are identified in Table 1.2 below, with an indicator of the financial risk attached to delivery.

Table 1.2: 2017-18 Efficiency and Redesign Projects

Recurring Efficiency Savings Proposals	LDP Plan	Low Risk	Medium	High Risk
	£	£	£	£
Move to a community based rehabilitation service	472,184		472,184	0
Off Island Patient Pathways Redesign to Shetland	250,000		130,000	120,000
Off Island Patient Travel Cost Reduction Redesigns	610,000		610,000	
Directly Provided CHCP Services: Community Nursing	240,000		240,000	0
Other Primary Care	150,000			150,000
Redesign of Shetland Mainland OOHs Provision	100,000			100,000
Procurement	140,000	140,000		0
Estates & Facilities	197,158	197,158		0
Public Health	31,424			31,424
Human Resources and Support Services	124,303			124,303
Finance	38,441	38,441		0
Corporate Management	23,912	23,912		0
Pharmacy Drugs Expenditure	328,500		328,500	0
Off Island Commissioned Healthcare Savings	422,358	294,500	127,858	0
Resource Transfer Funding	58,090		58,090	
Board wide schemes	200,000		200,000	
Service Redesign Challenges	tbc			1,215,629
Overall Total Recurring Efficiency Savings Proposals	3,386,370	694,011	2,166,632	**1,741,356**
2017-18 Cash Releasing Efficiency Savings Scheme Target	**4,601,999**		282,198	
Shortfall to Required Target (Full Year)	**1,215,629**			
Risk Profile of Savings (Percentage)		**15%**	**47%**	**38%**

It is recognised that these are not all expected to start on the 1st April. The status of each of the projects is outlined below:

Recurring Efficiency Savings Proposals	Project Status
Move to a community based rehabilitation service	Implementation
Off Island Patient Pathways Redesign to Shetland	Ongoing project; work in progress
Off Island Patient Travel Cost Reduction Redesigns	Ongoing project; work in progress
Directly Provided CHCP Services: Community Nursing	Option Appraisal
Other Primary Care	Option Appraisal; testing alternative models
Redesign of Shetland Mainland OOHs Provision	Option Appraisal
Procurement	Implemented
Estates & Facilities	Implemented
Public Health	Implemented
Human Resources and Support Services	Implemented
Finance	Implemented
Corporate Management	Implemented
Pharmacy Drugs Expenditure	Ongoing project; work in progress
Off Island Commissioned Healthcare Savings	Implemented
Resource Transfer Funding	Implemented
Board wide schemes	Project development stage
Service Redesign Challenges	Project development stage

In year financial plans assume the impact of any slippage in implementation is £0.6m, which results in a year end in year deficit of £1.8m. A number of non recurrent measures have also been identified to the value of £1.0m (a further 2.1% of the board's baseline). These are shown in Table 1.3 below.

Table 1.3: Non-recurring Efficiency Savings Proposals	LDP Plan	Low Risk	Medium	High Risk
	£	£	£	£
2016-17 Forecast Underspend brought forward as at month 11	100,000	100,000	0	
Profit on Sale of 52 Nederdale on or before 31 March 2017	63,600	63,600	0	
50% of Reserve not utilised	476,900		476,900	
Acute Services 2017-18 Non recurring plans	78,917	78,917	0	
Community Services 2017-18 Non recurring plans achieve same as 2016-17	100,000		100,000	
Finance Non-recurring 2017-18 Non Recurring Plan	35,633		35,633	
Chief Executive 2017-18 Non Recurring Plan: Partnership Fund	30,000		30,000	
Board Chair Joint with NHS Orkney	5,580	5,580	0	
Technical Financial Challenge: Schemes used elsewhere in 2016-17?	97,000		97,000	
Potential Profit on sale of excess properties.	50,000		0	50,000
Overall Total Non Recurring Efficiency Savings Proposals	1,037,630	248,097	739,533	50,000

It is also anticipated that the Integration Join Board will contribute a further £0.3m from its reserves towards the slippage in their savings schemes and these measures leave the Board with a projected yearend overspend of £0.5m (1% of the boards baseline allocation).

(NB: The figures above are based on a "whole health system" basis and therefore include the financial projections within the IJB. Savings identified also therefore include assumptions on proposed savings schemes that will be delivered by the IJB).

Delivering sustainable financial balance our approach

As indicated above, NHS Shetland's local financial plan covers a five-year period as returning to recurring financial balance in one year is not considered realistic. The LDP financial plan covers years one to three of this plan.

The projected brought forward savings requirement outlined in table 1.1 is equivalent to 4.6% of the Board's core funding in 2017-18.

At the end of 2017-18 this is projected to fall to 2.7% on the assumption that all of the proposed recurring saving schemes are delivered as planned. Additional schemes are required beyond 2017-18 to continue this downward trend in future years.

The projected overall efficiency savings requirement of £4.6m, to be delivered in 2017-18, is equivalent to 10.2% of the Board's core baseline funding. A breakdown of this target is shown in table 2.1.

Table 2.1 Analysis of causes for NHS Shetland 2017-18 Efficiency Targets

	£
Savings Target Carried Forward (As at month 10 2016-17)	2,100,999
To meet SG Plan of 3.0% for Public Sector	1,308,000
Additional Local 1.0% Target in 2017-18	443,000
Additional Costs Pressures - Primarily High Cost Drugs	330,000
Social Care Contribution for 2017-18	420,000
Net Target	4,601,999

In planning for 2017-18, the Board has fully recognised local recurring cost pressures and general inflation factors and has funded these within the planned 4% savings target and the general 1.5% inflation uplift the Board received on core funds. The use of the Board's general inflation uplift to fund the new Social Care contribution had not been included within the Board's draft financial plan, agreed at the beginning of December 2016. The change to the PPRS receipt assumption and the increase in the budget required for High Cost Medicines have also contributed to the need for £2.5m in new savings in 2017-18. The new savings target is equivalent to 5.6% of the Board's core funding in 2017-18.

In addressing Efficiency & Productivity (E&P) it is recognised this is closely linked to both the Quality and Redesign agendas.

To provide local direction to the E&P agenda, NHS Shetland established an Efficiency & Redesign programme. This programme is managed through our Executive Management Team, is reviewed bi-monthly at a Programme Board meeting and reports on a regular basis to the Board's Strategy and Redesign committee. Overall progress and the financial impact is reported to each Board meeting and Strategy and Redesign committee as part of their regular financial reports.

NHS Shetland recognises that further recurrent investment in the local Service Improvement and change teams, to increase and create sustainable capacity to support the overall Improvement and redesign agenda, is critical to achieving financial balance. This includes investing in training local staff to utilise national toolkits and local information to deliver evidence based change. This will require short term funding to support the delivery of the ambitious efficiency programme and will require additional non-recurrent efficiencies to generate the resources required.

To help address this capacity £250k of the additional NRAC parity allocation recently identified (£750k in total) has been earmarked to support change projects.

The balance of the NRAC parity funds will be used in 2017/18 to create an additional reserve that is expected to be used in 2017/18 on a non-recurrent basis to reduce the in year savings gap.

