Shetland Islands Health and Social Care Partnership

Shetland NHS Board	**Shetland Islands Council**

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5 March 2019

Dear Member

You are invited to attend the following meeting:

Integration Joint Board
Wednesday 13 March 2019 at 2.30 p.m.
Bressay Room, NHS Shetland HQ, Burgh Road, Lerwick

Please note the change in time of this meeting.

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.

C Confirm minutes of meeting held on 23 January 2019 (enclosed).

ITEM

1 Financial Monitoring Report to 31 December 2018
CC-13

2 Shetland Islands Health and Social Care Partnership – Quarterly Performance Overview, Quarter 3: October – December 2018
CC-12

3 IJB Medium Term Financial Plan 2019/20 to 2023/24
CC-16

4 2019/20 Budget
CC-15

5 Shetland Islands Health and Social Care Partnership – Joint Strategic Commissioning Plan 2019-2022
CC-14

6 Carers Eligibility Criteria and Directions
CC-11

7 IJB Business Programme 2019 and IJB Action Tracker
CC-17

Agenda Item

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Shetland Islands Council

MINUTES – PUBLIC

Meeting	**Integration Joint Board (IJB)**
Date, Time and Place	**Wednesday 23 January 2019 at 2pm** **Bressay Room, NHS Shetland (NHSS) Headquarters, Montfield, Burgh Road, Lerwick, Shetland**
Present [Members]	**Voting Members** Natasha Cornick Allison Duncan Jane Haswell Emma Macdonald Robbie McGregor Marjory Williamson **Non-voting Members** Sue Beer, Substitute for Third Sector Representative Simon Bokor-Ingram, Chief Officer/Director of Community Health and Social Care Maggie Gemmill, Patient/Service User Representative Susanne Gens, Staff Representative Jim Guyan, Carers Strategy Group Representative Denise Morgan, [Substitute for Martha Nicolson, CSWO] Graham Laing, Clinical Nurse Manager [Substitute for Edna Watson, Senior Clinician – Senior Nurse] Karl Williamson, Chief Financial Officer
In attendance [Observers/Advisers]	Susan Brunton, Team Leader – Legal and Insurance, SIC Ralph Roberts, Chief Executive, NHS Gary Robinson, Chairman of the NHS Board Hazel Sutherland, Head of Planning and Modernisation Leisel Malcolmson, Committee Officer, SIC *[note taker]*
Apologies	**Voting Members** Shona Manson **Non-voting Members** Catherine Hughson, Third Sector Representative Martha Nicolson, CSWO Ian Sandilands, Staff Representative

	Edna Watson, Senior Clinician – Senior Nurse Pauline Wilson, Senior Clinician: Local Acute Sector **Observers/Advisers** Lorraine Hall, Director of Human Resources and Support Services, NHS Jan Riise, Executive Manager – Governance and Law, SIC
Chairperson	Marjory Williamson, Chair of the Integration Joint Board, presided.
Declarations of Interest	None.
Minutes of Previous Meetings	The minutes of the meetings held on 8 November 2018 were confirmed on the motion of Mr Duncan, seconded by Ms Cornick. Min. Ref. 38/18 "Primary Care Improvement Plan Update" – The Chief Officer advised that reference was made at the last meeting to a Direction that would be presented for approval today, however it was advised that a Direction was not required at this time. In terms of the Carer Eligibility Criteria, the Chief Officer said that in drafting a report the financial information was not available therefore the decision was made in consultation with the Executive Manager – Governance and Law that the report would be presented to the next meeting of the Board, if possible. It was noted that the Carer Eligibility Criteria item was listed in the business programme as planned business to be scheduled, and that would be done when all information was available.
01/19	**Shetland Islands Health and Social Care Partnership Quarterly Performance Overview, Quarter 2: July - September 2018**
Report No. CC-04-19-F	The IJB considered a report by the Director of Community Health and Social Care/ IJB Chief Officer and Head of Planning and Modernisation that presented the strategic overview of all elements of progress towards delivering on the strategic plan. The Head of Planning and Modernisation introduced the main terms of the report and advised that the IJB were being asked to also look at the Ministerial Strategic Group indicators as the Scottish Government sought confirmation of the key indicators for 2019/20, and the retention of the current performance objectives and targets were presented for approval. The Head of Planning and Modernisation added that a new risk had been included in regard to Brexit and that was a more strategic level risk with each organisation taking account of Brexit within their own risk registers.

	During questions consideration was given to the alignment of the financial plan with the strategic plan, and it was considered that there was a difference between whether the two would be aligned or balanced. It was noted that progress was being made on elements of spend but the finances were not balanced overall. The good performance on targets was commented on and during further questions some figures in regard to employee costs were questioned and explanations provided. The Chief Officer advised that the longer term view around recruitment and training was being taken, and the invigoration of modern apprenticeships was seen as a positive step. The IJB was informed that a commitment had been made with the AHS to attend careers events and it was hoped that this would be arranged within other Junior High Schools across Shetland. The number of days in hospital was also explained and it was agreed that the target set was challenging but staff work hard to ensure discharges are planned to achieve effective outcomes particularly for complex cases. It was further noted that this figure had been at zero for the last three weeks but this was changeable position. There followed some discussion on the Risk Register and the wording used around targets. More clarity was provided at the meeting and it was agreed that this would be reviewed for future reporting. During further questions it was noted that upon request more detailed information had been provided on Indicator E15 and it was agreed moving forward to provide that on an ongoing basis as part of the performance report. It was also acknowledged that the information provided in Appendix 1A is out of date but it would be refreshed and updated for 2019/20 following the approval of the Joint Strategic Commissioning Plan. Reference was made to the "No Deal Brexit" item on the Risk Register and the implications for the supply of medication. The Chief Officer advised that both the UK and Scottish Governments were leading on resilience plans and that it is known that there are shortages of specific medicines. He said that locally Health Services are reliant on the UK procurement process to get supplies in. It was acknowledged that there are some medicines that had already been in short supply for a number of years so Brexit was not the only issue but it was important to look at alternative routes. The Chief Executive, NHS added that it was not possible to give assurances around this issue in terms of Brexit, but no-one in the UK could, and any additional costs could not be quantified at this time. He advised that Health Boards are being urged not to stockpile medicines as that could also lead to other problems. The Chief Executive, NHS did assure that Officers were in constant dialogue with the Government on this matter. He added that a self-assessment has been provided to

	the Government who are satisfied that NHS Shetland is doing all it can. The Chief Financial Officer informed that weekly bulletins are received and suggested that if there were a financial impact from the No Brexit Deal the Government would have to support that. Further comment was made around the impact of a No Brexit Deal and Officers were asked if the UK and Scottish Governments had been made aware of the special logistical issues that Shetland has being a remote Island area and that efforts should be made to ensure that Shetland is not at the end of the supply chain. The Head of Planning and Modernisation confirmed that remote and rural challenges are part of the planning assumptions being used by the Scottish Government. It was noted that the Carer's Representatives were working with the Strategic Planning Group and Carers Collaborative to identify better indicators for outcome 6 in regard to unpaid carers and their own health. Meaningful indicators would be brought to the Strategic Planning Group and then to the IJB. Mr Duncan moved that the IJB approve the retention of the current performance objectives and targets in respect of the Ministerial Strategic Group Key Performance Indicators 2019-20 as set out in Appendix 3. Ms Cornick seconded and the IJB concurred.
Decision	The IJB **APPROVED** the retention of the current performance objectives and targets in respect of the Ministerial Strategic Group Key Performance Indicators 2019-20, Appendix 3.
02/19	**Financial Monitoring Report to 30 September 2018**
Report No. CC-03-19-F	The IJB considered a report, by the Chief Financial Officer that presented the 2018/19 Management Accounts for the period to 30 September 2018. The Chief Financial Officer introduced the report and noted that due to the timing of closing ledgers the figures had been revised from those presented to Policy and Resources Committee on 11 December 2018. The Chief Financial Officer noted that the overall overspend at paragraph 2.1 were in part due to high locum costs. Reference was made to the Auditors report that picked up on the need for the IJB to approve and take responsibility for its own budget and highlighted the importance of having a Medium Term Financial place of its own. He advised that this would be discussed further at the IJB Seminar on 28 January 2019. Discussion was held around the use of the words "savings targets" at 4.18 and it was suggested that there could be no target without a plan in place. The Chief Financial Officer disagreed advising that the target was to deliver the same service for less money. He

	said that when the target is not met it is carried forward from one year to the next and remains the target until a better position is reached with the funding providers or savings are realised. He said that a Medium Term Financial Plan would show the indicative allocations against the inflated cost of services but at this stage there was limited detail of how to close the savings gap. The Chief Financial Officer said that he understood the frustration around this matter but assured the IJB that work was in progress to redesign services however it was taking time to develop. Chief Executive, NHS provided an update on the current position in terms of the funding gap for the NHS in Shetland and advised that there was a figure of 50-60% reliance of non-recurrent savings across Scotland. He said it was right to flag up that the savings target is not being met and challenge officers on that but work is ongoing on the Medium Term Financial plan however it would not identify choices that the IJB would be willing to make decisions upon and he was not prepared to bring forward options that the IJB would find neither safe nor achievable. The Chief Executive, NHS said that he wanted to ensure that he brought forward a credible plan. The Chair stated that the main focus was to make the Strategic Commissioning Plan into an operational plan. She said that the Health Board held scenario planning on this and upon her request the Chief Executive, NHS provided an update on that and what the next step would be. He advised that the next step was to work on the detail of the elements but these were not at a stage that could be brought before the IJB. The Chief Executive, NHS said that the management team were attending a number of sessions to focus on delivering a the Joint Strategic Commissioning Plan but it would take some time to get to what a balanced plan would look like in time for next year therefore Officers would need to continue to bring forward non recurrent savings plans for next year. A question was put forward on whether the Ministerial Visit had successfully acknowledged the special case that Shetlands location is in terms of high locum costs, travel and accommodation expenses. The Chief Executive, NHS said that Officers had, and continue to have discussions with the Scottish Government on these matters. He said that it was clear that Shetland spends more on Health and Social Care than other areas across Scotland and for valid reasons in terms of additional costs. He said that following the Ministerial visit he was clear that the Scottish Government would continue to support the NHS and that there would be assistance this year but the Minister did not specify a figure. Discussion was held around the need to minimise the need for locums both to reduce costs but to also provide a better service and continuity of care for patients. He commented that there was a lack of knowledge around the uniqueness of Shetland. The Chair confirmed that every opportunity would be taken to raise this issue but it was hopeful that there would be financial support this

	year with more lobbying needed next year. The Chief Executive, NHS was thanked for the work undertaken to get to this stage. *(Mr Laing and Ms Gens left the meeting)* During further discussion an explanation was provided for the figures noted in regard to a £203k overspend in Primary Care. The IJB were advised that these were salary costs as a result of a GP Practice moving from an independent practice to a Health Board practice. It was acknowledged that the staff involved move to a salaried position when such a transfer takes place and often their wages increase in line with the NHS. The IJB noted that GPs from an independent practice can be underpaid to keep the practice going but when they transfer to the Health Board they are paid the correct salary. The Chief Financial Officer advised that now the true costs are known the budget figure could be amended to reflect the true costs. The Chair asked IJB Members to consider whether they are being involved enough in the budget process before the next seminar on 28 January 2019.
Decision	The IJB **NOTED** the 2018/19 Management Accounts for the period to 30th September 2018.
03/19	**Domestic Abuse and Sexual Violence Strategy 2018-2023**
Report No. CC-08-19-F	The IJB considered a report by the Consultant in Public Health Medicine, NHS Shetland that sought approval for a revised Domestic Abuse and Sexual Violence Strategy, on behalf of the Shetland Domestic Abuse Partnership. The Consultant in Public Health Medicine introduced the report and advised that this was different from other strategies as it was a multi-agency strategy and the Head of Planning and Modernisation had assisted in its development. She advised that this is often considered a gender equality issue but men have been included in the Strategy as men can also be affected. The Consultant in Public Health Medicine went on to explain that sexual violence was included due to local concern dating back a number of years. She said that there was emphasis on what is best practice and what can produce good practice. The Consultant in Public Health Medicine also commented on the local activity with other agencies such as Women's Aid and Rape Crisis. She advised that these services no longer have dedicated support or dedicated budget so there is more reliance on the third sector, police and NHS. The Consultant in Public Health Medicine commented on the changing national context around forensic assessments and more work was to come. She also explained that the were a lot of Boards that have MARAC (Multi Agency Risk Assessment Conference) but this is currently voluntary. It is intended that this will be looked at to see if that should become a more strategic function.

	During discussions, the Safer Shetland website was considered a good link for support and it was noted that the Funding Coordinator Role funding would come to an end of March 2019. In terms of feedback, it was acknowledged that there was a lot of input from staff and but it was difficult to share feedback from users. It was noted that more was being done to look at outcomes and Women's Aid were looking at the experiences not just statistics. The IJB were advised that there are quality and quantity figures available through the Service Level Agreement in place. In responding to questions it was intimated that the IJB had provided funding of £5,600/year and that it would be considered again. In terms of allocating budget for this the Chief Officer advised that an invoice submitted and considered within the existing budget set for next year. He said that in terms of scale and benefit it was likely that funding would be provided again. It was then questioned whether the level of funding was sufficient and the Consultant in Public Health Medicine explained that the service was coordinated in Inverness therefore the contribution was right, however there may be a full review in the future on how it is funded. In terms of prevention against domestic abuse and sexual violence the IJB heard that work was being done with Women's Aid on this matter and it was noted that Rape Crisis and other organisations attend schools. It was noted that there was a lot happening in terms of prevention but it was in an uncoordinated way. It was acknowledged that this work should be mapped out to reduce duplication and address any gaps in delivery. Reference was made to this being a growth area and it was questioned whether there was an increase in domestic abuse and sexual violence or was it considered likely to be an increase in reporting. It was noted that work had been done to raise awareness and people were more able to come forward and although it was difficult to know what affected the increase this was a subject that was now less hidden. The Consultant in Public Health Medicine said that if individuals have a positive response and experience a good service this in turn encourages more people to come forward. In response to a further question the Consultant in Public Health Medicine said that there was a link to drinking and drugs in some cases which leads to an incident however it was not always the case however it was sometimes used as an excuse where there is no excuse. Tribute was paid to the staff involved in supporting the individuals accessing these services. In response to a question from the Chair the Chief Financial Officer confirmed that by approving the 'directions' the IJB were not committing money before it had received funding for 2019-20

	and he agreed that should the IJB approve this 'Directions' it was not committing finance. Mr Duncan moved that the IJB approve the recommendations contained in the report. Ms Haswell seconded.
Decision	The IJB **APPROVED:** • the Shetland Domestic Abuse and Sexual Violence Strategy 2018-2023, Appendix 1; and • the Direction for Domestic Abuse and Sexual Violence, Appendix 2.
04/19	**Mental Health Service Review: Findings and Directions**
Report No. CC-05-19-F	The IJB considered a report by the Director of Community Health and Social Care that presented the findings and directions from the Mental Health Service Review. The Chief Officer introduced the report and provided a summary of its content and the decision required. In introducing the Head of Mental Health, the Chief Officer explained that Ms Smith had led an extensive and involved piece of work looking at Mental Health in the round and with social care and health aspects included. It was clear that some efficiency savings could be made without impacting on services but the £200K savings identified could not all be met from Mental Health. He reported that the redesign work offered more resilience with two people doing project work and there is already a better understanding and benefits being reaped around palliative care strategy development and this will come before the IJB in due course. The Chief Officer said that this was an excellent review that validated the work of the Social Care team and the positive impact on individuals. The Head of Mental Health advised that there would be more efficiency savings to be made and that process would also be supported by the third sector. In responding to questions the Head of Mental Health advised that the Service Level Agreement with NHS Grampian allow the service to deliver more specialist services but it should be noted that NHS Grampian were also struggling for specialist services. Reference was made to the building space in Annsbrae being underused and the Head of Mental Health explained the accessibility issues with the listed building and use of the multipurpose building. She advised that she was in contact with the Asset and Property Staff and it was agreed that she would provide an email to IJB members to update on progress in regard to multipurpose accommodation for use by the Mental Health Team. In response to a question on whether the £200k savings was realistic. The Head of Mental Health explained how it was difficult

	to answer that question as the nature of the mental health service was very fluid in terms of the level of support required at any one time. She said that as someone becomes unwell their support is increased and other services also step up their support. During further discussion it was suggested that more could be done in communicating to individuals how to get the help they need. The Chief Officer said that it was important to get the support in place at the right time. It was acknowledged that a GP signposting patients is the right way for new patients as the Mental Health Team is not big enough to handle self-referrals. The Head of Mental Health agreed stating that there may be physical/medical reasons causing issues for mental health so it was important for individuals to be screened by a GP or hospital first. It was noted however that substance misuse clients can self-refer. She went on to explain that a menu had been developed to aid GPs in identifying the right resources needed and referring them as required or identifying whether there is more that the individual can do to help themselves. Comment was made that the report clearly shows that there is an outcome focus to the review and is not simply about saving money. The Head of Mental Health commented on the support of other services including Mind Your Head which was originally set up for people not being treated under a specific service. This had now gone further to consider social isolation and connecting individuals with their community so it is not service driven but allows people to integrate more into their own community. In regard to the uptake of self-directed support it was noted that an individual with Mental Health issues is least likely to take up self-directed support. The work of officers in supporting the process was explained and the IJB heard that everyone receives a single shared assessment to consider the different options available and once implemented there is support for individuals from the Self Directed Support team. Mr Duncan moved that the IJB approve the recommendations contained in the report. Ms Macdonald seconded.
Decision	The IJB **DIRECTED** the Community Health and Social Care Partnership to deliver the Service Review as set out in Appendix 1.
05/19	**IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker**
Report No. CC-01-19-F	The IJB considered a report by the IJB Chief Officer that presented the business planned for the financial year to 31 March 2020 and which sought a review of the IJB Action Tracker. The IJB Chief Officer introduced the report and it was noted that there was a number of items on the Business Programme, under

	planned business yet to be scheduled including, Self-assessment for IJB and consideration is to be given to how best that should be delivered; and Carer Eligibility Criteria the IJB were advised that consideration would be given to whether this would be reported to the next meeting. The Chief Officer noted a number of amendments to the action tracker to be updated before the next meeting.
Decision	The IJB: • **RESOLVED** to consider and approve its business planned for the financial year to 31 March 2020, Appendix 1; and • **REVIEWED** the IJB Action Tracker, Appendix 2.