The 2017-18 to 2019-20 financial plan

The financial plan contained within this document is based upon the paper discussed at the Board Meeting on 14 February 2017 and Strategy and Redesign committee meeting on 14 March 2017.

In the financial plans, all recurring savings are stated at full year effect and there is therefore a requirement for non-recurring savings to address the gap between the full year effect and in year delivery. An estimated value for these additional non-recurrent savings is currently only available for 2017-18.

NHS Shetland introduced a 1.0% general contingency plan into the Board budget in 2013-14 and this general contingency fund continues to be built in to these financial plans. The additional NRAC funding will allow an increased reserve to be available to support the Board's plan on a non-recurrent basis. The financial plan also provides for a 1.0% cost pressure or development fund in the final four years of the plan to address future service needs. To create this additional funding in 2017-18 and 2018-19, as outlined in table 3.1, the Board has planned for a 4.0% efficiency saving target rather than the national 3.0% target.

The plan assumes that the Social Care Fund will increase further in 2018-19 to 2019-20, and that the mechanism for funding this increase will be based on the arrangements in 2017-18.

The plan contains a number of assumptions that are summarised in table 3.1.

Table 3.1: General Assumptions In 2017-20 Financial Plan

	2017/18	2018/19	2019/20
Uplift to Core Budget	1.50%	1.50%	1.50%
Uplift to Bundle Funding	0	0	0
Pay Inflation	2.05%	2.05%	2.05%
Apprenticeship Levy	0.50%	0.00%	0.00%
Prescribing Inflation and Growth Net Uplift	4.00%	4.00%	4.00%
General Inflation	1.50%	1.50%	1.50%
Resource Transfer	+1.5% less 4% Efficiency	+1.5% less 4% Efficiency	+1.5% less 3% Efficiency
Rates & Water	23.00%	2.00%	2.00%
Utilities	4.00%	4.00%	4.00%
Income	1.50%	1.50%	1.50%

The key assumption is that the core baseline funding increases by 1.5% per year from 2018-19 and that there are no inflation uplifts or deduction in bundle funding.

The plan assumes base line pay inflation remains at a general 1%, with additional costs arising from pay increases for those below £22,000 and general incremental drift. The impact of the apprenticeship levy has been factored in to 2017-18 costs and is part of the reason why the savings target was increased in 2017-18.

The current financial projection assumes that the NHS Grampian Acute Services SLA value increases by £0.3m in each of the next 2 years to fund the agreed increase in the tariff value above the basic inflation uplift. Similarly the NHS Grampian Mental Health Services SLA value increases by £0.05m in each of the next 2 years to fund the proposed increase in the tariff value above the basic inflation uplift. These increases reflect the amount NHS Grampian currently "under charges" NHS Shetland based upon current historic tariff values.

In respect of the new drugs fund, NHS Shetland has set aside a reserve that takes account of our anticipated share of the resource envelope for these drugs plus local investment to match the 2016-17 out-turn and estimated cost increase in 2017-18.

In respect of CNORIS the Board has provided for a local budget that assumes the National cost of CNORIS is £50m.

Depreciation costs are based upon current best estimates and are subject to revision once the 2016-17 capital outturn position and the 2017-18 capital programme is confirmed.

Capital Planning

The capital planning assumptions made within the five year planning cycle is that the base allocation is constant throughout this period.

However within this timescale there are four key projects that require to be delivered that are not within this financial envelope

1. Ambulatory Care Centre, est: circa £1.4m
2. Replacement Fluoroscopy X-ray equipment, est: circa £0.8m
3. In-patient ward redesigns, est: circa £6.0m
4. Replacement CT Scanner, est: circa £1.2m

The Ambulatory Care centre project is proposed to start in 2017-18 but only in respect of the design fees being incurred. The Initial agreement for this scheme is currently under development and will be submitted to the Capital Investment group in due course.
None of the other projects start in 2017-18, although work will commence on appropriate Initial agreements and planning.

Sustainability and Value

To achieve greater sustainability and value from NHS Shetland, we have set out in this Plan / the LDP in general how we intend to minimise waste, reduce variation, to standardise and to share including:

- Implementation of the Effective Prescribing programme;
- A quality and cost assessed improvement plan to respond to Productive Opportunities identified from benchmarked performance;
- Reducing medical and nursing agency and locum expenditure as part of a national drive to reduce this spend by at least 25% in-year; and
- Implementation of opportunities identified by the national Shared Services Programme

Effective Prescribing Programme

The detail of the Effective Prescribing Programme is outlined in the Community Health and Social Care section at pages 35-36.

Potential Productive Opportunity Analysis (PPO)

An analysis has been done by the Scottish Government to identify some of the areas where routinely collated data suggest there may be opportunities for NHS Shetland to elicit some potential productive opportunity (PPO).

The variation between Boards is acknowledged and NHS Shetland faces many fixed costs and diseconomies of scale, recognised in the funding models that result in a comparatively higher unit cost per activity. NHS Shetland operates in a remote and rural setting, with dispersed populations across 15 inhabited islands. Some islands have a population of below 100; one island is below 20 people.

Other factors which might impact on our cost base include difficulties in recruiting to certain posts and requiring locum and agency cover to cover core service provision. There are also significant transport and logistical costs associated with the movement of goods and people within the islands and to and from mainland Scotland.

NHS Shetland remains keen to benchmark with similar boards with a view to continuous improvement.

The data highlighted that **Theatres Cancellations, Procedures of Limited Value and Infrastructure Costs** may be useful places to focus. Further, where there are opportunities in identified clinical areas such as cost per inpatient stay, the Effective Care Pathways work, is looking at unwarranted clinical variation.

The Table below identifies which of the Strategic Programmes take account of the Potential Productive Opportunities (PPO) highlighted.

Areas for Improvement Investigation	PPO £000	Linked to Strategic Programme:	Link to Financial / Efficiencies Plan £000
Inpatient cost per case – move to Scottish average	1,685	Sustainable Hospital	472
Day Patient cost per case– move to Scottish average	77	Sustainable Hospital	
Outpatient - AHP cost per attendance– move to Scottish average	301	Sustainable Primary Care	
A&E cost per attendance– move to Scottish average	979	Unscheduled Care	150
Ambulatory Care Amenable Conditions -– move to Scottish average	125	Sustainable Hospital	
BADS - move to Scottish average	6	Sustainable Hospital	
Theatres Efficiencies - eliminate cancellations due to capacity reasons	243	Sustainable Hospital	
Medical Locums – reduce by 20%	278	Sustainable Hospital	
Nurse Bank - reduce by 10%	31	Sustainable Hospital	
Nurse Agency - reduce by 20%	6	Sustainable Hospital	
Admin - move to Scottish mean performance per £1K gross hospital costs	145	Improve Business Efficiency	
Catering - move to Scottish mean performance per hospital inpatient week	256	Improve Business Efficiency	197
Cleaning - move to Scottish mean performance per SqM	120	Improve Business Efficiency	
Portering - move to Scottish mean performance per SqM	79	Improve Business Efficiency	
Laundry - move to Scottish mean performance per Inpatient week	41	Improve Business Efficiency	
Energy – move to Scottish mean performance per SqM	157	Improve Business Efficiency	See 197 above
Total	4,529		819

Reducing medical and nursing agency and locum expenditure as part of a national drive to reduce this spend by at least 25% in-year

In 2015-16, NHS Shetland spent £1.6m on medical and nursing agency and locum expenditure. This is forecast to be £1.9 in 2016-17.