The meeting concluded at 4.10pm.

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Chair

Shetland Islands Health and Social Care Partnership

Agenda Item

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Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	13 March 2019
Report Title:	Financial Monitoring Report to 31 December 2018	
Reference Number:	CC-13-19-F	
Author / Job Title:	Karl Williamson / Chief Financial Officer	

1.0 Decisions / Action required:

1.1 That the IJB NOTE the 2018/19 Management Accounts for the period to 31st December 2018.

2.0 High Level Summary:

2.1 The current projected outturn to the end of March 2019 for the services delegated to the IJB is an overall adverse variance of £2.419m which represents an over spend in the Shetland Island Council's (SIC) arm of the budget of £0.212m and an over spend in NHS Shetland's (NHSS) arm of £2.207m.

2.2 SIC will provide a one-off payment to balance its arm of the budget should the projected overspend in the Council arm of the IJB budgets come to fruition.

2.3 NHSS reported a break-even year-end overspend to its February Board meeting following positive discussions with the Scottish Government regarding specific services funding for primary care. As a result, NHSS will provide a one-off payment to balance its arm of the budget at the end of the financial 2018/19 year.

2.4 As a result of the agreed additional top up payments from both funding partners, the IJB, as a separate legal entity, will reach a break-even position for the financial year 2018/19.

2.5 The IJB currently has a General Reserve balance of £364k which can be used in line with the IJB Reserve Policy. This policy was approved at the IJB meeting on 06 September 2017 (Min. Ref. 40/17). Funding of £51k for a Falls Prevention Co-ordinator was approved on 08 March 2018 (Min. Ref. 11/18) so the remaining available reserve balance is £313k. Current projections indicate a further £78k will be added to the reserve at the end of the 2018/19 financial year.

2.6 NHSS needed to identify £2.077m savings in 2018/19, but to-date only £0.230m savings has been achieved. The majority of the savings achieved are non recurrent in nature leaving £2.057m to be carried forward into 2019/20.

2.7 SIC incorporated several service redesign projects in their 2018/19 budgets, including a projected £0.200m savings from the redesign of social care mental

health services. £0.079m of these savings has now been identified with the remainder of £0.121m being removed in 2019/20.

3.0 Corporate Priorities and Joint Working:

3.1 The IJB's vision, aims and strategic objectives are set out in the Integration Scheme and the Strategic Plan 2017-20.

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

4.0 Key Issues:

Background

4.1 The 2018/19 Integration Joint Board (IJB) budget was noted at the meeting of 08 March 2018 (Min. Ref. 10/18).

4.2 The Integration Scheme requires Management Accounts to be presented to the IJB at least quarterly.

4.3 This report represents the Management Accounts as at the end of the third quarter of the 2018/19 financial year.

Executive Summary

4.4 The Management Accounts for the period ended 31 December 2018 have been compiled following financial analysis and budget monitoring at SIC and NHSS.

4.5 Appendix 1 details the consolidated year-end outturn forecast for the services delegated to the IJB. Current projected outturn to the end of March 2019 is an adverse variance of £2.419m. It is important to note that the adverse variance relates to the services delegated to the IJB but the IJB itself will show a breakeven position in its annual accounts for 2018/19 because of the additional one-off balancing payments from NHSS and SIC.

Financial Commentary

Significant variances explained below.

4.6 **Mental Health – projected outturn overspend of (£446k), (21%)**
Consultant Mental Health Locum commitment plus flights and accommodation to the end of March 2019 (£619k). Offset by underspend against NHS Grampian Mental Health SLA £177k due to reduced activity.

4.7 **Pharmacy & Prescribing - projected outturn underspend of £173k, 3%**
Under spend on the GP Prescribing budget based upon actual drug expenditure growth to December 2018 (-2.4%) being replicated over the final months of 2018-19.

4.8 **Primary Care – projected outturn underspend of £285k, 5%**
Yell, (£151k) due to continued locum requirement. Whalsay (£110k) due to cost of current SLA and locum cover required for a 14 week period. Unst, (£116k) due to continued locum requirement. Brae, (£112k) due to GP locum covering up to the

end of March. Scalloway, (£233k) due to (£159k) funding gap for TUPE staff plus (£74k) on additional GP WTE and locum costs. Bixter, (£179k) due to (£57k) funding gap on TUPE staff plus (£122k) on locums. GP post will be filled from January 2019. Walls, (£145k) due to (£50k) funding gap plus (£95k) on locums. Offset by £1.2m additional primary care, island harmonisation, funding received from Scottish Government in January 2019.

4.9 **Community Nursing – projected outturn overspend of (£105k), (4%)**
(£36k) overspend due to anticipated bank usage, (£43k) overspend due to ANP sick leave being covered by GP locum from May to July 2018 and (£19k) due to travel costs.

4.10 **Adult Services - projected underspend of £152k, 3%**
The projected underspend relates to employee costs due to vacant posts at Eric Gray Resource Centre £65k, and SL & O Central £117k. Some of this underspend is offset by overspend in employee costs at Newcraigielea (£42k).

4.11 **Adult Social Work - projected outturn overspend of (£94k), (4%)**
The projected overspend relates mainly to the anticipated increase in grants to individuals for Self Directed Support based on the current level of packages (£129K). There is also further projected overspend as a result of an advised uplift to one of the Off Island Placements (£54k). Some of this overspend is offset by underspend in employee costs due to various vacancies throughout the year £83k.

4.12 **Community Care Resources – projected outturn overspend (£196k), (2%)**
The projected overspend relates mainly to increased costs of Off-Island Placement following the addition of 2 packages in year (£115k) and projected agency staff costs for the year of (£488k), required as a result of long-term sickness and difficulties in recruitment and retention in various localities. There is an overall projected underspend in employee costs for the year, £117k, which relates to underspend in various locations, significantly £120k in Support @ Home Central due to vacant posts which has been managed as a result of reduced demand for services at this time, £50k at Annsbrae, where 2 staff are seconded out but relief cover is only being provided where required, £81k at North Haven and Oventonlea due to difficulties in recruitment and retention, leading to agency staff requirement and £71k at Islehavn as a result of care home capacity being reduced to 6 beds (budgeted 10 beds) due to inability to staff the unit to correct level. Wastview and Montfield are projected to overspend for the year at (£130k) and (£75K) due to increasing the rota at the start of the year for specific packages of care. The overall projected underspend in employee costs includes the unbudgeted cost of Seniors working off the floor for part of their time, £183k, which is currently under review. There is a projected underspend in mileage costs across the service of £55k, due to efficiently planning routes, use of a fleet vehicle in Yell and the impact of change to HMRC mileage rates. Board and Accommodation charging income is projected to overachieve against budget by £340k. Charging income can fluctuate significantly during the year, dependent on the individual financial circumstances of those receiving care.

4.13 **Unscheduled Care – projected outturn overspend (£792k), (26%)**
2 vacant medical consultant posts being covered by locums (£792k).

4.14 **Scottish Government Additionality Funding – projected outturn underspend £78k, 13%**

There is a projected underspend of £78k against the £80k allocated to the enhanced intermediate care team. This £78k can be added to the IJB's general reserve and carried forward into 2019/20.

General Reserve

4.15 The IJB currently has a General Reserve balance of £364k, which can be used in line with the IJB Reserve Policy. This policy was approved at the IJB meeting on 06 September 2017 (Min. Ref. 40/17). Funding of £51k for a Falls Prevention Co-ordinator was approved on 08 March 2018 (Min. Ref. 11/18) so the remaining available reserve balance is £313k. A further £78k is expected to be added to the reserve at the end of 2018/19 as a result of an under spend against the Enhanced Intermediate Care Team allocation of £80k.

Overall Year End Forecast Position

4.16 The projected financial outturn to the end of March 2019 for services delegated to the IJB is an overall adverse variance of £2.419m which represents an over spend in the SIC arm of £0.212m and an over spend in NHSS arm of £2.207m. It is important to note that these forecast figures are subject to change and are often difficult to predict due to a variety of factors outwith our control.

4.17 Despite the variances in the operational budgets of both SIC and NHSS the IJB is expected to break even at the end of the financial year 2018/19. This break even position will only be achieved through additional one off payments from the funding partners. This is not sustainable in the long term.

4.18 The unachieved savings target of £2.057m will be carried forward and added to next year's target of est. £0.476m resulting in a total savings target of £2.533m (5%) for 2019/20.

5.0 Exempt and/or confidential information:	
None	
6.0	
6.1 Service Users, Patients and Communities:	May be affected should services be redesigned. However appropriate consultation procedures will be followed should any changes have an impact on this group.
6.2 Human Resources and Organisational Development:	May be affected should services be changed. However appropriate consultation procedures will be followed should any changes have an impact on this group.
6.3 Equality, Diversity and Human Rights:	None
6.4 Legal:	There are legal implications with regard to the delegation of statutory functions of the Council and the Health Board to the IJB and the budget allocated to the IJB by each Party in order to deliver the delegated functions for that Party. These are set out in the Public Bodies (Joint Working) (Scotland) Act 2014, the associated Regulations and Guidance. The Council, the Health Board and the IJB must adhere to the terms of the Integration Scheme approved by the Scottish Government under the terms of the Public Bodies Act. This includes a section on Finance with details regarding the treatment of under/over spends.

6.5 Finance:	The NHSS and SIC have agreed to provide the IJB with one off additional payments to cover the projected year end over spends in their respective arms of the IJB budget. It is important to note that this arrangement is not sustainable and may not be available in future years.
6.6 Assets and Property:	None arising directly from this report. There may be implications for assets and property depending on the projects/ options considered to meet the NHSS budget overspend.
6.7 ICT and new technologies:	None arising directly from this report. There may be implications for ICT depending on the projects/ options considered to meet the NHSS budget overspend.
6.8 Environmental:	None arising directly from this report. There may be implications for the environment depending on the projects/ options considered to meet the NHSS budget overspend e.g. regarding carbon footprint.
6.9 Risk Management:	There are numerous financial risks involved in the delivery of services and the awareness of these risks is critical to successful financial management. The IJB has a Risk Management Strategy in place and considers the risks regarding the activities of the IJB itself as a body corporate and also the risks associated with the services provided to meet the obligations of the IJB with regard to the functions delegated by the Council and NHSS on a regular basis. Specific issues and risks to the IJB associated with this report are those concerning failure to deliver the Strategic Plan within the budget allocation specifically regarding the delegated functions and budget allocation from NHSS. These risks are articulated in the IJB Risk Register and the Health and Social Care Risk Register.
6.10 Policy and Delegated Authority:	This report presents information with regard to the budgets allocated to the IJB including the NHSS "set aside" allocation. The IJB has delegated authority to deliver the approved Strategic Plan within the budget allocated.
6.11 Previously considered by:	The proposals in this report have not been presented to any other committee or organisation.

Contact Details:
Karl Williamson, Chief Financial Officer, karlwilliamson@nhs.net
11th February 2019
Appendices:
1 – Year end forecast outturn position

Appendix 1

Consolidated Financial Monitoring Report
Forecast year-end outturn position

Service Heading	2018/19 Approved Delegated Budget £000s	2018/19 Revised Delegated Budget £000s	Projected Outturn at Q3 £000s	Year End Projected Variance £000s
Mental Health	1,993	2,102	2,548	-446
Substance Misuse	582	587	549	38
Oral Health	3,177	3,084	3,084	0
Pharmacy & Prescribing	6,229	6,665	6,492	173
Primary Care	4,405	5,681	5,396	285
Community Nursing	2,591	2,859	2,964	-105
Directorate	1,027	865	884	-19
Pensioners	78	78	78	0
Sexual Health	40	45	45	0
Adult Services	5,209	5,430	5,278	152
Adult Social Work	2,489	2,528	2,622	-94
Community Care Resources	10,989	11,227	11,423	-196
Criminal Justice	26	56	43	13
Speech & Language Therapy	85	81	81	0
Dietetics	118	116	116	0
Podiatry	234	236	236	0
Orthotics	135	138	138	0
Physiotherapy	599	569	569	0
Occupational Therapy	1,601	1,652	1,606	46
Health Improvement	212	268	268	0
Unscheduled Care	2,800	2,944	3,736	-792
Renal	194	201	201	0
Intermediate Care Team	43	86	86	0
Reserve	541	495	0	495
Scottish Government Additionality Funding for Adult Social Care	592	592	514	78
Integrated Care Funding	410	410	410	0
Efficiency Target	-2,277	-2,277	-230	-2,047
Grand Total	**44,122**	**46,718**	**49,137**	**-2,419**

Shetland Islands Health and Social Care Partnership

Agenda Item

2

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board (IJB)	13 March 2019
Report Title:	Shetland Islands Health and Social Care Partnership Quarterly Performance Overview, Quarter 3: October – December 2018	
Reference Number:	CC-12-19-F	
Author / Job Title:	Simon Bokor-Ingram, Director of Community Health and Social Care / IJB Chief Officer and Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board:

a) COMMENT, REVIEW and DIRECT on any issues which they see as significant to sustaining and progressing service delivery in order to meet the objectives of the Shetland Islands Health and Social Care Partnership's Strategic Commissioning Plan 2017-2020; and

b) CONSIDER and AGREE which, if any, of the performance indicators, set out at Appendix 2 should be included in the quarterly performance reports in support of the Health and Wellbeing Outcomes.

2.0 High Level Summary:

2.1 Delivery of the Strategic Commissioning Plan relies on four key elements:

- maintaining and developing flexible and responsive services to meet patients / service users needs, with a focus on meeting health and wellbeing outcomes
- delivery of the strategic change programmes and projects, in a timely manner
- identifying and managing risks
- effective use of resources – money, staff and assets – to meet needs.

2.2 This Report presents an overview of progress towards delivering on the Strategic Plan.

2.3 The Report is supported by a number of Appendices, as follows:

- Appendix 1 (A) – Projects and Actions
- Appendix 1 (B) – Council Wide Indicators
- Appendix 1 (C) – Annual Operational Plan
- Appendix 1 (D) – Directorate Performance Report
- Appendix 1 (E) – National Integration Indicators
- Appendix 1 (F) - Complaints
- Appendix 1 (G) - Risk Register
- Appendix 2 – Consideration of Additional Performance Indicators
- Appendix 3 – NHS Shetland Complaints and Feedback report 2017/18

2.4 The key issues highlighted this quarter are listed below:

Projects	**Service Performance**
Update of Projects and Actions	Key Performance Indicators
	Consideration of Additional Performance Indicators

3.0 Corporate Priorities and Joint Working:

3.1 The 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 Partnership 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. **Projects and Action Plans**

4.1.1 Appendix 1 (A) is a summary of four key projects and a progress update of the current position. Further updates will include projects as they come on stream, linked to the efficiency target in the 2019/20 budget setting. The four projects are:

- Learning Disability Services
- Mental Health Services
- Community Care Resources

– Community Area Structures

Service Performance

4.2 Key Performance Indicators and Trends

4.2.1 The detailed quarterly performance report for Quarter 3 of 2018-19, October – December 2018, is included at Appendix 1 (B-E), as follows:

- Appendix 1 (B) – Council Wide Indicators
- Appendix 1 (C) – Annual Operational Plan
- Appendix 1 (D) – Directorate Performance Report
- Appendix 1 (E) – National Integration Indicators

4.3 Consideration of Additional Performance Indicators

4.3.1 At the IJB Meeting on 23 January 2019, an action was agreed to include more detailed information on delayed discharge, end of life care and occupancy of care homes. The information requested, together with a note on data capture and key issues are set out in Appendix 2. Where the information is not routinely captured, the IJB will need to weigh up the balance between the cost of collection and the value of the information provided in terms of achieving outcomes and/or informing strategic planning. The information is, in some cases, gathered and made available for managerial / operational reasons but is not routinely made available for governance oversight. Another consideration will be how well the partnership is currently performing in particular areas and the extent to which increasing the number of performance indicators will assist in improving performance and outcomes for our service users.

4.4 **Complaints**

4.4.1 Appendix 1 (F) includes a report on complaints.

4.5 Risks

4.5.1 Appendix 1 (G) shows the Risk Register and the status of each of the strategic risks.

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 several strategic change programmes. This work is intended to put in place service models which are equitable, affordable and sustainable, during the life of the Plan. This work is in recognition of the increasing demand for

	services, alongside reducing resources and staff recruitment challenges.	
6.2 Human Resources and Organisational Development:	There are no specific issues to address for HR.	
6.3 Equality, Diversity and Human Rights:	There are no specific issues to address with regard to equality, diversity and human rights.	
6.4 Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act") established the legislative framework for the integration of health and social care services. The IJB must monitor performance with regard to the functions delegated to the IJB by SIC and NHSS (the Parties) under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014. The IJB and the Parties must share information in this regard. Performance monitoring allows the IJB to measure performance and monitor progress against delivery of the Strategic Plan and achieving agreed national and local outcomes.	
6.5 Finance:	Regular and effective monitoring of service delivery and funding arrangements will allow the IJB to make strategic commissioning decisions regarding the choices over which services should be provided, at what level and in what location in accordance with the financial allocations made available by the funding partners.	
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:	There are no specific risks to address in the consideration of this Report.	
6.10 Policy and Delegated Authority:	The IJB is responsible for the oversight of service delivery of its delegated functions through the Chief Officer.	
6.11 Previously considered by:		

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

25 February 2019

Appendices
Appendix 1 Performance Report (A-E Performance, F Complaints, G Risks)
Appendix 2 Consideration of Additional Performance Indicators
Appendix 3 – NHS Shetland Complaints and Feedback report 2017/18

Appendix A - Projects and Actions - IJB

Report Type: Actions Report
Generated on: 25 February 2019

There are 4 redesign projects:

1. **Learning Disability Services**

   Project scope: To review the Council funded service for adults with learning disability, autism and complex needs, and to include unpaid carers in the project.

   Project purpose: ensure fair and equitable access to resource and service where eligible need has been assessed; ensure sustainable resource and service delivery in an area of demographic rise; and consider support for adults with assessed need not related to LD (eg. acquired brain injury).

   Desired outcome: Arrangements that meet eligible need; reduce inequality; support people to maintain and improve their own health and wellbeing and quality of life; meet base value objectives.

   Financial consequences: To meet need and improve outcomes without growth in budget. The demographics mean that the client base is growing, and is predicted to continue growing over time.

   Progress position: The first area of service being examined is short breaks and respite. The work has started. Families and users of the service have engaged with a facilitator over 2 pre arranged sessions. Project Board meeting frequently to maintain pace. Next Project Board meeting will consider the outputs from the facilitated sessions.

2. Mental Health Services

Project scope: To review and redesign the Council funded community mental health support services, provided from Annesbrae.

Project purpose: ensure that the service is effective, and that need is being appropriately met.

Desired outcome: reduce cost; more appropriate service provision leading to better outcomes for individuals and less reliance on services.

Financial consequences: a £200,000 challenge was given to the service.

Progress position: an extensive piece of work has been carried out, which reported to the IJB- link below:
(http://www.shetland.gov.uk/coins/viewSelectedDocument.asp?c=e%97%9De%92r%7E%87)
Although the review has completed, and did not make all the savings expected, the work affirmed that the service provided is appropriate and efficient. In the longer term the work undertaken has opened up possibilities for how clients might be managed differently in the future, as we explore all the possibilities of improving outcomes using self directed support, and this is already happening in the service. The potential is that further efficiencies will be possible.

3. **Community Care Resources**

Project scope: to review how services are delivered across residential and care at home services for predominantly older people.

Project purpose: to support early intervention and preventative services; to further develop the objective of enabling people to live in their own home for as long as it is safe to do so.

Desired outcome: sustainable services across Shetland supporting people to be independent and able to live at home in the community.

Financial consequences: to restrict growth; to release cash savings; to cap future growth.

Progress position: Review completed. Strategic Outline Case presented to CMT. Investment required to transition from one model of delivery to a new state. Individual business cases being prepared for tests of change. Total investment sought is circa. £600,000, to support tests of change that will allow transition or partial transition.

4. Community Area Structures

Project scope: to establish locality focus across Shetland.

Project purpose: to strengthen the cohesiveness of locality working across Shetland between health and social care, and to draw in the necessary enablers to support individuals to remain living in their communities.

Desired outcome: sustaining people to continue living in their communities and in their own homes.

Financial consequences: to support release of cash savings in services; to cap future growth.

Progress position: each locality has established multi-disciplinary ways of working, with regular case review meetings to support individual residents to remain in their communities. Work was undertaken within the Directorate management team to review options for localities, with the test of change being a challenge to localities to establish their working arrangements. This project underpins a number of initiatives where success will rely on a team approach and shared common goals, while recognising the uniqueness of each locality.

Appendix B - Council-wide Indicators - Community Health & Social Care

Shetland Islands Council

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Code & Short Name	Previous Years		Quarters			(past) Performance & (future) Improvement Statements
	2016/17	2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	
	Value	Value	Value	Value	Value	
OPI-4A Staff Numbers (FTE) - Whole Council	2230	2234	2257	2234	2243	Managers continue to carefully manage staff numbers and associated costs and reflects recruitment pressures in some areas.
OPI-4A-E+NHS Staff Numbers (FTE) - Community Health & Social Care Directorate inc. NHS	743.82	711.19	703.15	694.05	694.65	These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4A-E+NHS Staff Numbers (FTE) - Community Health & Social Care Directorate inc. NHS	743.82	712.37				These are actual numbers of staff in post (rather than what is actually budgeted for)
OPI-4C Sickness Percentage - Whole Council	3.1%	4.0%	3.9%	3.6%	4.2%	
OPI-4C-E Sick %age - Community Health & Social Care Directorate	5.2%	6.3%	5.0%	5.5%	6.0%	Managers in all areas are working with both HR teams to ensure consistent application of the Maximising Attendance policies.
OPI-4E Overtime Hours - Whole Council	87,608	102,909	23,018	23,976	21,371	Overtime and Overtime budgets are devolved to departmental level. Overtime is often the most cost effective way to utilise existing teams and ensure prompt service to our customers.
OPI-4E-E Overtime Hours - Community Health & Social Care Directorate	2,231	7,184	581	898	952	Continues to be actively monitored
OPI-4G Employee Miles Claimed - Whole Council	1,284,834	1,244,630	311,688	278,015	286,275	
OPI-4G-E Employee Miles Claimed - Community Health & Social Care Directorate	667,557	640,990	152,743	146,714	144,827	
E01 FOISA responded to within 20 day limit - Health & Social Care Services	95%	94%	96%	82%	69%	Continue to strive to meet target.

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

Shetland Islands Council

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

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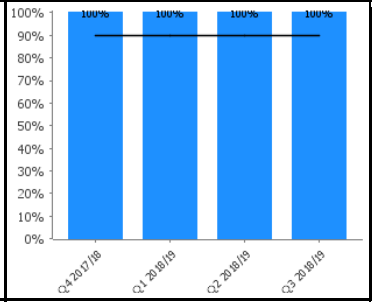
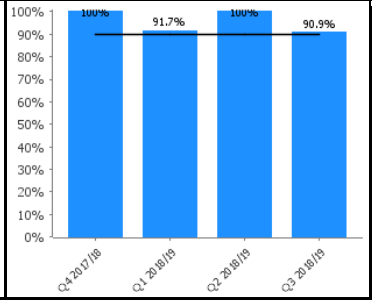
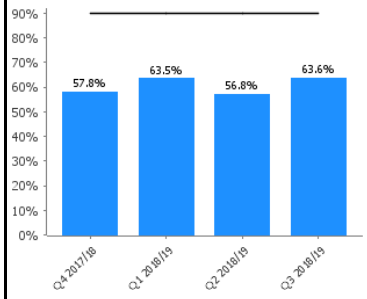
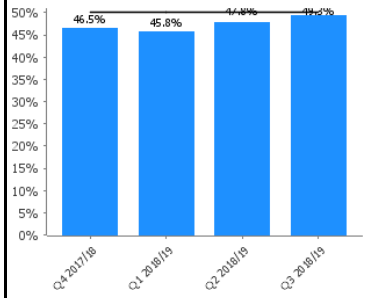
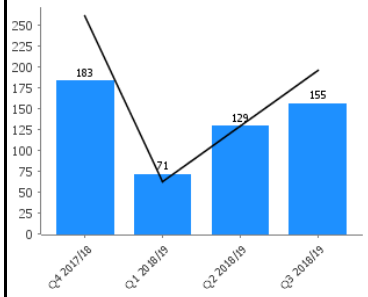
	Previous Years				Last year	This year	
Code & Short Name	2014/15	2015/16	2016/17	2017/18	Q3 2017/18	Q3 2018/19	(past) Performance & (future) Improvement Statements
	Value	Value	Value	Value	Value	Value	
OPI-4C Sickness Percentage - Whole Council	4.2%	3.7%	3.1%	4.0%	3.5%	4.2%	
OPI-4C-E Sick %age - Community Health & Social Care Directorate	6.0%	5.6%	5.2%	6.3%	5.1%	6.0%	Managers in all areas are working with both HR teams to ensure consistent application of the Maximising Attendance policies.

Appendix C - Directorate Performance Report - Annual Operational Plan: Quarterly Measures

Generated on: 25 February 2019

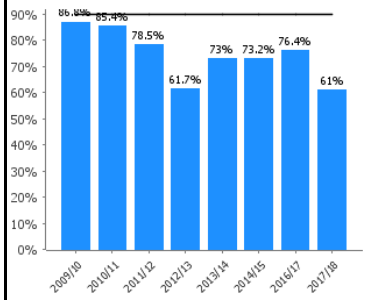
Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CH-DA-01 Clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery.	91.3%	90%	97.1%	90%	100%	100%	100%	90%			
CH-DA-02 Clients will wait no longer than 3 weeks from referral received to appropriate alcohol treatment that supports their recovery.	88.9%	90%	96.6%	90%	91.7%	100%	90.9%	90%			

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CH-MH-01 18 weeks referral to treatment for Psychological Therapies (percentage of completed waits less than 18 weeks)	77.6%	90%	55.4%	90%	63.5%	56.8%	63.6%	90%			05-Feb-2019 Demand remains high. Capacity exercise across adult mental health service being carried out to identify opportunities for managing demand using wider team. Action 15 funding earmarked for an additional Therapist post. Training delivered during Sept/Oct for group work and specific individual interventions in order to provide alternatives for people on the waiting list.
CH-MH-04 People with newly diagnosed dementia who take up the offer of post diagnostic support (ie have an active link worker)	44.9%	50%	46.5%	50%	45.8%	47.8%	49.3%	50%			04-Feb-2019 Note: interim measure showing percentage of people newly diagnosed who take up the offer of post diagnostic support (ie have an active link worker) as national data is not yet available. 138 of 280 cases. Continuing to promote the value of having this support to all patients at point of diagnosis, but it is down to individual choice as to whether they take up the offer.

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
PH-HI-03 Sustain and embed Alcohol Brief Interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	207	261	183	261	71	129	155	195			22-Jan-2019 A drop in quarter 3 means we are behind our trajectory again. The additional training that is being delivered should start to show results soon; however we are still struggling with recording issues in A&E. Split is as follows: Primary Care = 48, A&E = 7, Antenatal = 1 and Other Settings = 99.

Appendix C (cont)- Directorate Performance Report - Annual Operational Plan: Annual Measures

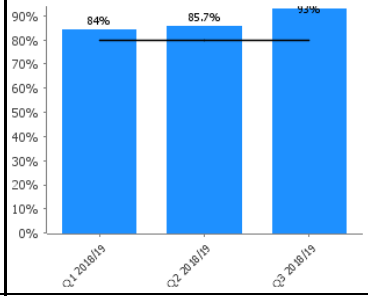
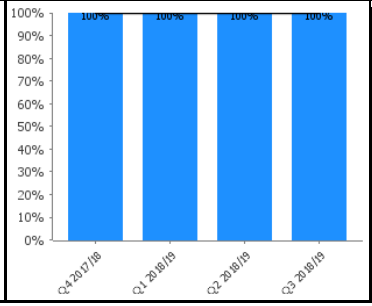
Generated on: 25 February 2019

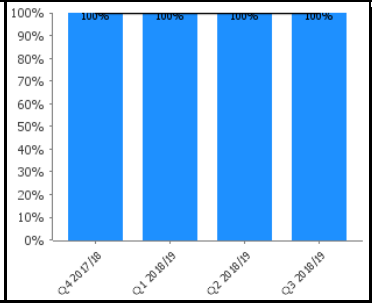
	Years			Current Target	RAG Status		
Indicator	2015/16	2016/17	2017/18	2017/18	2017/18	Graphs	Note
	Value	Value	Value	Target	Status		
CH-PC-02 Advance booking - GP Practice Team	N/A	76.4%	61%	90%			04-Jun-2018 Large decreases seen nationally and locally in 2017-18 survey, but a more significant decrease locally. Patients who need to speak with a clinician within 48 hours can do so and practices also all offer advance appointments with a member of the practice team. National data only produced every 2 years - next publication due in May 2020.