The target saving of 25% therefore equates to £0.4m in 2017-18.

NHS Shetland is in the process of putting in place new procurement arrangements for interim staffing.

The Strategic Programmes to redesign acute and primary care services are done with the intention of resolving the underlying difficulties in recruiting to certain posts in specific locations and this will also reduce bank, agency & locum spend.

NHS Shetland is also fully involved in the North of Scotland Workforce group and Scottish Rural Medical Collaborative that are both involved in long term work to improve the supply, recruitment and retention of key staff groups that will also support the reduction of spend in these areas.

Implementation of opportunities identified by the national Shared Services Programme.

NHS Shetland is also an active participant in the National Shared Services programme, some of the impact of which is included in the Potential Productive Opportunity table above.

There are often logistical and transportation reasons as to why it is difficult for NHS Shetland to fully participate in national solutions. However, use of technology can sometimes overcome geographical barriers.

Specific projects which NHS Shetland intends to participate in include:

- Human Resources
- Diagnostic Services
- Catering
- Laundry

NHS Shetland has already entered into shared services arrangements with NHS Grampian in relation to Finance (Payroll and Accounts payable) and National Services Scotland with respect to the management of our procurement services.

Workforce Plan

The core purpose of NHS Shetland is to provide the healthiest life possible for the 23,000+ people who live and work in Shetland and to achieve this we are committed to continual service improvement both in service delivery and population health to help deliver the Scottish Government 'Everyone Matters' 2020 Vision for Scotland and the Quality Strategy.

We are currently working in Partnership with our colleagues in Shetland Islands Council to reframe our OD Strategy to take cognisance of the Health and Social Care agenda and to join up the People strategies wherever possible.

The main narrative for NHS Shetland's Workforce plan will be contained within our Workforce Plan that we are governed to submit under CEL32(2011).

We are utilising this year as a transition year as the National Workforce planning process is currently under review and therefore like other Northern territorial Boards are opting to update our projections and action plan so that the capacity that we have can be focussed on developing a planning process both locally and across the North region linked to our local Service delivery integrated plan and the Service Delivery plan for the North.

We are committed to looking at how we can attract and retain staff to improving staff health, safety wellbeing and motivation. Resilience and sustainability is a key factor in delivering patient focused centred services and we will continue to focus on the five priority areas in the 2020 Workforce Strategy "Everyone Matters", namely: a healthy organisational culture, sustainable, capable and integrated workforce and effective leadership and management.

Our deliverables under this agenda for 2017/18 will be described in more detail in our Staff Governance Action plan and will include how we:

- prioritise workforce investment and development in themes linked to redesign;
- work with an ageing workforce undertaking a review of retiral trends over the last five years to understand the likely impact for our future workforce and to make more intelligent predictions about when particular groups of staff may retire and how we support;
- look to recruit when our target audience is either from England or Europe and the impact/affect of a potential Scottish Referendum and Brexit; and
- get young people interested in a career within Health and Care; all the more complex when trying to establish in a financially difficult situation when the focus is on financial short term immediacy as opposed to investment for medium/long term recruitment gains.

The Board on an annual basis publishes its Workforce Plan and consistently uses the national workforce and workload tools and its service plans and associated staffing levels are predicated on that. Due to our challenging financial efficiency targets each Director is looking at its workforce and taking steps to reduce headcount. Our financial position means that for a number of service areas reducing headcount no longer means opportunistic head count savings but in 2017/18 and beyond means placing staff on the Redeployment register and describing the risks around service provision and quality. We are also looking at what services we can no longer provide or provide in the same way as we do currently. Service redesign and service Improvement therefore have a key focus on our future service delivery and head count. These work streams are set out in the 10 Strategic Programmes.

As a board we have for a number of years monitored the demographics of our workforce including age profile and are utilising that in conjunction with the afore mentioned tools to ensure not only appropriate numbers but appropriate skill mix and development roles for staff. An example of where this is currently in development is in our Medical Imaging Department where last year we highlighted in our LDP that this was an area of concern for us both locally in terms of our staffing profile and nationally with key shortages. Working with the local team we have created a future delivery model that builds in resilience, succession planning, opportunities for career development and an efficiency financial saving.

There are currently a number of workforce concerns being addressed some of which are national or regional and some local. Our issues are reflected in the National Clinical Strategy and our challenges on recruitment and retention do impact on the sustainability of services. We have been fortunate as evidenced in our Annual and Mid Year reviews to still be able to be delivering well against the HEAT targets but like all Health Boards we have particular issues. We have been upfront with Scottish Government colleagues around issues with having appropriate dialogue around service delivery and how to deliver services differently with our colleagues in NHS Grampian, and whilst Scottish Government colleagues have offered to facilitate further dialogue in how they support these conversations around particular patient pathways, the reality is that our colleagues in Grampian are struggling with the same workforce issues that we have and getting senior consistent clinicians around the table to talk about facilitating different pathways is difficult and complex. NHS Shetland is a very small part of the NHS Grampian delivery model and for pathways to be changed in a whole system way will take a sustained amount of effort by all parties.

Working in remote, rural and island settings is a constant challenge for staff who need to have a generalist skill set to deal with whatever, whomever and whenever. NHS Shetland serves not only a local population on both mainland and outer isles but also transient North Sea and Oil and Gas workers.

In Primary Care (Health) we have real issues in recruitment. By the 1st June 2017, seven out of the ten GP Practices based in Shetland will be employed practices. We have struggled to

recruit to substantive GP posts particularly in more remote areas and whilst we have the drivers of the National Primary Care Strategy and National Clinical Strategy focusing on multidisciplinary team working to reduce pressures on services and ensure improved outcomes for patients with access to the most suitable professional recruitment remains a challenge. We are utilising the Government's Primary Care fund to help support initiatives in recruitment and retention and are part of the Scottish Rural Medicine Collaborative Programme where the focus is on the recruitment and retention needs of remote and rural General Practice in Scotland. As part of that group we have 6 Programmes of work that we are taking forward:

- Production of a rural GP Recruitment Good Practice Guideline
- Production of rural GP Recruitment Yearly wheel
- Production of rural GP marketing resources
- Defining a rural GP Community of Practice model
- Creating a rural GP Recruitment and Retention Toolkit and
- Developing better rural GP Recruitment support

In community nursing we have been as high as 35% down on overall nursing numbers in the last financial year and are currently 20% down on overall staffing numbers, particularly in nursing staff for the Non Doctor Islands.