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

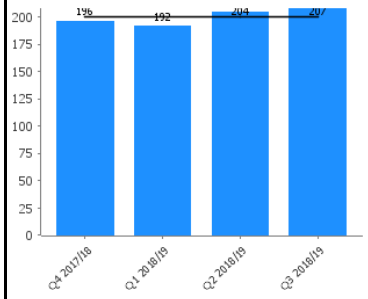
Generated on: 25 February 2019

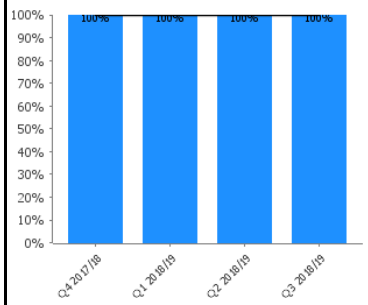
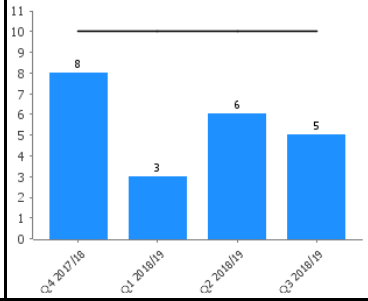
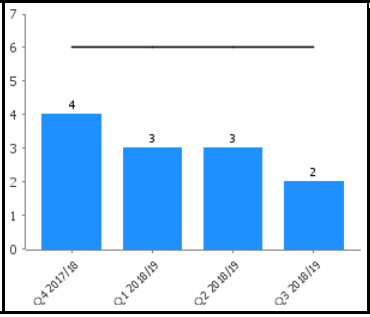
Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer

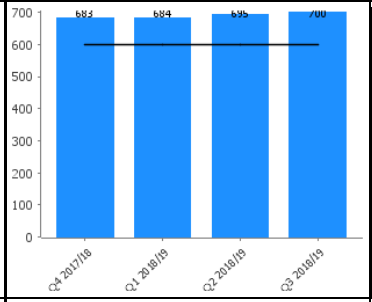
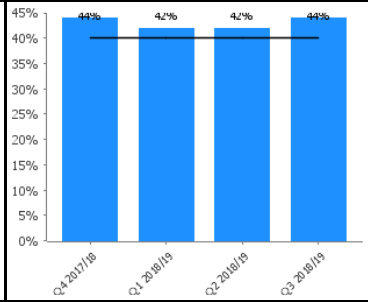
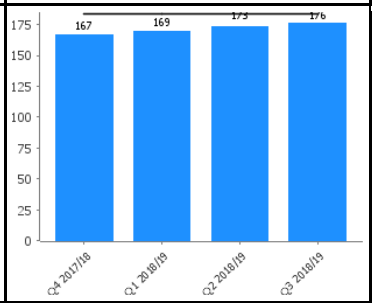
Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
ASW003 Percentage of outcomes for individuals are met	N/A	N/A	N/A	N/A	84%	85.7%	93%	80%			14-Jan-2019 New indicator under development - the % of people who have achieved, or mostly achieved, their agreed outcomes after assessment.
PC002 Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre	100%	100%	100%	100%	100%	100%	100%	100%			11-Feb-2019 Monthly data return from practices shows 100% compliance for those patients who need to speak to a healthcare professional on the day.

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
PC004 Percentage access to a Primary Care health professional for an appointment within 48 hours at any Shetland Health Centre	100%	100%	100%	100%	100%	100%	100%	100%			11-Feb-2019 Monthly data return from practices shows 100% compliance for those patients who request an appointment within 48 hours.

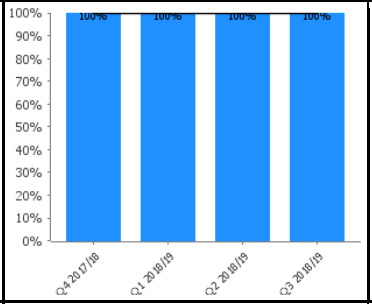
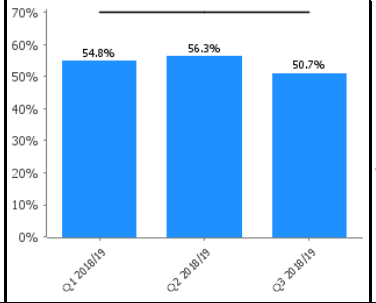
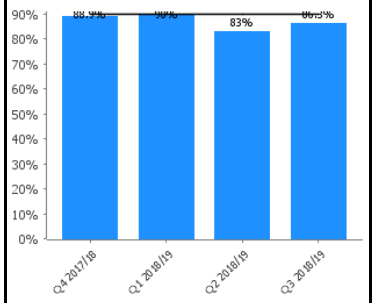
Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CCR007 Number of 65 and over receiving Personal Care at Home.	204	200	196	200	192	204	207	200			14-Jan-2019 Personal care is offered to those who need it. Assessments are thorough and the Council's policy of reablement, which includes a six week period of free support, has helped us to achieve good performance over a number of years.

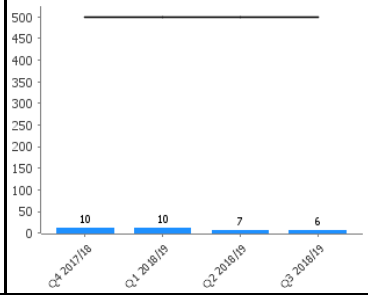
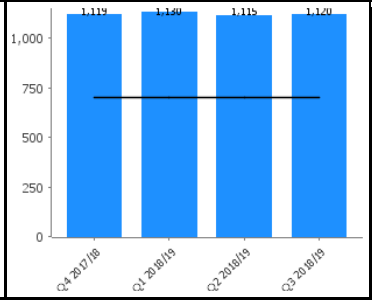
Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CN002 Percentage of early supported discharges with no readmission in 30 days by Intermediate Care Team	90%	100%	100%	100%	100%	100%	100%	100%			07-Feb-2019: 9 patients discharged from ICT support in this quarter. 4 Early Supported Discharge from Hospital - 1 identified as requiring residential care, 3 supported home from care centre, 2 admission avoidance - 1 subsequently admitted due to health decline and passed away.
CCR009 Number of people waiting for a permanent residential placement.	5	10	8	10	3	6	5	10			14-Jan-2019 Target to have less than 10 people waiting for a permanent residential placement. Currently within target.
MH002 Admissions to Psychiatric Hospitals	18	24	20	24	3	3	2	6			

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
AHP006 Increased number of people receiving home monitoring for health and social care (technology enabled care)	653	599	683	599	684	695	700	599			14-Jan-2019 Technology enabled care continues to be used wherever possible to support people to live as independently as possible.
CH-SC-01 Percentage of people 65 and over requiring intensive care package (over 10 hours per week) in their own home	51%	40%	44%	40%	42%	42%	44%	40%			14-Jan-2019 Enabling people to be as independent and safe as possible remains one of our primary aims. We continue to provide appropriate support in people's own home to assist in achieving this.
MD-MH-01 People with a diagnosis of dementia on the dementia register	170	184	167	184	169	173	176	184			

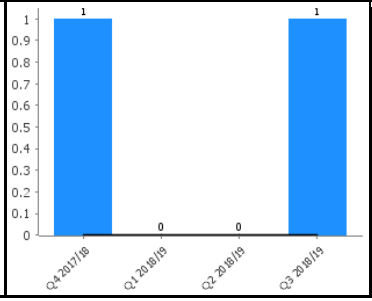
Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CJ002 Percentage of new Community Payback Orders (Supervision) seen within 5 working days of the order being made	90.9%	100%	93.75%	100%	100%	100%	100%	100%			
ASW001 Percentage of assessments completed on time	91%	100%	79.5%	100%	54.8%	56.3%	50.7%	70%			14-Jan-2019 Assessment data is now extracted from our recording system and completion rates should rise when recording issues are resolved. Figures are currently low and will be looked at closely by management team.
ASW002 Percentage of reviews completed on time	89%	100%	88.9%	100%	90%	83%	86.3%	90%			14-Jan-2019 Percentage of all reviews completed within 7 days of due date. Reviews often miss target dates due to factors such as availability of client or family member or a change of circumstances. Completion target reset to more realistic 90%.

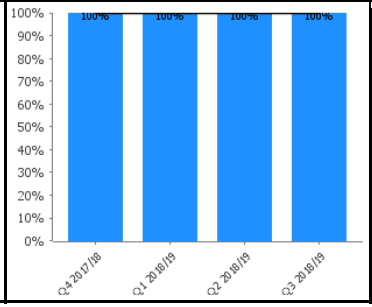
Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users

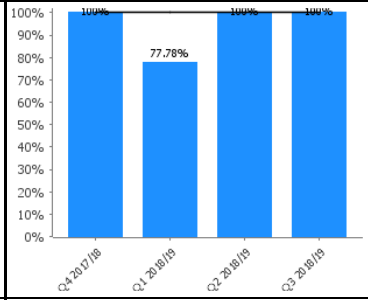
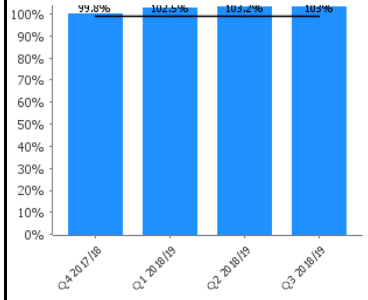
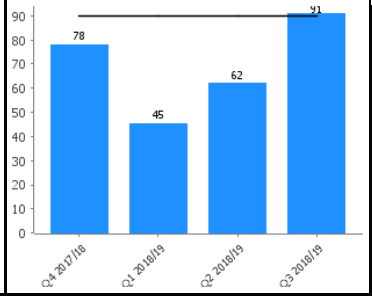
Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
DS004 Number of people who are waiting to register with Public Dental Service (PDS) for ongoing Care	572	500	10	500	10	7	6	500			14-Feb-2019 Source: Local data. Despite waiting, all these people are able to access NHS dental care elsewhere.
CN001 Number of Anticipatory Care Plans in Place	1,061	700	1,119	700	1,130	1,115	1,120	700			07-Feb-2019 Continued month on month increase in Anticipatory Care Plans

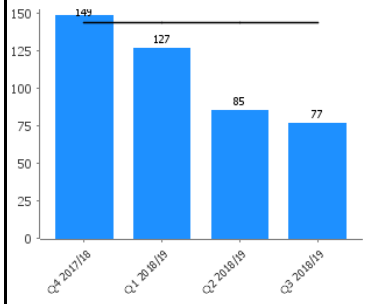
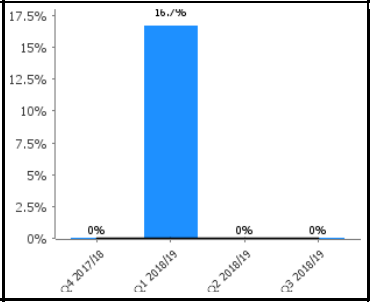
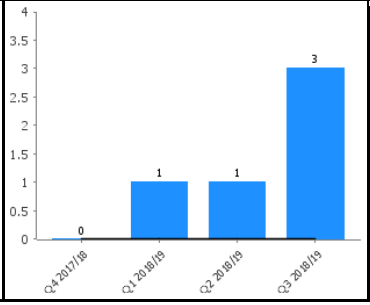
Outcome 6 - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
AS003 Number of incidents of emergency respite provided for adults with Learning Disability/Autistic Spectrum Disorder	2	0	4	0	0	0	1	0			

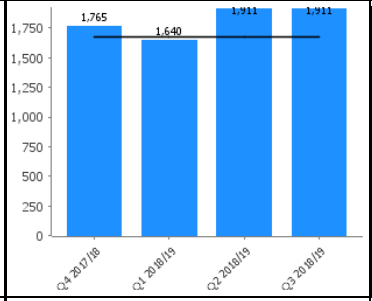
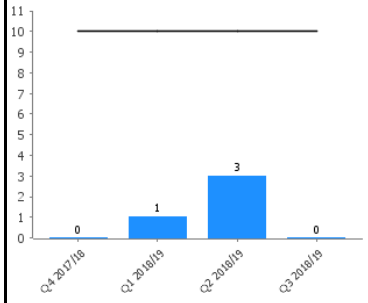
Outcome 7 - People who use health and social care services are safe from harm

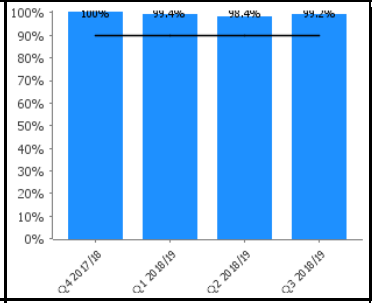
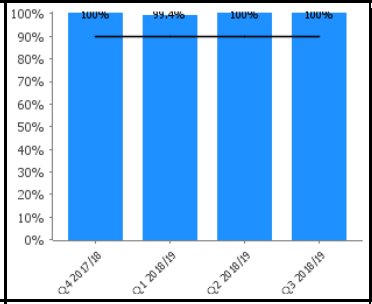
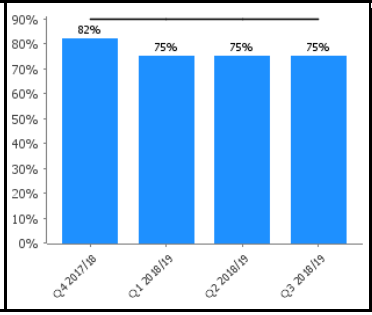
Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CJ001 Percentage of Criminal Justice Social Work Reports submitted to Courts on time	100%	100%	100%	100%	100%	100%	100%	100%			

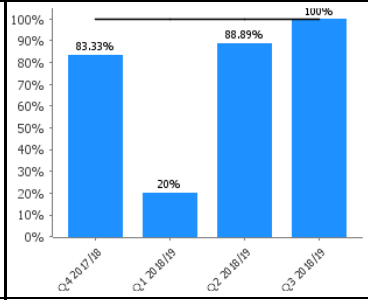
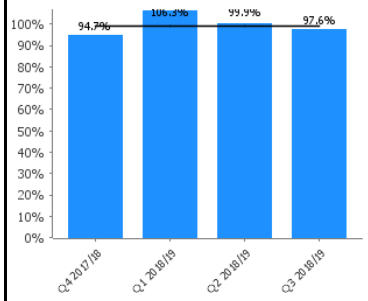
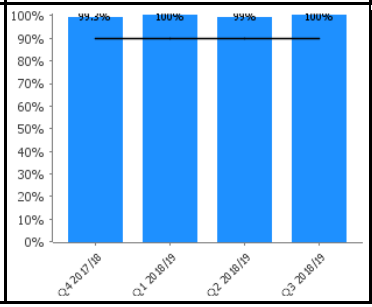
Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CJ004 Risk and need assessment completed and case management plans in place within 20 days	100%	100%	94.29%	100%	77.78%	100%	100%	100%			
PPS002 Percentage rate of antibiotic prescribing in relation to Scottish average	101.2%	99%	99.8%	99%	102.5%	103.2%	103%	99%			25-Feb-2019 In general we are expecting less antibiotics to be prescribed in Shetland than in the Scottish population. This is not always achievable and prevalence of infection in Shetland does not always coincide with national prevalence figures.
PPS003 Number of polypharmacy reviews completed	383	360	298	360	45	62	91	90			

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
PPS004 Number of discharge prescriptions dispensed out of hours by nursing staff	164	192	496	576	127	85	77	144			25-Feb-2019 Good discharge planning continues to reduce the need for nurses to dispense medicines out of hours. Dispensing by pharmacy is always more appropriate. Note: December figure not available at time of reporting. Will be updated in Q4 report.
CN003 Percentage of Catheter Associated Infections in individuals with an indwelling urinary catheter	0%	0%	0%	0%	16.7%	0%	0%	0%			07-Feb-2019 No audit due until next quarter
CH-DD-02 Delayed Discharges - number of people waiting more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes.	0	0	0	0	1	1	3	0			

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

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
DS002 The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland	2,083	1,670	1,765	1,670	1,640	1,911	1,911	1,670			14-Feb-2019 New Senior Dental Officer started at the beginning of February and have agreement on another clinical recruitment which will improve the ratio further later in the year.
AHP001 Number of people waiting longer than nationally agreed referral to assessment timescales for an occupational therapy assessment (count)	1	10	0	10	1	3	0	10			14-Jan-2019 To achieve the nationally agreed referral to assessment timescales we have initiated a number of initiatives including streamlining our referrals and screening processes, reviewing all processes, and reconfiguring the team into a north and a south team to gain staff efficiency.

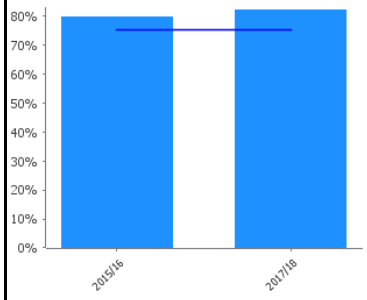
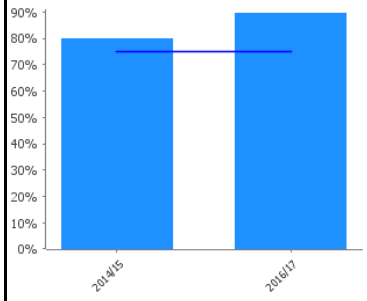
Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
AHP002 Percentage Waiting Time from Referral to Treatment for Orthotics Services (18 weeks)	99.4%	90%	100%	90%	99.4%	98.4%	99.2%	90%			
AHP004 Percentage Waiting Time from Referral to Treatment for Podiatry Services (18 weeks)	98.6%	90%	100%	90%	99.4%	100%	100%	90%			
CCR005 Occupancy of care homes	85.75%	90%	82.9%	90%	75%	75%	75%	90%			14-Jan-2019 Increased use of permanent beds for enablement and respite care means occupancy levels decrease. Effectiveness of care provided at home results in less demand for residential beds.

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CJ003 Unpaid Work commenced within 7 working days	80.9%	100%	71.05%	100%	20%	88.89%	100%	100%			
PPS001 Percentage spend for Shetland on GP Prescribing compared to the national average	95%	99%	94.7%	99%	106.3%	99.9%	97.6%	99%			25-Feb-2019 Shetland has traditionally spent less on medicines per patient. The costs per patient are increasing and there will be a need to undertake additional prescribing efficiency work to maintain the current position.
CH-AO-01 Maximum Waiting Time from Referral to First Consultation for Physiotherapy Services - %age of patients seen within 18 weeks	99.3%	90%	99.3%	90%	100%	99%	100%	90%			

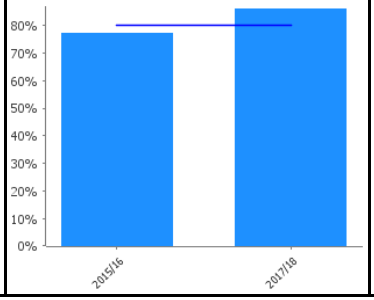
Appendix D (cont) - Directorate Performance Report - Outcomes 1-9: Annual Measures

Generated on: 25 February 2019

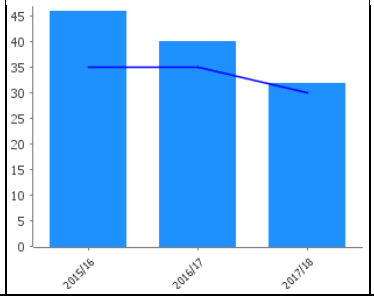
Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer

Indicator	Previous Years						Current Target	RAG Status	Graphs	Note
	2015/16		2016/17		2017/18		2017/18	2017/18		
	Value	Target	Value	Target	Value	Target	Target	Status		
DS001a Decay experience of children in P1: Percentage of children with no obvious caries in deciduous teeth	79.4%	75%	N/A	75%	81.9%	75%	75%			23-Oct-2018 Source: NDIP data. Gives prevalence of dental decay in one age group (P1 or P7) each year, as a percentage of the total child population. 2nd highest rate in Scotland and well ahead of the Scottish rate of 71.1%. Next P1 data release due Oct 20.
DS001b Decay experience of children in P7: Percentage of children with no obvious caries in deciduous teeth	N/A	75%	89.3%	75%	N/A	75%	75%			27-Nov-2018 Source: NDIP data. Gives prevalence of dental decay in one age group (P1 or P7) each year, as a percentage of the total child population. 2nd highest rate in Scotland and well ahead of the Scottish rate of 77.1%. Next P7 data release due Oct 19.

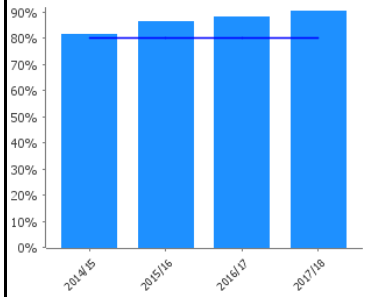
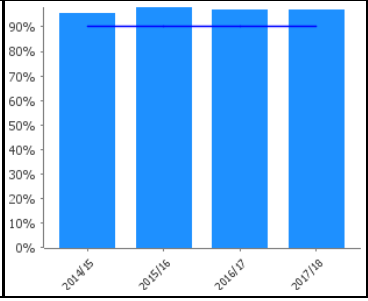
Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected

Indicator	Previous Years						Current Target	RAG Status	Graphs	Note
	2015/16		2016/17		2017/18		2017/18	2017/18		
	Value	Target	Value	Target	Value	Target	Target	Status		
ASW004 Overall, how would you rate your help, care or support services?	77%	80%	N/A	80%	86%	80%	80%			23-Nov-2018 Health & Care Experience Survey 2 yearly data. Well above the national rate of 80%.

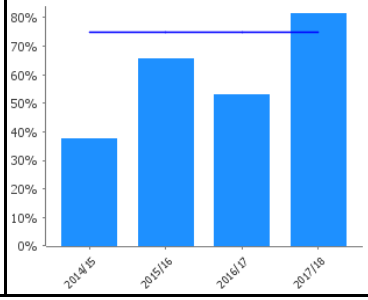
Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users

Indicator	Previous Years						Current Target	RAG Status	Graphs	Note
	2015/16		2016/17		2017/18		2017/18	2017/18		
	Value	Target	Value	Target	Value	Target	Target	Status		
AS002 Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills	46	35	40	35	32	30	30			

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

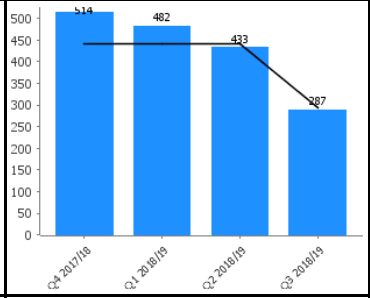
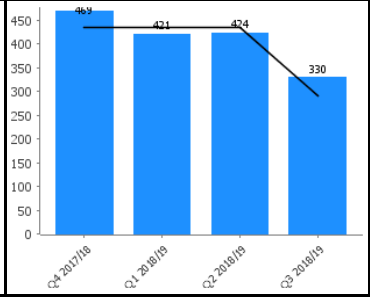
Indicator	Previous Years						Current Target	RAG Status	Graphs	Note
	2015/16		2016/17		2017/18		2017/18	2017/18		
	Value	Target	Value	Target	Value	Target	Target	Status		
DS003a The percentage of the adult populations who are registered with Shetland dentists for NHS dental care	86.4%	80%	88.3%	80%	90.6%	80%	80%			21-Feb-2019 Provisional figures as at Sept 18. Target is to see a net rise in registration figures. Registration brings with it the responsibility to provide on-going care, for which the PDS alone does not have sufficient capacity. Larger rises are therefore dependent on an independent NHS practice opening alongside the Public Dental Service to increase capacity. Note: now published on an annual basis. Next data available January 20.
DS003c The percentage of the child populations who are registered with Shetland dentists for NHS dental care	97.6%	90%	96.8%	90%	96.8%	90%	90%			21-Feb-2019 As above.

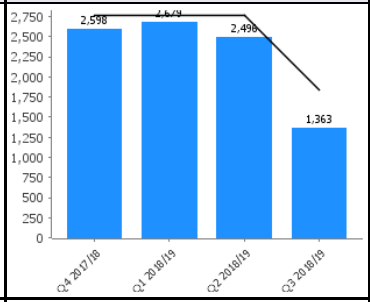
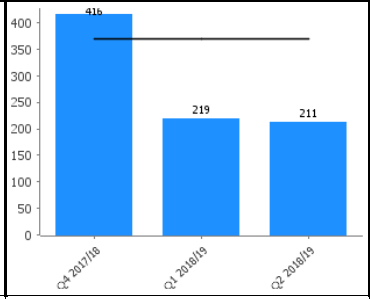
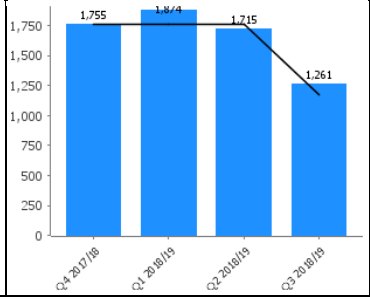
Outcome 7 - People who use health and social care services are safe from harm

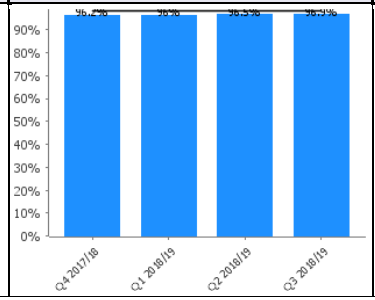
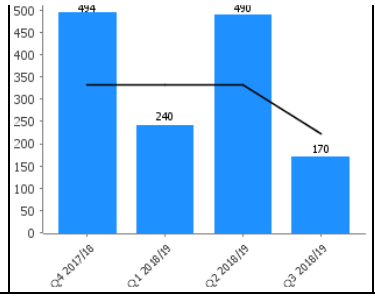
Indicator	Previous Years						Current Target	RAG Status	Graphs	Note
	2015/16		2016/17		2017/18		2017/18	2017/18		
	Value	Target	Value	Target	Value	Target	Target	Status		
CJ005 Percentage of individuals showing a decrease in assessed risk and need at end of order	65.4%	75%	52.94%	75%	81.48%	75%	75%			

Appendix E - National Integration Performance Indicators: Quarterly Measures

Generated on: 25 February 2019

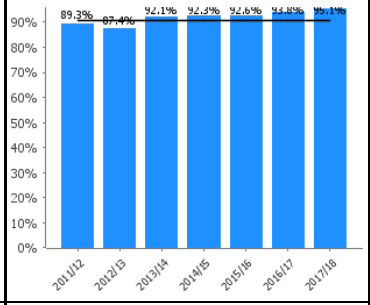
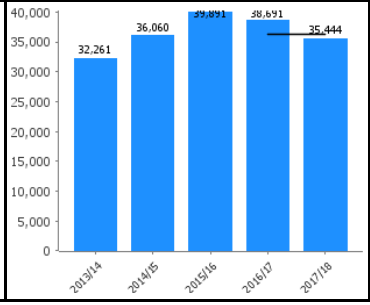
Indicator	Years				Quarters		Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Target	Status		
NIPI01a Number of emergency admissions	1,948	N/A	2,004	1,764	433	287	294			21-Feb-2019 Objective - maintain current position within Peer Group. (Monthly average was 147 over 12 months Jan to Dec 2017). Note: Q3 only includes Oct and Nov data at present.
NIPI01b Number of admissions from A&E	1,725	N/A	1,774	1,740	424	330	290			21-Feb-2019 Objective - maintain current position within Peer Group. (Monthly average was 145 over 12 months Jan to Dec 2017). Note: Q3 only includes Oct and Nov data at present.

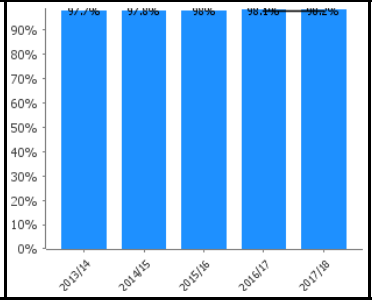
Indicator	Years				Quarters		Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Target	Status		
NIPI02a Number of unscheduled hospital bed days; acute specialties	12,285	N/A	10,972	2,760	2,496	1,363	1,840			21-Feb-2019 Objective - maintain current position within Peer Group. (Monthly average was 920 over 12 months Jan to Dec 2017). Note: Q3 only includes Oct and Nov data at present.
NIPI02b Number of unscheduled hospital bed days; long stay specialties (mental health)	1,421	N/A	1,623	1,476	211	N/A	369			30-Nov-2018 Objective - maintain current position within Peer Group. (Quarterly average was 369 over 12 months Jan - Dec 17)
NIPI03a A&E attendances	6,893	N/A	7,110	7,044	1,715	1,261	1,174			21-Feb-2019 Objective - maintain current position. (Monthly average was 587 over 12 months Jan - Dec 17). Note: Q3 only includes Oct and Nov data at present.

Indicator	Years				Quarters		Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Target	Status		
NA-EC-01 A&E 4 Hour waits (NIPI03b)	96.1%	98%	96.5%	98%	96.5%	96.9%	98%			
E19 Number of days people spend in hospital when they are ready to be discharged (NIPI04)	1,158	N/A	1,499	333	490	170	222			

Appendix E (cont) - National Integration Performance Indicators: Annual Measures

Generated on: 25 February 2019

Indicator	Years			Current Target	RAG Status	Graphs	Note
	2015/16	2016/17	2017/18	2017/18	2017/18		
	Value	Value	Value	Target	Status		
E15 Proportion of last 6 months of life spent at home or in community setting (NIPI05a)	92.6%	93.8%	95.1%	90.8%			29-May-2018 Note: provisional data. Best performing partnership in Scotland by some margin. Managed Clinical Network for Palliative Care established in 2015. Note: Next data available May 19.
NIPI05b Number of days spent at home or in community setting during the last six months of life	39,891	38,691	35,444	36,276			29-Aug-2018 Objective - maintain current position. (Average is 36,276 over past 4 years.)

Indicator	Years			Current Target	RAG Status	Graphs	Note
	2015/16	2016/17	2017/18	2017/18	2017/18		
	Value	Value	Value	Target	Status		
NIPI06 Balance of care: Percentage of population living unsupported in the community	98%	98.1%	98.2%	98%			23-Nov-2018 Objective - maintain current position. (Average is 98% over past 3 years.)

Appendix F - Complaints - Community Health & Social Care

Shetland Islands Council

This shows all complaints that were open during the Quarter.

Generated on: 20 February 2019

Failure to provide a service

ID	Stage Title	Received Date	Status	Closed Date	Service /Directorate	Days Elapsed	Complaint Upheld?
COM-18/19-858	Frontline	05-Nov-2018	Closed	13-Nov-2018	Community Care - Resources	6	Upheld

Standard of service received

ID	Stage Title	Received Date	Status	Closed Date	Service /Directorate	Days Elapsed	Complaint Upheld?
COM-18/19-822	Frontline	17-Aug-2018	Closed	17-Dec-2018	Adult Social Work	86	Partially Upheld
COM-18/19-844	Frontline	24-Sep-2018	Closed	05-Oct-2018	Community Care - Resources	9	Not Upheld

Behaviour/Attitude of staff

ID	Stage Title	Received Date	Status	Closed Date	Service /Directorate	Days Elapsed	Complaint Upheld?
COM-18/19-855	Frontline	01-Nov-2018	Closed	08-Nov-2018	Community Care - Resources	5	Upheld

Appendix G

Risk Register - Integration Joint Board

Risk & Details	Current Likelihood	Current Impact	Current Risk Profile	Current and Planned Control Measures	Target Probabilty	Target Impact	Target Risk Profile	Responsible Officer
Category	**Corporate**							
Corporate Plan	*Integration Joint Board Strategic Plan*							
Failure of Governance Arrangements. The complexity of the governance arrangements may detract from rather than support a journey towards 'single system' working across health and care services. Trigger : Policy framework misunderstood. Policy framework ignored. Conflict of interest between professional, organisational and IJB roles. Decisions are taken outwith the IJB arrangements. Consequences : Strategic Plan not implemented. NHS Shetland and Shetland Islands Council interests take priority to IJB: IJB unable to fulfil its remit. Risk type : Partnership working failure Reference - IJB20001	Almost Certain	Major	High	• Integration Scheme, Scheme of Administration and Delegations, Standing Orders and Financial RegulationsIJB Committees and supporting groups / forums established and predominantly working effectively. Liaison Group of senior representatives from each organisation meeting regularly to resolve issues. Corporate Services Support Group established and working effectively. Formal Induction Programme. Strategic Plan approved by each of the partners - IJB, NHS Shetland and Shetland Islands Council. Budget and Financial Plan approved by each of the partners. Formal agenda mangement arrangements including Report Templates	Unlikely	Minor	Low	Simon Bokor-Ingram Integration Joint Board
Failure of Governance Arrangements. The individual needs of each of the partner organisations being greater than the partnership agreement in influencing how services are designed and delivered. Trigger : Policy framework misunderstood. Policy framework ignored. Conflict of Interest between professional, organisational and IJB roles. Decisions are taken outwith the IJB arrangements. Consequences : Strategic Plan not implemented. NHS Shetland and Shetland Islands Council interests take priority to IJB: IJB unable to fulfil its remit. Risk type : Partnership working failure Reference - IJB20002	Almost Certain	Major	High	• Integration Scheme, Scheme of Administration and Delegations, Standing Orders and Financial Regulations.IJB Committees and supporting groups / forums established and predominantly working effectively. Liaison Group of senior representatives from each organisation meeting regularly to resolve issues. Corporate Services Support Group established and working effectively. Formal Induction Programme. Strategic Plan approved by each of the partners - IJB, NHS Shetland and Shetland Islands Council. Budget and Financial Plan approved by each of the partners. Formal agenda mangement arrangements including Report Templates.	Unlikely	Minor	Low	Simon Bokor-Ingram Integration Joint Board