We are currently developing our ANP model and are engaged in a redesign project with external consultants to look at the Configuration of Community Nursing.

Last year we developed 2 videos to support GP recruitment and we are currently developing this further with further videos and days in the life of ANP's, OTs, Consultant Physicians and Theatre teams.

Whatever we do we need to design quality services that are sustainable and as a Board we will need to make tough workforce investment V disinvestment decisions about what services we can afford to provide. We have a £4.6 million deficit forecast for 2017/18 and therefore how we provide viable services and deliver elements of Scottish Government policy will be a fine balance.

<u>Responding to the National Health and Social Care Delivery Plan</u>

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 service 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".*

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

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:

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, has caused significant delay to progress. Longer term costs may shift from HR if the demand for administration support across other services increases to support 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.

Appendix 1:

Mapping NHS Shetland Strategic Programmes to the National Health and Care Plan

The following tables maps how each of the Government's commitments in the National Health and Care Plan will be address by NHS Shetland.

Government Commitment	**NHS Shetland Key Delivery Mechanisms (Strategy / Strategic Programme)**
People will be equal partners with their clinicians, working with them to arrive at decisions about their care that are right for them. They will be supported to reflect on and express their preferences, based on their own unique circumstances, expectations and values. This might mean less medical intervention, if simpler options would deliver the results that matter to them.	Effective Prescribing Asset Based Approach (Realistic Medicine)
People will be supported to have the confidence, knowledge, understanding and skills to live well, on their own terms, with whatever conditions they have. They will have access to greater support from a range of services beyond health, with a view to increasing their resilience and reinforcing their whole wellbeing.	Sustainable Primary Care
Hospitals will focus on the medical support that acute care can and should provide, and stays in hospital will be shorter. Individuals will benefit from more care being delivered in the community, and where possible, at home.	Sustainable Hospital Model Sustainable Primary Care Sustainable Social Care
Everyone will have online access to a summary of their Electronic Patient Record and digital technology will underpin and transform the delivery of services across the health and social care system.	Improving Business Performance and Efficiency
Children, young people and their families will benefit from services across the public sector – including health, education, social care and other services – working together to support prevention and early intervention of any emerging health issues.	Children and Young Peoples Integrated Strategic Plan
The diet and health of children from the earliest years will improve from coordinated and comprehensive nutritional support for children and families.	Children and Young Peoples Integrated Strategic Plan

Government Commitment	**NHS Shetland Key Delivery Mechanisms (Strategy / Strategic Programme)**
There will be a significant reduction in the harmful impact on health of alcohol, tobacco and obesity, and our approach to oral health will be founded on prevention.	Alcohol and Drugs (Substance Misuse) Strategy
People will have access to more and more effective services across the health system to support mental health, including the specialist services for children and young people. Mental health will be considered as important as physical health.	Mental Health Strategy Sustainable Mental Health Services
People will lead more active, and as a result, healthier lifestyles	Public Health 10 Year Action Plan
People will receive more sensitive, end of life support that will aim to support them in the setting that they wish. All those who need hospice, palliative or end of life care will receive it and benefit from individual care and support plans. Fewer people will die in hospitals.	Sustainable Primary Care Sustainable Social Care
Most care will be provided locally through an expanded Community Health Service, avoiding the need to go into hospital.	Sustainable Primary Care Sustainable Social Care
People will benefit from local practices and other community care with a wider range of available support. Practices will typically consist of complementary teams of professionals, bringing together clusters of health support and expertise. Communities will have access to quicker and joined-up treatment – this might be the GP, but supported by a team including highly-trained nurses, physiotherapists, pharmacists, mental health workers and social workers. GPs will take on a greater leadership role.	Sustainable Primary Care

Government Commitment	NHS Shetland Key Delivery Mechanisms (Strategy / Strategic Programme)
Local practices will be able to provide more information and secure better advice for people locally without the need to attend hospitals to get specialist consultancy advice. That advice will be increasingly delivered locally.	Sustainable Primary Care
Families will receive more integrated and extended primary and community care for their children. There will be more home visits from health care professionals, including three child health reviews, and teenage mothers will receive more intensive and dedicated maternal support.	Sustainable Primary Care Sustainable Social Care
Some clinical services will be planned and delivered on a regional basis so that specialist expertise can deliver better outcomes for individuals, services can be provided quicker and stays will be shorter. This will ensure that the services provided to people are high quality and the expertise remains as effective as possible.	Sustainable Hospital Model North of Scotland Regional Strategy
There will be a national set of health priorities giving clear, consistent direction for how to improve public health across the whole of Scotland and a single national body to drive the priorities.	Public Health 10 Year Action Plan
Services and functions of the health service which can be delivered more efficiently at national level will be done on a 'Once for Scotland' basis.	Improving Business Performance and Efficiency

Appendix 2 EQIA Rapid Impact Checklist

Local Delivery Plan 2017-18 NHS Shetland

An Equality and Diversity Impact Assessment Tool:

Which groups of the population do you think will be affected by the Local Delivery Plan? **The Plan aims to ensure equality of access to all groups of the population.**

Other groups:

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

N.B The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed	What positive and negative impacts do you think there may be?
	Which groups will be affected by these impacts?
What impact will the Local Delivery Plan have on	

lifestyles? **For example, will the changes affect:** • Diet and nutrition • Exercise and physical activity • Substance use: tobacco, alcohol and drugs? • Risk taking behaviour? • Education and learning or skills?	The Prevention and Health Inequalities section of the LDP will have a positive impact on lifestyles. We work hard on targeting our programmes to ensure that they are focussed on those in most need, so that we don't inadvertently increase health inequalities.
Will the Local Delivery Plan have any impact on the social environment? Things that might be affected include: • Social status • Employment (paid or unpaid) • Social/Family support • Stress • Income	Improved access to Mental Health Services including the Substance Misuse Service, will have a positive impact on the social environment. The Keep Well programme aims specifically to reduce inequalities where possible. The Prevention and Health Inequalities section details how we are tackling health inequalities in Shetland.
Will the Local Delivery Plan have any impact on the following? • Discrimination? • Equality of opportunity? • Relations between groups?	Smoking cessation is an example of a programme where we capture equality data and modify our programmes appropriately to ensure equality of opportunity, etc. The maternity department is working hard to ensure that maternity services are accessible

	to all. Waiting times targets aim at 100% compliance which reduces inequalities in access. The work on tackling inequalities for people with learning disabilities has a specific focus on reducing discrimination and ensuring equality of opportunity.
Will the Local Delivery Plan have an impact on the physical environment? For example, will there be impacts on: • Living conditions? • Working conditions? • Pollution or climate change? • Accidental injuries or public safety? • Transmission of infectious disease?	Healthcare Associated Infection targets aim to reduce transmission of infectious diseases both for patients and staff. The Patient Safety and Quality of Care agendas contribute to preventing and improving the clinical environment and public safety.
Will the Local Delivery Plan affect access to and experience of services? For example, • Health care • Transport • Social services • Housing services	Access targets aim to reduce the waiting times patients have to receive services. The Patient Safety and Quality of Care agendas contribute to improving the experience of people receiving services.