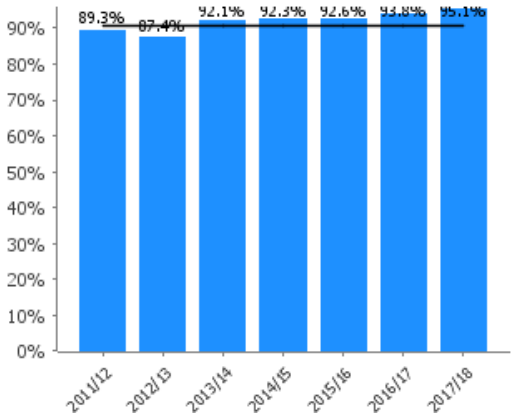
Failure of Governance Arrangements. Failure to implement the Strategic Programmes. Trigger : Lack of strategic direction. Lack of resources to deliver the change programmes and projects. Consequences : National and local priorities not achieved. Failure to redesign services to secure equitable, sustainable and affordable services. Not achieve financial balance in 2017-18. Diminished reputation from failure to deliver. Risk type : Strategic priorities wrong Reference - IJB20003	Likely	Major	High	• Timetable for Delivery was agreed as part of the Strategic Plan.Transformational Change Board established within NHS Shetland and Service Redesign programme established within SIC to support delivery of the Strategic Programmes.	Possible	Minor	Medium	Simon Bokor-Ingram Integration Joint Board
Lack of leadership. The Strategic Commissioning Plan not adequately reflecting the transformational change required to build sustainable and affordable health and care services for Shetland (NOTE this includes making sure that the plan addresses need) Trigger : Options for change do not adequantely address issues of equity, sustainability and affordability. Resistance to change; campaigns for 'status quo' to remain. Options for change modelled on inputs and resources and not outcome to meet service needs. Scale and scope of options for change not sufficiently challenging. Consequences : Failure to redesign services to secure equitable, sustainable and affordable services. Issues are addressed piecemeal with no strategic overview. Diminished reputation from failure to deliver. Risk type : Strategic priorities wrong Reference - IJB20004	Possible	Major	High	• Strategic Plan approved by each of the partners - IJB, NHS Shetland and Shetland Islands Council.Participation and Engagement Strategy is part of core suite of policies. Working towards alignment of Strategic Commissioning Plan, Strategic Change Programmes and Budget. Transformational Change Board established within NHS Shetland to support delivery of the Strategic Programmes, and Service Redesign programme in SIC.	Unlikely	Minor	Low	Simon Bokor-Ingram Integration Joint Board

Lack of leadership. The need for transformational change not being effectively understood or communicated to all stakeholders with resulting lack of support for change. Trigger : Options for change do not adequately address issues of equity, sustainability and affordability. Resistance to change; campaigns for 'status quo' to remain. Options for change modelled on inputs and resources and not outcomes to meet service needs. Scale and scope of options for change not sufficiently challenging. Consequences : Failure to redesign services to secure equitable, sustainable and affordable services. Issues are addressed piecemeal with no strategic overview. Diminished reputation from failure to deliver. Risk type : Strategic priorities wrong Reference - IJB20005	Almost Certain	Major	High	• Strategic Plan approved by each of the partners - IJB, NHS Shetland and Shetland Islands Council.Participation and Engagement Strategy is part of core suite of policies. Working towards alignment of Strategic Commissioning Plan, Strategic Change Programmes and Budget. Transformational Change Board established within NHS Shetland and Service Redesign programme with SIC, to support delivery of the Strategic Programmes.	Likely	Significant	High	Simon Bokor-Ingram Integration Joint Board
Lack of leadership. Failure to investigate, explore, invest in and implement new and sustainable service models. Trigger : Options for change do not adequately address issues of equity, sustainability and affordability. Resistence to change; campaigns for 'status quo' to remain. Options for change modelled on inputs and resources and not outcomes to meet service needs. Scale and scope of options for change not sufficiently challenging. Consequences : Failure to redesign services to secure equitable, sustainable and affordable services. Issues are addressed piecemeal with no strategic overview. Diminished reputation from failure to deliver. Risk type : Partnership working failure Reference - IJB20006	Almost Certain	Major	High	• Strategic Plan approved by each of the partners - IJB, NHS Shetland and Shetland Islands Council.Participation and Engagement Strategy is part of core suite of policies. Working towards alignment of Strategic Commissioning Plan, Strategic Change Programmes and Budget. Transformational Change Board established within NHS Shetland to support delivery of the Strategic Programmes, and Service redesign programme established within SIC.	Unlikely	Significant	Medium	Simon Bokor-Ingram Integration Joint Board

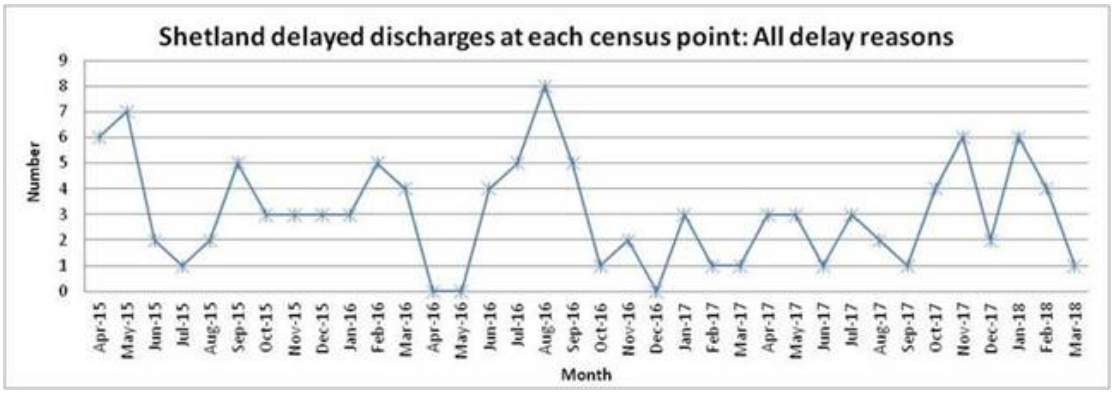
Lack of leadership. Lack of leadership in the transformational change agenda, including insufficient clarity of purpose. Trigger : Options for change do not adequately address issues of equity, sustainability and affordability. Resistance to change; campaigns for 'status quo' to remain. Options for change modelled on inputs and resources and not outcomes to meet service needs. Scale and scope of options for change not sufficiently challenging. Consequences : Failure to redesign services to secure equitable, sustainable and affordable services. Issues are addressed piecemeal with no strategic overview. Diminished reputation from failure to deliver. Risk type : Strategic priorities wrong Reference - IJB20007	Almost Certain	Major	High	• Strategic Plan approved by each of the partners - IJB, NHS Shetland and Shetland Islands Council.Participation and Engagement Strategy is part of core suite of policies. Working towards alignment of Strategic Commissioning Plan, Strategic Change Programmes and Budget. Transformational Change Board established within NHS Shetland to support delivery of the Strategic Programmes.	Unlikely	Significant	Medium	Simon Bokor-Ingram Integration Joint Board
Insufficient Finance, or funding not being applied to strategic plan objectives. When the fixed costs of maintaining the current model of service is factored into the financial planning process, the savings may have to fall disproportionately on community health and social care and health improvement services, which is contrary to the Government guidance on where investment should be targeted to achieve the best outcomes for individuals. Trigger : Contuined reliance on non-recurring (one-off) savings to balance financial plan. Financial Plan remains out of balance; potential need for Recovery Plan. Inability of parnters to agree on Financial Plan and Savings Plans. Consequences : Strategic Plan and Financial Plan not aligned; inability to meet strategic objectives. Existing service needs not met. Emerging and new service needs not met. Inability to meet Government targets on investment in primary care. Ability to function as a 'going concern'. Risk type : Govt. Funding issues Reference - IJB20008	Likely	Major	High	• SIC funded services, aligned to Strategic Commissioning Plan and allocation of funding meets identified service needs.NHS funded services, aligned to Strategic Commissioning Plan and allocation of funding meets 90% of current service models. Pace of redesign will need to increase so that funding can match delivery requirements.	Unlikely	Significant	Medium	Simon Bokor-Ingram Integration Joint Board

Failure to Direct service delivery. Failure to adequately direct service delivery to meet the outcomes required. Trigger : Strategic Plan, Financial Plan and Service Plans are not aligned. Formal Directions are insufficient. Consequences : Service needs (existing, unmet and future demand) not met. Strategic direction from IJB not implemented by delivery partners (NHS Shetland and Shetland Islands Council). Risk type : Strategic priorities wrong Reference - IJB20009	Likely	Significant	High	• Quarterly reporting arrangements in place for performance, risk and finance.Strategic Plan includes detailed Service Plan, performance framework, financial plan and strategic change programmes upon which to base detailed 'Directions' from the IJB to the Health Board and Council to deliver the services as required. The IJB is an active member of the Shetland Partnership, and the Strategic Plan supports the work to make Shetland the best place to live and work.	Possible	Minor	Medium	Simon Bokor-Ingram Integration Joint Board
The underpinning requirement for resilient and complete broadband coverage to take advantage of technological solutions might not be secured within the timescale of this Plan. Trigger : Technology solutions that rely on broadband not robust or unable to take advantage of full functionality. Consequences : Service needs (existing, unmet and future demand) not met. Risk type : Missed opportunities Reference - IJB20010	Almost Certain	Significant	High	• Strategic objective of the Shetland Partnership's Local Outcome Improvement Plan.Activity ongoing to secure funding and prioritisation of Shetland's requirements.	Likely	Significant	High	Simon Bokor-Ingram Integration Joint Board
Category	**Strategic**							
Corporate Plan	*Not Set*							
A No Deal Brexit has the potential to severely disrupt the operational delivery for the NHS and SIC which will adversely impact on the ability of the IJB to deliver its strategic aims and objectives. Trigger : Disruption to the supply of goods and services which support the operational delivery of the NHS and SIC. Consequences : Inability to deliver outcomes for individuals and communities. Supply chain issues. Recruitment challenges. Risk type : Govt policy - failure to meet Reference - IJB20011	Almost Certain	Major	High	• Active planning by Council and NHSRisk identification and plans to mitigate where possible with both organisations working in partnership, to ensure service continuity.	Unlikely	Minor	Low	Simon Bokor-Ingram Integration Joint Board

Appendix 2, Consideration of New Indicators to Include in the Quarterly Performance Reports

Indicator Requested	Data Source / Capture	Key Issues / Considerations
Further Breakdown on End of Life Care	Currently capture: – Proportion of last 6 months of life spent at home or in community setting (NIPI05a)  Source: January 2019 Performance Report	Best performing partnership in Scotland by some margin. Managed Clinical Network for Palliative Care established in 2015. Further breakdown by setting: residential care setting and at home is currently not recorded.

Indicator Requested	Data Source / Capture	Key Issues / Considerations
Delayed Discharge: more detail	Daily records are maintained and summarised on a monthly basis (sample report included below). The usage of hospital beds in the Gilbert Bain Hospital is maintained on a daily basis for managerial / operational decision making. The usage of care beds is maintained on a daily (Monday to Friday) basis for managerial / operational decision making.	There is a target to have less than 10 people waiting for a permanent residential placement. That target has not been missed for a significant amount of time. Managerial action is taken by the Director of Community Health and Social Care when the number of people delayed reaches 3. The current reporting arrangements show: CH-DD-01 Delayed Discharges - total number of people waiting to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes. CH-DD-02 Delayed Discharges - number of people waiting more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes.



Source: Managerial Records

Indicator Requested	Data Source / Capture	Key Issues / Considerations
Occupancy level for individual Care Centre	Data recorded and shared at managerial level for operation decision making.	The care centre occupancy figures are gathered every month by individual settings; for any reported data we have always used the aggregated figures for all units. A sample of the Report, showing the totals for all care homes places is shown below. The designation of Permanent and Respite Places are based on Care Commission registered places but there will be some deviation from this to accommodate respite / short term demand and address staffing situations. Managers have discretion to use the beds to best meet identified need, regardless of the 'designation'. The allocation of beds is determined on a Shetland-wide basis and is determined by need. The variation by care centre is not therefore necessarily an indicator of the performance of the system as a whole.

Permanent				RESPITE				Overall Occupancy %
Permanent Beds	Max Nights Occup.	Actual Nights Occup.	Permanent Occupancy %	Respite Beds	Max Nights Respite Occup.	Actual Nights Respite Occup.	Respite Occupancy %	
117	3,510	2,372	68	29	870	1,322	152	84

Indicator Requested	Data Source / Capture	Key Issues / Considerations
Waiting List for Residential Care	As well as the hospital based 'delayed discharges' data is also maintained on movement between and within care settings for managerial / operational decision making. A sample of the reports which are available is included below.	There is a target to have less than 10 people waiting for a permanent residential placement. Managerial action is taken by the Director of Community Health and Social Care when the number of people delayed in hospital reaches 3.

	Number of People on Waiting List
In Own Home / Extra Care	1
Intermediate Care (Interim Care / Respite)	6
In Hospital	1
Waiting for First Choice	0
Total	**8**

A report on the learning, action and improvements made or proposed in response to feedback and complaints about NHS Shetland health care services in 2017/18

NHS Shetland values and welcomes any feedback about the service or care we provide as this knowledge is important in supporting our aim of continuous improvement. We need to understand what you feel is, and is not, working well for you. If you think there may be a better way of providing services or care then please pass on your ideas. There are many ways in which you and your family can 'get involved' to help shape and improve your local health services.

We receive a lot of different types of feedback in a variety of ways (from compliments to serious expressions of concern) and some people are clear they wish to make a complaint about their health and care experience. A new NHS Scotland Model Complaints Handling Procedure was introduced in April 2017 which embraces a consistently person-centred approach to complaints handling across NHS Scotland. This introduced nine key performance indicators by which we should measure and report our performance. These indicators, together with information on actions taken to improve services as a result of all types of feedback should provide valuable performance information about the effectiveness of our feedback processes and the learning opportunities to support our improvement.

For the year 1 April 2017 to 31 March 2018, this report[1] comprises:

1. a summary of the range of ways we gather feedback, including complaints on our own services and those provided by our health service providers (e.g. GPs, Dentists, Opticians and Community Pharmacists);
2. how we encourage and handle responding to complaints received;
3. a summary of the themes emerging from our feedback methods in 2017/18 and examples of how we can demonstrate improvements to services as a result of feedback and complaints;

[1] This report is available in other languages and formats on request

4. how we are performing against the nine model complaint handling procedure indicators, including training and development for NHS staff on responding to feedback and concerns; and
5. the way we report feedback and complaints to our Board Members and clinical teams to ensure we learn from these and make changes to improve our services.

NHS Shetland is committed to improving services for all our patients and their families. One of the best ways we can do this is by hearing directly from you about your experience of healthcare and treatment and understanding what actions we can take to make services better for you.

1) How can you feed back to us about your care?

We always want to hear about the care you have received, be it a positive or less than satisfactory experience. This feedback is one of the best ways we have to understand how services are working for people. It helps us decide how we can make improvements to them. Positive feedback is also welcomed and appreciated by our staff.

During 2017/18 we have continued to encourage people to tell us about their experiences and the information that we have received through our Feedback and Complaints team is summarised within the appendices to this report. In 2017/18 the team has received and responded to 183 pieces of feedback: 10 thank you letters, 65 concerns, 66 Stage 1 (early resolution) complaints and 39 Stage 2 (formal investigation) complaints.

If you would like to provide feedback there are lots of different ways you can do this:

- Patients, their families and carers can **speak directly** to the person involved in the delivery of care;
- Through taking part in **departmental audits** of patient experience and satisfaction. Patient feedback continues to feature in our audit and service improvement programme, which means that all our clinical teams are asked to undertake an appropriate evaluation of the experience and satisfaction of their patients and service users on a regular basis;
- Through taking part in **patient surveys** (for inpatient stays and through national initiatives such as Health and Care Experience postal surveys about GP care, cancer care or the national Maternity Patient Experience survey);
- Using the independent **Care Opinion** website - (https://www.careopinion.org.uk/). This is an online third-party feedback tool which captures patient and carer experiences of health and care provided by NHS Shetland and Shetland Islands Council and is completely anonymous;
- By speaking with the **Patient Advice and Support Service (PASS).** This is currently hosted by the Citizens Advice Bureau where non-NHS staff are able to advise and assist;
- By providing **feedback,** including **making a complaint** by speaking with any member of staff. If they cannot help you they should be able to signpost you to someone that can, such as the PASS service above, or by contacting NHS Shetland's Feedback and Complaints Team;
- By becoming part of the **Shetland Public Engagement Network (SPEN).** This is a network made up of patient groups, members of the public, carers and voluntary organisations that work in partnership with NHS Shetland. The network is open to individuals or groups who have an interest in health and care related issues. This group has evolved from our Public Participation Forum and now offers the ability to engage with people in an on-line forum.