• Education	

Rapid Impact Checklist: Summary Sheet

Positive Impacts (Note the groups affected)	**Negative Impacts (Note the groups affected)**
General health Mental health Access to services Physical environment	None. Service changes need to continue to monitor potential adverse impacts and mitigate where necessary, through the process of continued impact assessment.

Additional Information and Evidence Required

None

Recommendations

None

From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?

No negative impacts identified, so no full EQIA required.

Health Performance and Delivery Directorate
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Ralph Roberts
Chief Executive
NHS Shetland

17 May 2017

Dear Ralph

NHS SHETLAND: LOCAL DELIVERY PLAN

1. The challenges that NHSScotland face mean that we need to deliver fundamental reform and change to the way that the NHS delivers care. The Health and Social Care Delivery Plan sets out the actions required to reform and further enhance health and social care services. Through the triple aim approach we must prioritise the actions which will have the greatest impact on delivery on better care, better health and better value.

2. We acknowledge the planning that you have already carried out and that further planning is underway in your Board and Region.

3. It is vital that work now moves at pace in collaboration with Integration Authorities, acknowledging their statutory planning remit, to ensure the transformational change needed can be effectively delivered. Only by adopting a whole system approach can assurance be given that any potential financial and delivery risks have been identified and mitigated.

4. Regional planning and delivery is a key component of the Delivery Plan, and over the coming months I expect Boards to work collaboratively to develop Regional Delivery Plans (RDPs), setting out broad actions and priorities. Initial plans should be submitted through your Regional Implementation leads by the end of September 2017. Finalised plans should be submitted by the end of March 2018. You should consider whether aspects of the RDP will impact on your current (2017-18) LDP and update this accordingly by the end of September. Regional Planning Guidance will be developed over the summer to support these plans including the submission process.

5. As Accountable Officer, you have a responsibility for ensuring that the resources of your Board are used economically, efficiently and effectively. Your LDP financial plan forecast an outturn deficit for 2017-18. As a result, I would ask that following the first quarter of this financial year, you submit a revised plan to the Scottish Government detailing the steps in place to address this forecast deficit and for the Board to deliver financial balance this year. This should be submitted no later than 31 July 2017 and will be followed up formally as part of an in-year review meeting to happen in either September or October. The revised plan should include an update on the progress made by the Board in relation to the sustainability and value programme.

6. Further specific feedback is set out in the accompanying annex.

7. If you have any questions about this letter, please contact Jim May in the East Performance Management Team or Dan House in the West Performance Management Team. May I take this opportunity to offer my thanks to you and your team for all of your hard work in 2016-17.

Yours sincerely

JOHN CONNAGHAN CBE
NHSScotland Chief Operating Officer

ANNEX

1. Regional Planning

Regional Planning Guidance will be developed over the summer and we expect outline Regional Delivery Plans, setting out broad actions and priorities, to be submitted by the end of September 2017. Finalised plans should be submitted by the end of March 2018. NHS Boards will also want to consider whether this will impact on their current (17/18) LDPs and update these accordingly. We will continue to engage with NHS Boards around the development of the LDP process and its relationship to regional planning over the coming months.

2. Integration

The Health and Social Care Delivery Plan includes a focus on reducing inappropriate use of hospital services, improving links between Acute Hospital and Primary Care teams to improve patient care by appropriately shifting resources to primary and community care and supporting the capacity of community care. This demands a more coherent whole system strategic planning approach than that which currently exists. Moving forward and building on the improvement plans shared by Integration Authorities and LDPs submitted to Scottish Government, it is imperative that work now moves at pace in collaboration with Integration Authorities, acknowledging their statutory planning remit, to ensure the transformational change needed can be effectively delivered. Only by adopting a whole system approach can assurance be given that any potential financial and delivery risks have been identified and mitigated.

3. Waiting Times

You will be aware that additional funding is being identified for elective services for 2017/18 and should be announced shortly. The Scottish Government Access Support Team are engaging with your executives on elective plans and trajectories for 2017/18. We expect that regional capacity will be a key consideration in local planning so as to minimise activity being carried out in the independent sector. NHS Boards must ensure that clinical priority is given to patients – including cancer and patients referred with urgent status.

We expect that the template on activity, finance and performance circulated by the Access Support Team on 12 May 2017 will be completed by the end of May 2017 in accordance with the agreed timescale set out in the letter. Following receipt we will release additional funding on sign-off. We anticipate the release of funds will occur no later than mid-June.

Please be advised that we will be holding a second tranche investment for release in September 2017 against receipt of Regional Plans.

Steps are also being taken to strengthen improvement capability to improve elective services, particularly around the modern outpatient programme and MSK waiting times. These steps, alongside the capital investment in elective centres, will transform elective services in Scotland. There is also a requirement for initial

regional sign off of elective centres plans by June 2017 with next stage approval as part of the Regional Delivery Planning process.

4. Alcohol Brief Interventions (ABI)

The Board are facing challenges in delivering the current ABI target and it is expected that planning will support improved performance in 2017-18. The Scottish Government will continue to offer support where necessary and will discuss progress with you throughout the year.

5. Drug and Alcohol Waiting Times

The Board should be commended for continuing to meet current targets around Drug and Alcohol waiting times and it is expected that this will continue to be built in to future planning throughout 2017-18.

6. Unscheduled Care

Through the 6 Essential Actions programme objectives and funding for unscheduled care in 2017/18 have been agreed on the basis that further improvements will be delivered. This will build on Scotland's good performance in comparison to other countries. A greater focus this year will be placed on joint working across Integration Authorities to further improve processes to:

- Ensure that patients are discharged as soon as they are fit and ready, given the negative impact delay has on patient outcomes and service efficiency, and where appropriate, maintain patient care in a community/homely setting.

- Supporting the avoidance of unnecessary admissions.

NHS Boards and their partners must also ensure that they address the patient care delay evidenced by the poorer rate of discharge at the weekend compared to midweek rates. This requires a whole system response, but the benefits to patients and optimal use of resources will be material. The national 4 day public holiday review will help NHS Boards and Integration Authorities tackle this key issue. Boards should not await the outcome of this group, given the potential whole system performance and financial benefits improving performance in this area will deliver.

7. Primary Care

We expect NHS Boards to be working with their Integration Authorities in developing the delivery of primary care services (General Practices, Dentistry, Optometry, Pharmacy). The Health and Social Care Delivery Plan makes it clear that primary care services need to be better resourced and more flexible to deliver a service that is fit for patients and work "hand in glove" across the sectors. We expect your Board, with strategic guidance and support from Integration Authorities, to consider how to deliver new ways of working within primary care for both in and out of hours services linked effectively to acute services. It will be particularly important to consider the development of GP clusters in line with the National GP Cluster

Framework, and the creation of robust plans to ensure GP practices at risk of becoming unsustainable are identified and supported.

As the primary care transformation programme moves into a maturity phase, we will expect to see a focus on sharing and spreading the impact of tests of change, and mainstreaming activities and processes that are working well. Existing programmes of monitoring and evaluation should also continue.