The results from gathering all the patient feedback we can, including where appropriate the lessons learned and actions taken, are reviewed by the NHS Shetland Board through quarterly reporting. The Clinical, Care and Professional Governance Committee and the Integration Joint Board (which has membership from NHS Shetland and Shetland Islands Council) also take a keen interest in complaint information at their regular meetings.

We have continued to work with the community section of BBC Radio Shetland in 2017/18 so that feedback and information on services in general has been provided to the public through a series of programmes called “Shetland’s Heartbeat”. These have involved a member of the former PPF interviewing health professionals and others about specific topics that included conditions such as liver disease, bipolar disorder and COPD (Chronic Obstructive Pulmonary Disease). These programmes have been a great tool for communicating important issues. The next cycle for 2018/19 is currently in the collation stage.

We hold our Annual Review meeting in public and invite people to attend in person or to submit questions to us. In recent years when we have not had a Scottish Government Cabinet Secretary / Minister in attendance, the review meeting has been aired live on BBC Radio Shetland. This has given a wider audience than those able to come along on the day and for them to get a real time response from key Board officials about service performance and the challenges that lay ahead. In 2017/18 Aileen Campbell, Scottish Minister for Public Health and Sport chaired the Annual Review meeting for NHS Shetland and you can see the outcome summary letter of the discussions about Board performance on our website at: http://www.shb.scot.nhs.uk/board/documents/AnnualReviewSummaryLetter2017.pdf

Printed information leaflets and posters about Care Opinion, the PASS service and on our Complaints Procedure should be available in all our public waiting areas. You can also visit our website page on Patient Feedback, Comments, Concerns and Complaints at http://www.shb.scot.nhs.uk/board/feedback.asp to find out about ways to tell us about your experiences. There is always someone available to speak to you about the different ways you can provide feedback. You can contact us by phone on 01595 743064 or 743069. You can also contact us in writing at Corporate Services, NHS Shetland, Montfield Upper Floor, Burgh Road, Lerwick, ZE1 0LA.

If you wish to make a complaint you can visit our website at http://www.shb.scot.nhs.uk/board/complaints.asp for further advice on how to do this, or you can write to us at the above address. You may also find the Feedback and Complaints factsheet helpful: http://www.shb.scot.nhs.uk/board/documents/FeedbackAndComplaintsFactsheet.pdf This gives information on the sorts of things you can complain about, how the process will work, and the support available to help you make your views known.

What happens next?

When we receive feedback we always try to acknowledge this quickly and tell the person or group that has given us the feedback what we will do with it. On occasion we receive feedback which is anonymous. We still send this to the appropriate department(s) for consideration. If someone provides feedback in an open forum (for example on the Care Opinion website), and we would like to get more information to investigate the matters raised, or we would like to respond in greater detail directly to the service user, we encourage them to make contact with us offline so their patient confidentiality is protected.

We share anonymised learning outcomes, where appropriate, through our internal staff newsletter 'Team Brief' and also have local media opportunities to respond to feedback where staff or a group of people have expressed a concern/interest in a particular topic.

All the feedback received centrally is logged by Feedback and Complaints staff. The information is anonymised for the purposes of reporting to governance groups and our Board. This allows key members of staff and our Board Members (the people that are responsible for seeking assurance about the smooth-running of services) to understand the nature of the feedback received. It also ensures that if there are emerging trends in the types of concerns received then they can ask for reassurance these are being managed effectively by staff.

We know that staff receive many more instances of positive feedback through verbal and written thank yous than we are able to capture.

Feedback is also considered through clinical governance work. We have established a routine joint meeting between the Feedback and Complaints Team and the Clinical Governance Team to discuss any areas of concern that have been identified and any significant adverse or duty of candour events that have been investigated. Findings are used as a learning tool in staff meetings such as GP practice meetings, hospital ward meetings and at community services meetings.

2) How we encourage and handle complaints

We value complaints alongside all of the other forms of feedback. We actively welcome and encourage everyone to let us know when we get things wrong. This means that we can make improvements and maintain the quality and safety of our services.

We can be contacted about complaints in a number of ways. From April 2017 we implemented a new NHS Scotland national complaints procedure which actively encourages our staff to speak with people. If possible we will resolve their concerns at a local or 'front-line' level. This is known as **early resolution**. Some people still prefer to write to us or send us an email documenting their concerns. Others prefer to come and speak with the Complaints Officer who will then offer to document the concerns raised, speak with them about the process and ensure there is an agreed complaint summary before the investigation process begins. The Complaints Officer will also speak with people in the Gilbert Bain Hospital, local care homes and on occasion people's homes when they are too unwell to make contact through the usual routes. This can be very useful when there are immediate concerns about treatment that patients feel unable to raise directly with their care team, or they feel they are not being listened to. The Director of Nursing and Acute Services, the Medical Director and the Director of Community Health and Social Care will also make themselves available whenever possible to speak with people who wish to give feedback, including making a complaint about their healthcare experience.

When we receive a complaint we make a judgement about whether it can be resolved by early 'front-line' resolution (a Stage 1 complaint), or, if it appears more complex in nature, we handle it as a Stage 2 complaint investigation. An example of a complex complaint is one which spans more than one area, or more than one health board. Stage 1 complaints should be dealt with within five working days, and Stage 2 within 20 working days, with the latter always receiving a written response from the Feedback and Complaints Manager (for NHS Shetland this is the Chief Executive).

We always acknowledge complaints as quickly as possible. At the same time we route the complaint to an appropriate member of staff for resolution (either at the 'front-line' or by asking one of our Executive Management Team to carry out an investigation into the matters raised). We encourage all complaint investigators to make contact with the complainant at an early stage in their investigation process. This is so that there is absolute clarity about what the complainant is hoping will happen as a result of making a complaint. If someone contacts us and they are not sure if they wish to make a complaint but feel they need to let us know something, we will try to encourage a more direct discussion with the staff or service involved in order to achieve an earlier resolution of their issues. This type of contact will be logged as a **concern**.

We are monitored by Board Members, and ultimately the Scottish Government about how many of our complaints we respond to within the five and 20 working days. These performance monitoring measures are included as part of the nine key performance indicators included in Section 4.

3) Thematic concerns and improvement measures

When people contact us to leave comments, express concern or complain, it is important we respond to them accordingly. It is also important we take steps to capture the concerns in a way that we can identify any themes that are emerging and take action to address these.

Looking across 2017/18 at our concerns (including Care Opinion), Stage 1 and Stage 2 complaints, the top three areas that stand out as issues for people are:

1) Staff attitude
2) Access to services
3) Service change uncertainty

Staff attitude
During 2017/18 poor staff attitude featured in 23 types of feedback - six concerns and 17 complaints. A number of the concerns relate to doctors and dentists, but also on occasion to administrators such as reception staff.

We recognise that both our service users and our clinicians can sometimes have difficult interactions for a variety of reasons. In a number of the concerns raised about poor attitude it is not the sole cause of the complaint. Clinicians are often very surprised to understand that they have been perceived as having a poor attitude with a patient or service user and will readily apologise for any miscommunication once they become aware of a patient's dissatisfaction. Occasionally if we have seen repeat concerns raised, these have been handled through discussions with the clinician and their professional lead. These discussions are both to allow the clinician an opportunity to reflect on the feedback, and also to determine what further supportive measures might be required to promote better practice.

Access to services
We received 20 types of feedback about access issues – six of which were concerns and 14 complaints. As we have seen in previous years, two areas come up most frequently – with seven about access to Lerwick Health Centre appointments and nine about access to dental appointments.

Whilst we anticipate access complaints to continue, particularly in light of recruitment challenges for some specialties, this figure has reduced from the 25 received in 2016/17. With regard to the two areas above, recent recruitment has increased the GP levels at Lerwick Health Centre, and we have recently been able to confirm the very good news about additional NHS dental capacity in Shetland through a second independent provider.

Service change uncertainty
In 2017/18 there were staffing changes in rheumatology and pain management where action had to be taken to provide continuity of care for service users. For the former this involved negotiating a redesign of service delivery with our partner Board NHS Grampian, and for the latter a recruitment drive to bring us back to our full complement of anaesthetists.

Service users were quite understandably concerned about when their next appointment would take place and with whom. There were 14 feedback episodes about this (12 concerns and two complaints). Staff were working hard behind the scenes to ensure re-provision would be safe, effective and of high quality, however there was a timing issue in that details of the new service could not be released quickly enough to allay some individuals' fears. The Director of Nursing and Acute Services has made herself available to speak with concerned service users whilst keeping an overview of changes in care pathways.

Other areas of concern and actions taken

We received a number of concerns and complaints about communication (nine) and diagnosis/treatment (five) which span different clinical pathways and areas with no particular themes emerging. There were learning points identified from some of these which are detailed in the appendices to this report. There were three areas where there were repeat concerns identified: Issues with patient escort approvals (4); issues with the continence service (4); and issues with paediatric care (3).

Patient escort approvals

When patients need to travel off island for their care, they sometimes need some additional support getting to and from their appointments. In such cases a family member or friend can be approved as a patient escort. Following some negative feedback both from clinicians and patients/carers, a review of the patient escort approval process took place. In September 2017 a revised process was launched which attempts to provide clearer criteria for the approval of patient escorts. When an individual does not meet the criteria for a patient escort but the reviewing clinician believes this is indicated, a request is made to the escort review team (the Executive Management Team). In 2017/18 we received two concerns and two Stage 2 complaints about patient escort approval decisions, however only one of these was following the introduction of the new system (during which time the review team has considered 55 requests).

Continence service

During the year we received four stage 1 complaints about the supply of continence products to individuals in the community which in part were triggered by a change to the delivery system. There have been concerns about communication and also the wrong products being issued. As a result of these contacts a customer satisfaction survey is being issued in the coming weeks to better understand how the service is working for people and where improvements might be made.

Paediatric care

A number of concerns have been raised regarding safe delivery of emergency paediatric services within NHS Shetland. One aspect of these is through patient feedback, with three Stage 2 complaints received about the case management of sick children. The complaints differed in terms of symptoms and presentation, but all ultimately ended up with emergency transfer to Aberdeen following a potential delay in diagnosis. We have responded rapidly to all three complaints. In each case we have met with parents, listened, learned and identified actions to be taken. One of the recommendations is a review of paediatric care pathways. A paediatric taskforce under the leadership of the Medical Director, and involving relevant clinical input from across primary and secondary care has been established to review future arrangements for the clinical management of children. This will consider all aspects

including clinical pathways and the training and continuous professional development required for relevant staff. We have already made some key advances with training and development, including recent training for 33 members of staff with ScotSTAR, the paediatric intensive care unit retrieval service, in the mobile training unit in May.

4) Performance against the nine model complaint handling procedure indicators

4.1) Indicator One: Learning from complaints

It is really important that we learn from the feedback and complaints we receive.

For gathering feedback and learning from complaints we have in place a framework which sets out the general principles for gathering feedback, sharing results and presenting the findings of improvement work. A flow chart has been developed to describe the process for members of staff to follow when learning has been identified from clinical audit, adverse events, complaints, service improvement work etc. This involves the completion and appropriate sharing of a 'lessons learnt' summary. An updated Datix (an electronic incident and complaint handling software package) reporting form also includes a section on who the lessons learnt have been shared with.

Individual complaints are discussed at departmental governance meetings. This is how wider dissemination of investigation findings and agreed actions are communicated to frontline staff. It is evidenced (in an aggregated/anonymous format) in the quarterly clinical governance reports which are received by the Clinical, Care and Professional Governance Committee (CCPGC).

Specific debrief exercises are also undertaken as necessary. This ensures that there is learning from adverse events (which may also include concerns raised by a patient or service user). The outturn of the debrief is also included in the quarterly reports to CCPGC or the Risk Management Group (RMG) depending on the nature of the concern or adverse event.

In terms of the organisational focus on ensuring that feedback results in learning and improvement, we also have a system in place which includes a high level review of complaints that is undertaken by the Director of Nursing and Acute Services, the Medical Director and the Director of Community Health and Social Care on a quarterly basis. The review report summarises the complaint details and the extent to which actions have been completed and lessons learnt disseminated. The report is shared with the Professional Leads and Heads of Service at the Joint Governance Group (JGG) so that there is an organisational overview and assurance of individual complaint handling and emerging or cross cutting themes.

A quarterly report on complaint data against the nine key performance indicators is included in the regular Quality Report for the Board's information. The wider Quality Report includes a high level summaryof complaint outcomes and examples of improvement work as a result of feedback received from patients. It ranges from survey findings to videos and audio files of patient stories.

The presentation of real-time feedback, for instance creating a more rapid turnaround of inpatient survey data, remains a key priority for 2018/19. This goes along with evidencing that actions arising from complaints have been implemented so that we can demonstrate to staff and patients that improvements are being made across a wide range of health and social care services.

For examples of actions taken as a result of feedback and complaints, please see Section 3 above. Further information detailing the learning points and actions taken as a result of all concerns and complaints received is included in appendices A, B and C of this report or on our website at:
http://www.shb.scot.nhs.uk/board/feedback.asp.

4.2) Indicator Two: Complaint process experience

In 2017/18 we have introduced a simple feedback questionnaire which we send to complainants a few weeks after their final response letter to try and better evaluate their experience of making a complaint to us. This is set up with a free post response service, however responses remain limited across the four quarters. The information we have received is included at Appendix D.

In 2016/17 a quarter of complainants got back in touch with us after our investigation findings letter was sent to seek additional clarity or advising they intended to escalate their complaint to the Scottish Public Services Ombudsman or to our MSP. We saw a similar figure in 2017/18, though only one case was escalated to the Scottish Public Services Ombudsman. This is a somewhat crude measure of the quality of our complaint responses but it continues to provide us with a benchmark figure that we aim to decrease.

4.3) Indicator Three: Staff awareness and training

Clearly if we are really to take on board the learning from feedback and complaints, and encourage staff to see the value in this, we need to ensure they understand what we are trying to do. We also need to give them the confidence to deal directly with people's concerns or know how to help them provide feedback through the most appropriate route.

All new members of staff attend an induction day to make sure they are aware of the Board's key policies and procedures and how they are expected to behave. Part of this induction is a section on feedback and complaints. Here staff learn about the various ways the Board can get feedback, some examples of front line resolution and how this is always the first choice in handling concerns. It also shows how complaints can link to adverse and duty of candour events. One of the key messages given at this induction session is about why the Board actively encourages feedback. It shows how the Board tries to ensure that as a result of

feedback, actions are taken to improve services and that the learning is shared throughout the organisation.

In addition staff are encouraged to use a series of e-learning modules on feedback and complaints that have been developed by NHS Education for Scotland in order to further their knowledge in this area. The Complaints Officer recommends that **all** staff complete the first two of these online e-learning modules – 'Valuing Feedback' and 'Encouraging Feedback and Using It' as part of their induction training. The Complaints Officer is also ensuring that any new complaint investigators are aware of the NHS NES Complaints Investigation Skills e-modules resources.

Staff members receive a feedback and complaints factsheet as part of their Mandatory Refresher Training which has to be undertaken every 18 months. This has been developed by the Complaints Officer to remind existing staff about the importance of seeking and responding appropriately to feedback and complaints. It also aims to keep fresh in their minds independent services such as the Patient Advice and Support Service they are able to signpost service users to. This information is also to be included in a series of focussed management presentations on feedback and complaints which have been developed for 2018/19.

The Complaints Officer has attended a number of key staff meetings about complaint handling in 2017/18, including the Hospital Management Team, all Public Dental Service staff, the Consultants Group, Community Nursing, the Senior Acute Nurses Group and the Community Mental Health Team. This has been a useful exercise not only in explaining and reinforcing the changes to the procedure which came into effect in April 2017, but also in reminding staff about best practice in handling feedback and complaints. It has generated some useful debate and resulted in some tweaking to local documentation.