We expect progress to continue to be made on the recommendations made in the National Review of Primary Care Out of Hours Services.

As you develop your regional plans, we would expect a continued focus on transforming primary care, with a particular focus on the recruitment and retention of the primary care workforce, as well as ensuring a joined-up approach with the Scottish Ambulance Service and NHS 24.

8. Person-Centeredness and Patient Safety Programme

In January the Scottish Government wrote to NHS Boards' Quality and Safety Leads, Safety Programme Managers and Person-Centred Programme Managers, to provide further advice on setting this year's improvement aims for safety and person-centeredness. The Scottish Government will be in touch with Boards over the coming weeks to arrange a series of visits and conversations to discuss local priorities.

9. Healthcare Associated Infection

Reducing Healthcare Associated Infection remains a key priority for the Scottish Government and we would ask you to continue working towards reductions in healthcare associated infections and appropriate antimicrobial prescribing.

10. Digital Health & Care

Work is underway to develop a new approach to how we use digital technology, this will position our NHS as a digital first organisation that will support a digitally-active population, a digitally-enabled workforce, health and social care integration, whole-system intelligence and sustainable care delivery. We will continue to consult with Boards on this development. In preparation for this change, Boards are asked to consider how digital can support all service changes and will wish to consider how digital technology can further support the actions outlined in their LDPs above and beyond their existing work on technology enabled care and eHealth, including supporting their workforce.

I would also ask that you review the action that you took in relation to my letter of 21 February 2017 on cyber security resilience.

11. Workforce

As part of the implementation of Everyone Matters: 2020 Workforce Vision Implementation Plan 2017-18, we expect continued progress against the 5 priorities:

healthy organisational culture, sustainable workforce, capable workforce, a workforce to deliver integrated services and effective leadership and management.

A National Health and Social care Workforce Plan is planned for publication in Spring 2017. NHS Boards are expected to publish their workforce plan during 2017.

Strengthening the approach to Nursing and Midwifery Workforce planning will be a focus this year. We expect to see evidence that the Nursing and Midwifery Workload and Workforce Planning Tools have been applied to all clinical areas where validated tools are available and that a triangulated approach has been taken.

12. Mental Health

The Scottish Government's Mental Health Strategy, published in March 2017, set out its ambition to deliver "parity of mental and physical health" over the next 10 years. This is the first national strategy since the integration of health and social care and Health Boards and Integration Authorities should continue to work collaboratively to ensure its successful implementation through widening access to services and supporting earlier intervention.

13. Maternity, Neonatal and Early Years

The Scottish Government will continue to provide support to Boards and their partners to deliver additional Health Visitor numbers, alongside delivering the Universal Health Visiting Pathway and Family Nurse Partnership expansion. The progress made to date is welcome and should be maintained. The emphasis on prevention and early intervention to improve the lives of all children should feature strongly as part of any future decision making and planning.

As outlined in the Health & Social Care Delivery Plan we expect NHS Boards to continue to have a focus on early intervention for children through addressing needs identified through the Universal Health Visiting Pathway, which started in 2016. As a result of this, every family should be offered a minimum of 11 home visits by a qualified health visitor including three child health reviews by 2020, ensuring that children and their families are given the support they need for a healthier start in life.

14. Reduce Unscheduled Bed-days in Hospital Care

The Health & Social Care Delivery plan sets out the intention to reduce unscheduled bed-days in hospital care by 400,000 bed days by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. NHS Boards will be working in partnership with their Integration Authorities towards delivery through the work on "Health and Social Care Integration - Local Improvement Objectives" and "6 Essential Actions programme" to ensure all relevant programmes of work are joined up, not least through respective Board and Integration Authority planning processes. Annex 1 provides some relevant statistics to support this work to reduce unscheduled bed-days in hospital care.

15. Next Steps

We expect NHS Boards to report on progress against the LDP to their Boards. The Scottish Government will also consider progress against LDPs at the NHS Board Annual and In-Year Reviews.

Annex 1:

This annex provides some relevant statistics to support work around reducing unscheduled bed-days in hospital care.

Bed Days Occupied by Delayed Discharges in February 2017

NHS Board	Number of bed days for all delays for 18+	Number of bed days for all delays for 75+	Rates per 100,000 population over 75+
Scotland	**40,246**	**28,298**	**6,464.9**
Ayrshire & Arran	**2,938**	**2,562**	**7,435.1**
Borders	**693**	**528**	**4,529.5**
Dumfries & Galloway	**760**	**517**	**3,207.0**
Fife	**1,699**	**1,069**	**3,424.1**
Forth Valley	**2,628**	**1,819**	**7,613.7**
Grampian	**3,806**	**2,637**	**5,933.0**
Greater Glasgow & Clyde	**4,863**	**2,586**	**2,957.9**
Highland	**3,821**	**3,256**	**10,688.4**
Lanarkshire	**5,928**	**4,198**	**8,501.2**
Lothian	**9,049**	**6,498**	**10,431.2**
Orkney	**64**	**50**	**2,384.4**
Shetland	**70**	**62**	**3,395.4**
Tayside	**3,271**	**2,074**	**5,258.1**
Western Isles	**656**	**442**	**14,777.7**

Average Length of Stay for Emergency Admissions (All Specialties)

NHS Board	Average Length of Stay in FY 2015/16[p]	Average Length of Stay in CY 2016[p]
Scotland	**6.9**	**6.9**
Ayrshire & Arran	**6.5**	**6.5**
Borders	**5.1**	**5.3**
Dumfries & Galloway	**8.8**	**8.2**
Fife	**6.6**	**6.5**
Forth Valley	**7.3**	**7.4**
Grampian	**7.5**	**7.5**
Greater Glasgow & Clyde	**6.6**	**6.7**
Highland	**7.8**	**7.7**
Lanarkshire	**5.8**	**5.6**
Lothian	**7.4**	**7.9**
Orkney	**7.2**	**7.6**
Shetland	**5.8**	**6.0**
Tayside	**7.7**	**7.2**
Western Isles	**10.5**	**9.4**

[p] - provisional

Number of Emergency Admissions in 2015/16[p]

NHS Board	Number of Emergency Admissions	Rate of Emergency Admissions per 100,000 population
Scotland	**565,344**	**10,571.9**
Ayrshire & Arran	**50,313**	**13,557.4**
Borders	**14,241**	**12,488.8**
Dumfries & Galloway	**14,759**	**9,843.3**
Fife	**37,526**	**10,217.8**
Forth Valley	**28,546**	**9,502.3**
Grampian	**49,272**	**8,433.5**
Greater Glasgow & Clyde	**138,833**	**12,150.8**
Highland	**28,301**	**8,823.1**
Lanarkshire	**77,543**	**11,869.3**
Lothian	**70,437**	**8,208.6**
Orkney	**1,851**	**8,573.4**
Shetland	**2,048**	**8,816.2**
Tayside	**42,635**	**10,303.3**
Western Isles	**2,817**	**10,337.6**

[p] - provisional

Number of Emergency Bed Days in 2015/16[p]

NHS Board	Number of Emergency Bed days	Rate of Emergency Bed days per 100,000 population
Scotland	**3,914,991**	**73,210.2**
Ayrshire & Arran	**332,450**	**89,582.6**
Borders	**75,935**	**66,592.1**
Dumfries & Galloway	**131,674**	**87,817.8**
Fife	**260,444**	**70,915.4**
Forth Valley	**208,807**	**69,507.3**
Grampian	**372,528**	**63,762.8**
Greater Glasgow & Clyde	**904,908**	**79,198.7**
Highland	**227,248**	**70,846.7**
Lanarkshire	**466,930**	**71,471.4**
Lothian	**528,493**	**61,589.5**
Orkney	**13,459**	**62,339.0**
Shetland	**13,205**	**56,844.6**
Tayside	**325,279**	**78,607.8**
Western Isles	**30,236**	**110,957.8**

[p] - provisional

7 and 28 day Readmissions, July to September 2016

	Surgical Readmissions within 7 Days[1]	Surgical Readmissions within 28 Days[2]	Medical Readmissions within 7 Days[3]	Medical Readmissions within 28 Days[4]
	Standardised Rate[5] per 1,000 admissions	Standardised Rate[5] per 1,000 admissions	Standardised Rate[5] per 1,000 admissions	Standardised Rate[5] per 1,000 admissions
	Jul - Sep 16	Jul - Sep 16	Jul - Sep 16	Jul - Sep 16
Scotland	25.34	45.55	53.42	116.45
Ayrshire & Arran	21.27	41.15	49.46	110.05
Borders	38.02	63.72	50.56	111.41
Dumfries & Galloway	17.25	33.60	44.36	112.37
Fife	42.53	68.43	55.10	127.42
Forth Valley	39.12	61.97	54.76	136.23
Grampian	21.89	42.72	40.69	88.28
Greater Glasgow & Clyde	22.34	41.62	53.61	114.47
Highland	21.19	33.75	49.89	106.73
Lanarkshire	28.02	51.98	64.56	135.05
Lothian	31.54	52.88	55.92	119.93
Orkney Islands	30.89	44.40	40.35	92.75
Shetland Islands	14.86	29.85	30.03	85.63
Tayside	26.83	49.49	59.66	132.58
Western Isles	15.12	24.89	64.58	128.25

Notes:

1 - Numerator = The number of emergency readmissions to any surgical specialty within 7 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a surgical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

2 - Numerator = The number of emergency readmissions to any surgical specialty within 28 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a surgical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

3 - Numerator = The number of emergency readmissions to any medical specialty within 7 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a medical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

4 - Numerator = The number of emergency readmissions to any medical specialty within 28 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a medical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

5 - This measure has been standardised by age, sex and deprivation (SIMD 2009).

Source: ISD Hospital Scorecard

The numbers below show the additional weekend discharges required to bring the proportion of patients who were admitted on a Wed / Thu / or Fri with and had a LOS of 2 or 3 days, up to the average proportion of the rest of the week.

Potential Additional Weekend Discharges*

SCOTLAND	290.1
ABERDEEN ROYAL INFIRMARY	14.5
BELFORD HOSPITAL	0.9
BORDERS GENERAL HOSPITAL	7.7
CAITHNESS GENERAL HOSPITAL	2.3
DUMFRIES & GALLOWAY ROYAL INFIRMARY	10.7
FORTH VALLEY ROYAL HOSPITAL	16.2
GLASGOW ROYAL INFIRMARY	16.1
HAIRMYRES HOSPITAL	9.3
INVERCLYDE ROYALHOSPITAL	8.2
LORN & ISLANDS HOSPITAL	1.3
MONKLANDS DISTRICT GENERAL HOSPITAL	14.7
NINEWELLS HOSPITAL	21.5
PERTH ROYAL INFIRMARY	8.6
QUEEN ELIZABETH UNIVERSITY HOSPITAL	30.3
RAIGMORE HOSPITAL	10.9
ROYAL ALEXANDRA HOSPITAL	11.0
ROYAL HOSPITAL FORCHILDREN	1.8
ROYAL HOSPITAL FOR SICK CHILDREN (EDINBURGH)	1.5
ROYAL INFIRMARY OF EDINBURGH AT LITTLE FRANCE	12.9
UNIVERSITY HOSPITAL AYR	11.3
UNIVERSITY HOSPITAL CROSSHOUSE	21.0
VALE OF LEVEN GENERAL HOSPITAL	1.4
VICTORIA HOSPITAL	10.8
WESTERN GENERAL HOSPITAL	8.4
WESTERN ISLES HOSPITAL	1.8
WISHAW GENERAL HOSPITAL	15.9
WOODEND GENERAL HOSPITAL	0.6

Almost every hospital in Scotland has the potential to increase the number of discharges that they are making at weekends. Analysis suggests that an additional 290 patients who had been admitted in the previous week as an emergency could be discharged every weekend.

These are typically patients admitted on an Wednesday, Thursday or Friday who would normally have a length of stay of two to three days, but who have their length of stay extended to over the weekend. These additional discharges are broadly equivalent to improving acute bed occupancy on a Monday morning by 2%. This is a significant change that would dramatically reduce the levels of boarding, reduce long delays at the front door experienced by patients waiting for admission to an inpatient bed and contribute to safely and appropriately reducing length of stay.

Shetland Islands Health and Social Care Partnership

Agenda Item

5

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	13 July 2017
Report Title:	Directions to Shetland Islands Council	
Reference Number:	CC-37-17 F	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board approves the Directions to Shetland Islands Council set out in Appendix 1.

2.0 High Level Summary:

2.1 On 23 June 2017, the IJB approved a report by the Executive Manager – Governance and Law (SIC) (Min.Ref. 2917) in respect of the legislative requirements for Directions. This set the mechanism and template to be used for the IJB to direct the operational bodies – NHS Shetland and Shetland Islands Council – to deliver the services as required. The template covers, amongst other things, the functions or services, a description of what it is the IJB is directing the parties to do, the resources required, the outcomes expected and the performance monitoring arrangements.

2.2 The IJB is in a position whereby there is a high degree of certainty on the Shetland Islands Council funded services in that there is adequate funding to continue with the existing service models in 2017-18. This report therefore proposes the approval of Directions to Shetland Islands Council.

2.3 However, there remains a gap in NHS funded services and work is progressing on bringing forward options for bridging the funding gap to the IJB meeting on 23 August. The Directions for NHS funded services will therefore follow later in the year, once there is more certainty on the funding arrangements. The current Directions, based on detailed service plans, remains in place until the new Directions are in place.

3.0 Corporate Priorities and Joint Working:

3.1 The IJB Joint Strategic Commissioning Plan (The Strategic 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 IJB is required by law to issue Directions in writing to the Council and NHS Shetland to deliver services in accordance with the Strategic Plan.

3.3 Directions will impose obligations on Shetland Islands Council in respect of matters delegated by the Integration Scheme. Each delegated function and the associated net budget required to deliver the services is detailed in the written Directions.

4.0 Key Issues:

4.1 The Directions, alongside the Service Plans, set out a clear description of what is it the IJB is commissioning from the delivery partners, NHS Shetland and Shetland Islands Council. There is then an expectation that NHS Shetland and Shetland Islands Council will deliver those services, within the resources allocated and achieve the performance targets and outcomes as determined. This will be monitored by the IJB throughout the year, through various performance reports and management accounts.

4.2 The IJB needs a mechanism to action their Strategic Plans and the legally binding Direction is that mechanism.

4.3 In June 2017, the IJB approved the template for the new Directions to the Council and NHS Shetland, which met all the legislative and best practice guidelines. These templates have now been completed for the services wholly funded by Shetland Islands Council within the Integration Scheme. The services which are jointly funded by the Council and NHS Shetland have been held back until the NHS budget work is complete. Therefore the services under consideration at this meeting are:

Service Area
Adult Social Work
Unpaid Carers
Community Care Resources
Criminal Justice

5.0 Exempt and/or confidential information:

5.1 None.

6.0 Implications :

6.1 Service Users, Patients and Communities:	The Strategic Plan sets out the way in which services will respond to the needs of service users, patients and communities. The Directions, and supporting services, plans sets out more detail of the service delivery arrangements, expected outcomes and performance measures for certain categories of service users.
6.2 Human Resources and Organisational Development:	There are no impact on Human Resources and Organisational Development arising from this Report.
6.3 Equality, Diversity and Human Rights:	There are no specific issues to consider.

6.4 Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to issue Directions in writing. The Directions must set out how each function is to be exercise and the budget associated with that function.
6.5 Finance:	The IJB have a statutory responsibility for the delivery of services within the budget allocations.
6.6 Assets and Property:	There are no specific issues to consider.
6.7 ICT and new technologies:	There are no specific issues to consider.
6.8 Environmental:	There are no specific issues to consider.
6.9 Risk Management:	Having in place formal written Directions between the IJB and the delivery partners will assist with clarity of expectation and therefore minimise any potential for misunderstanding in terms of service delivery and performance. It provides the Chief Officer and Chief Financial Officer with clear instructions on what each partner organisation needs to deliver on behalf of the IJB.
6.10 Policy and Delegated Authority:	The IJB was formally constituted on 27 June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration and Financial Regulations. The IJB is responsible for the functions delegated to it by the Council and NHS Shetland. These delegated functions are detailed in the Integration Scheme and the IJB is required to issue Directions to the parties to ensure services are delivered within the allocated budgets.
6.11 Previously considered by:	None

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4 July 2017

Appendices:
Appendix 1 Direction to Shetland Islands Council

Background Documents
Full details of Service provision and Budgetary provisions are contained in the Shetland Islands Health and Social Care Partnership Strategic Commissioning Plan approved on the 10 March 2017 and the Financial Monitoring Report (ref CC-31-17) considered by the IJB on 23 June 2017 http://www.shetland.gov.uk/coins/Agenda.asp?meetingid= 5257 and http://www.shetland.gov.uk/coins/Agenda.asp?meetingid= 5598.

APPENDIX 1

Direction from the Integration Joint Board

Adult Social Work Services

1.	**Reference Number**	IJB date/paper number/unique ref for decision
2.	**Date Direction issued by IJB**	13 July 2017
3.	**Date from which Direction takes effect**	1 August 2017
4.	**Direction to:**	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No
6.	**Functions covered by the Direction**	• Screening of Referral to establish whether or not a social work response is required • Assessment of social need and care management • Mental Health assessment, support and intervention • Adult Support and Protection
7.	**Full text of Direction**	• People are able to look after and improve their own health and wellbeing and live in good health for longer • People are able to live, as far as is reasonably practicable, independently at home or in a homely setting • People who use 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 service users • Contribute to reducing health inequalities • Unpaid carers are supported to reduce any negative impact of their caring role • Service Users are safe from harm • Staff are supported to continuously improve the information, support and care they provide • Resources are used effectively and efficiently in the provision of

		services
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £2,385,625 SIC
9.	**Outcomes**	• To enable older people to remain at home • To maintain or increase levels of independence • To reduce unplanned, emergency and inappropriate admission to hospital • To facilitate discharge from hospital appropriately • To protect adults from abuse • Linked to Our Plan 2016-2020 Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes
10.	**Performance monitoring arrangements**	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018

Direction from the Integration Joint Board

Unpaid Carers

1.	**Reference Number**	IJB date/paper number/unique ref for decision
2.	**Date Direction issued by IJB**	13 July 2017
3.	**Date from which Direction takes effect**	1 August 2017
4.	**Direction to:**	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No
6.	**Functions covered by the Direction**	Implementation of the Carer's Strategy approved by the IJB in January 2017. Cares are:- – Identified – Supported and empowered to manage their caring role – Enabled to have a life outside of caring – Free from disadvantage and discrimination – Fully engaged in the planning and shaping of services – Recognised and valued as equal partners in care.
7.	**Full text of Direction**	Implement the Carer's Strategy Implementation plan (EPiC Principle 1 to 6 Inclusive) in partnership with third sector and carer's representatives.
8.	**Budget allocated by IJB to carry out Direction.**	No specific budget allocation.
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan (2016 - 2020), Shetland's Corporate Plan; the Joint Strategic commissioning Plan and the National Health and Wellbeing Indicators.
10.	**Performance monitoring arrangements**	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018

Direction from the Integration Joint Board

Community Care Resources

1.	**Reference Number**	IJB date/paper number/unique ref for decision
2.	**Date Direction issued by IJB**	13 July 2017
3.	**Date from which Direction takes effect**	1 August 2017
4.	**Direction to:**	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No
6.	**Functions covered by the Direction**	• Residential Care for long term care and short breaks (respite) • Day Services • Care at Home • Domestic • Meals on wheels
7.	**Full text of Direction**	• Review current models of care in Shetland to ensure sustainability of service • Thematic Self Evaluation in the area of Day Care Services • Develop a Performance Management Framework
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £10,031,999 SIC
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes
10.	**Performance monitoring arrangements**	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018

Direction from the Integration Joint Board

Criminal Justice

1.	**Reference Number**	IJB date/paper number/unique ref for decision
2.	**Date Direction issued by IJB**	13 July 2017
3.	**Date from which Direction takes effect**	1 August 2017
4.	**Direction to:**	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No
6.	**Functions covered by the Direction**	• Provision of criminal justice social work services for individuals awaiting sentencing; subject to community based disposals or custodial sentences including;- 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; rehabilitation of offenders who have been subject to custodial sentences and support and advice to family members.
7.	**Full text of Direction**	• Review internal processes and intervention to ensure they remain fit for purpose • Work with partners to plan and deliver services with a focus on recreational and employment opportunities • Raise awareness of criminal justice services within the local community.
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £18,209 SIC
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the

		Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes
10.	**Performance monitoring arrangements**	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018