The Medical Director, the Director of Nursing and Acute Services and the Director of Community Health and Social Care meet with the Complaints Officer on a regular basis to consider the complaints that have been received. They also look at adverse or duty of candour events which have been categorised as potentially significant. These may or may not have been identified through a complaint. This ensures that serious issues are fully understood by the directors responsible for clinical service provision, there is an agreed approach to the actions that are taken and the learning that needs to be shared with the relevant clinicians. Often complaints and adverse events span more than one staff group which makes this multidisciplinary review crucial.

The increase in use of social media such as the Care Opinion website as a platform for providing feedback about NHS care is valued by NHS Shetland. When feedback is received through this route, an automatic alert is triggered to all Board Members and Heads of Service. They can see the positive and negative comments alike, and also how we respond to them. We try to actively encourage new staff to look

through the feedback we have received and to consider how any learning points can be applied in their areas. Such a transparent method of receiving feedback is not without its challenges. A number of service providers are concerned that open social media platforms are not appropriate forums to enter into dialogue about patient care. Whenever we receive feedback requiring a personal response, we encourage the individual to make contact offline for this purpose.

We periodically use internal communication methods such as our intranet and Team Brief newsletter to promote the various feedback methods to staff. We target displays which provide information both to staff and members of the public about the different feedback routes and also some examples of the types of feedback that we receive.

4.4) Indicator Four: The total number of complaints received

In 2017/18 we received 105 complaints (69 Stage 1 complaints with 3 of these escalating to Stage 2, and an additional 36 Stage 2 complaints). We have also received and responded to 65 concerns.

Whilst this is the first year of complaint reporting under the revised procedure, in 2016/17 we received 60 formal complaints and 96 pieces of feedback and the contacts are therefore comparable. What is different however is the lower number that have been handled through a formal investigation process, with a reduction from 60 in 2016/17 to 39 in 2017/18. This suggests a greater number of less complex issues being handled by staff at an early stage in a complaint (early resolution). This is beneficial to the complainant as they are more likely to receive a resolution to their concerns in a faster timescale, and often also from the people they are more likely to continue to interact with in terms of their clinical care.

With regard to the complaints received in 2017/18, these relate to the following service areas:

	2017/18	
Service	**Number**	**%**
Directorate of Acute and Specialist Services	40	38.1
Directorate of Community Health and Social Care	57	54.3
Acute and community	2	1.9
Corporate	6	5.7
Other	0	0
Withdrawn	0	0
Totals:	**105**	

It should be noted that the two service areas that have experienced greater access issues (Public Dental Service and Lerwick Health Centre) fall under the Directorate of Community Health and Social Care. This directorate now has responsibility for eight of the 10 GP practices in Shetland as they have become salaried practices.

Complaints relating to salaried GP practices (for 2017/18 these are Lerwick Health Centre, Whalsay Health Centre, Yell Health Centre, Unst Health Centre, Brae Health Centre, Scalloway Health Centre and Bixter Health Centre) are included in the figures and commentary (Appendices A, B and C) for complaints and concerns handled by NHS Shetland.

Complaint data for the remainder of Family Health Services has been sought through the year, however the return rate remains very low. These should be figures for the two independent GP practices, and should also include community pharmacies, opticians and NHS dentists.

Both Hillswick and Levenwick GP practices have provided a nil return. Brae Pharmacy reported one Stage 1 complaint that was handled within the five working days. This related to patient privacy and the complaint was upheld. Learning about the location and timing of discussions with service users has been taken forward.

Unfortunately, despite follow up there have been no further returns. The Complaints Officer will be speaking with NHS colleagues who act in a liaison role for the community services and will also make further approaches to improve this matter.

4.5) Indicator Five: Complaints closed at each stage

Complaints closed *(responded to)* at Stage One and Stage Two as a percentage of all complaints closed.	
Description	2017/18
Number of complaints closed at Stage One as % of all complaints	62.86%
Number of complaints closed at Stage Two as % of all complaints	34.28%
Number of complaints closed at Stage Two after escalation as % of all complaints	2.86%
Notes:- The escalated complaints referred to above were also responded to at Stage 1 during the period.	

4.6) Indicator Six: Complaints upheld, partially upheld and not upheld

The number of complaints upheld/partially upheld/not upheld at each stage as a percentage of complaints closed *(responded to)* in full at each stage.	
Upheld	
Description	2017/18
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	50% (33 of 66)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	50% (18 of 36)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	66.66% (2 of 3)

Partially Upheld	
Description	2017/18
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	22.73% (15 of 66)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	33.33% (12 of 36)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 3)

Not Upheld	
Description	2017/18
Number complaints not upheld at Stage One as % of complaints closed at Stage One	27.27% (18 of 66)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	16.67% (6 of 36)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	33.33% (1 of 3)

4.7) Indicator Seven: Average times

The average time in working days for a full response to complaints at each stage		
Description	2017/18	Target
Average time in working days to respond to complaints at Stage One	5	5 wkg days
Average time in working days to respond to complaints at Stage Two	32	20 wkg days
Average time in working days to respond to complaints after escalation	27	20 wkg days

Performance against response targets has been a particular challenge in 2017/18. Some complaints were complex in nature (spanning more than one area or health board). We also had a six month period with interim Medical Director cover where the change in personnel prolonged a number of medical complaint investigations, more noticeably at the Stage 2 level. It is anticipated that these figures will improve in 2018/19.

4.8) Indicator Eight: Complaints closed in full within the timescales

The number and percentage of complaints at each stage which were closed *(responded to)* in full within the set timescales of 5 and 20 working days		
Description	2017/18	Target
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	77.28% (51 of 66)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	47.22% (17 of 36)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	33.33% (1 of 3)	80%

4.9) Indicator Nine: Number of cases where an extension is authorised

The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.	
Description	2017/18
% of complaints at Stage One where extension was authorised	19.69% (13 of 66)
% of complaints at Stage Two where extension was authorised	52.77% (19 of 36)
% of escalated complaints where extension was authorised	66.66% (2 of 3)

5) How we report feedback and complaints

Reporting of feedback and complaints takes place at a number of different levels and areas both in and outside the organisation.

1. Board level

Once a year the Board receives the Annual Feedback and Complaints Report. It provides an opportunity for the Board to understand the information related to concerns and complaints (numbers and investigation performance) along with the key themes identified and how action is being taken to address these.

In addition, as part of the Board's regular Quality Report the Board receives on a quarterly basis a progress report against the nine key performance indicators included in Section 4 and an anonymised summary of all Stage 2 complaints, the outcome of the complaints; and the actions taken as a result of them.

The complaints raised with the Scottish Public Services Ombudsman (SPSO) are included in the Quality Report to the Board. This shows:

- where people have continued dissatisfaction with the response offered by the Board;
- the findings of SPSO once available; and
- progress against any actions required to be taken as a result of the external scrutiny.

Board Members take a keen interest in formal complaints. They have had some useful insights into particular issues through further discussion at the meetings. Board Members have in the past requested changes to the way the formal complaints are reported to ensure they are getting the most information they can from them.

Board Members have expressed a desire to hear directly from complainants about their experiences. The Director of Nursing and Acute Services, as the designated Patient Experience lead continues to identify suitable cases where there is real benefit from an in depth discussion of the concerns raised.

2. Clinical, Care and Professional Governance Committee and sub committees

The anonymised formal complaints and feedback report is discussed at our Clinical, Care and Professional Governance Committee.

In addition this committee will discuss in more detail the outcomes of serious adverse events including anything which falls under our duty of candour. These can also be either complaints and/or feedback. These are discussed at some length.

Where appropriate the committee will review action plans and monitor progress against these.

Anonymised complaints are also considered through the Joint Governance Group as appropriate. This group has senior clinical and care representation from NHS Shetland and Shetland Islands Council.

3. National reporting

Anonymised formal complaints data is submitted to Information Services Division Scotland on an annual basis. This allows information to be scrutinised by the Government's Health and Social Care Directorate. It is also benchmarked against other Health Boards.

4. Executive Management

As described in Section 4.1, key members of the Executive management team (the Medical Director, Director of Nursing and Acute Services and the Director of Community Health and Social Care) meet with the Complaints Officer to discuss serious complaints, adverse and duty of candour events regardless of how they have been notified of them. This ensures appropriate action is taken and that the learning opportunities are disseminated and embedded into the culture of the organisation (see below).

5. Departmental level

There are a number of governance meetings at directorate or departmental level where anonymised adverse events, feedback or complaints may be discussed (as appropriate).

These will focus on relevant events and also provide a local opportunity, along with regular departmental management meetings to review and identify learning from individual complaints or summary reports.

Where appropriate the Complaints Officer and/or relevant Executive Directors (see above) will flag individual issues to these groups.

6. Individual clinician/members of staff

All concerns and complaints that are received centrally are recorded by the Complaints Team. The method of recording is in a way which allows that they can be searched and reported on when medical staff have their annual appraisals and revalidation exercise which allows them to remain registered with the General Medical Council.

The revalidation process for registered Nurses and Midwives is now live and it is expected that any significant complaints linked to an individual nurse of midwife would be reviewed as part of the appraisal process that will support this revalidation.

And finally...

To put the formal concerns raised into context, they represent a small amount of the overall feedback received. We are actively trying to encourage patients and service users to also provide positive feedback wherever possible. Much of that feedback is provided at the time a patient is accessing a service and it is difficult (and arguably impractical) to collect this systematically. We are encouraging all staff to log emails and cards they receive so we can ensure that all staff are aware that the care they provide is recognised by patients and the wider organisation.

Examples of positive feedback include postings on the Care Opinion website, the numerous thank you letters and cards that are received (including 10 formal thank you letters to Corporate Services) and through public acknowledgements such as in the Shetland Times newspaper and on social media sites. We will continue to work on ways to improve how we record positive feedback.

We hope you find this report of interest and that you will feel encouraged and able to work in partnership with us to help improve the services we provide.

This report has been considered by our Patient Focus Public Involvement (PFPI) group, our Clinical, Care and Professional Governance Committee and the Board of NHS Shetland to inform what further work will be useful in this area.

A copy of this report has been sent to the Scottish Ministers, the local Patient Advice and Support Service, Healthcare Improvement Scotland and the Scottish Public Services Ombudsman.

June 2018

NHS Shetland Annual Feedback and Complaints Report for 2017/18

Appendix A

Summary of Stage 1 Complaints in 2017/18

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
1	Maternity	03.04.17	Existing medical condition; delivery must take place in consultant-led unit; patient wishes to deliver in Glasgow not Aberdeen	Escalated to Stage 2	Patient advised of SLA with NHS Grampian	2
2	Dental	03.04.17	Patient unhappy about wait for an appointment; had lost filling and tooth was sensitive	Upheld	Patient given appt to replace filling and a following check-up	1
3	Elective Services	04.04.17	Carer refused escort status to accompany family members for routine review appt at ARI	Not upheld	Booked and paid for flight, advising ward staff that a complaint would be made	1
4	Child Health	27.03.17	Parent wanted to self-refer child direct to paediatrician without going through GP	Not upheld	Patient had been discharged from paediatrics due to multiple DNAs. Patient unhappy when advised of correct referral procedure and ended call	2
5	Whalsay HC	05.04.17	Patient unhappy about waiting time for an appointment at OP clinic	Upheld	Patient offered appt with GP if in need of treatment in the meantime	1
6	Lerwick HC	07.04.17	Patient unable to make appt for follow-up injection 'for foreseeable future'	Upheld	Patient given appt as an 'extra' with GP who can give injection needed (14.04.17) Review of follow up appointments	1
7	Dental	07.04.17	Patient unable to make appt with regular dentist; advised to attend as emergency patient (broken tooth)	Upheld	Patient agreed to attend as emergency in order for treatment; concerns passed to dental management	1

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
8	Dental	11.04.17	Patient unhappy at not being able to see 'usual' dentist for review and ongoing treatment at SOSt. Unhappy with explanation given re staffing and funding pressures on service	Not upheld	Patient indicated wish to escalate to Stage 2; ACO contacted Dental Director who agreed to speak to the patient. No escalation received	2
9	Dental	03.04.17	Patient concerned with continuity of care, pressure on service and staff causing follow-up appts recall to be delayed	Part upheld	Patient happy to register concerns as Stage 1 to be raised with management and complaints team	1
10	Dental	12.04.17	Patient frustrated at appt being cancelled at short notice due to staff illness. Attempts to contact patient (who does not have mobile phone) failed; patient attended appt unaware of cancellation	Part upheld	Patient re-booked into emergency slot next day; patient advised in future to phone in advance to check appointment to avoid wasted journey. Patient content to be re-booked appt for following day	1
11	Dental	01.04.17	Patient unhappy of changes to booking appointment system at Montfield; unaware of changes; suggested that patients should have been individually advised by letter/email of changes.	Part upheld	Agreement to pass concerns about communication to Dental Management	1
12	Dental	05.04.17	Patient reported lost filling, not in pain. Offered appt for 18/04; decided to go private to be seen sooner than 18/4	Upheld	Patient chose to go private owing to wait and cancelled appt made	1

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
13	Dental	04.04.17	Overdue recall for review appt	Not upheld	Patient advised of alternative (LDP or private) and decided to stay registered at Montfield; wishes feedback to be noted by management	1
14	Community Nurse	18.04.17	Patient unhappy with injection given by Community Nurse	Part upheld	Forwarded to Chief Nurse Community for Stage 1 resolution	10
15	Dental	18.04.17	Overdue 6 month recall appt (on notes) due to dentist on sick leave; but in Feb 2017 when advised of this, patient did not wish to receive treatment from any other dentist. Patient queried use of locums and transferability of patient notes	Part upheld	Patient given explanation of current situation in PDS and notes	1
16	Dental	20.04.17	Registered patient unable to book appointment; unhappy with advice given about accessing dental service options; also copied complaint to Scottish Commission for the Regulation of Care	Part upheld	Patient given full explanation of reasons for advice given. Advised that they may remain with preferred practice but that there is no guarantee how long they will have to wait for an appointment	5
17	A&E	05.05.17	Patient complained about attitude of treating doctor in A&E	Upheld	Staff member took advice from Chief Nurse; staff member spoke with doctor, and called patient back to report.	1
18	Child Health	08.05.17	Parent unclear about how to access child prescription issued by Child	Not upheld	Parent advised to call GP	1

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
			Health			
19	CMHS	18.05.17	Patient unhappy that re-referral to CMHS was to Consultant Psychiatrist and not Consultant Clinical Psychologist as anticipated; also queried potential conflict of interest between Consultant Psychiatrist and Specialty Doctor in Psychiatry	Upheld	Copy of filenote of conversation with complainant to Director of Community Health and Social Care for pick up through the service	7
20	Catering	18.05.17	Lack of provision of information about allergens in hospital servery and options available for staff and patients; attitude of staff member when challenged about this	Escalated to Stage 2	Discussed possible solutions with complainant inc better labelling etc. Agreed to forward to Catering Manager for comment	7
21	OP/O&G	10.04.17	Complainant waiting for procedure in Aberdeen; advised by Aberdeen not on waiting list	Upheld	Patient added to list at ARI, a date expected for August 2017, advised 30.05.17	36
22	Continence service	01.06.17	Continence service - mistakes and difficulty making contact	Part upheld	Difficult to look into properly without patient details (not willing to provide them). Feedback through Levenwick HC	4

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
23	Patient Travel	04.07.17	NHS Shetland did not advise Flybe that patient needed use of lift to access aircraft	Not upheld	NHS Shetland had advised Flybe of patient needs but had not happened. Copy of booking shared with PASS and sent on to Flybe	5
24	Ward 3	06.07.17	Email to consultant raising concerns about family member's care	Not upheld	Concerns for inpatient – discussed and resolved locally	1
25	Outpatient Clinic Letter	30.06.17	Letter addressed to child not to parent/guardian, not marked Confidential	Upheld	Clerical error; explanation and apology given	26
26	Ward 1	14.07.17	Staff attitude	Upheld	Discussed with clinician by Interim Medical Director	40
27	Service change, rheumatology	14.07.17	Patient concerned about onward clinical care	upheld	Forwarded to Interim Medical Director for further advice. Letter sent to complainant and new address forwarded to Information for inclusion in records	20
28	Child Health	14.07.17	Parent not advised that CP referral had been made before Social Work visited home	Upheld	Staff contacted to remind them that all parents/guardians should be informed of CP referrals at the time they are made	1

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
29	Continence service	21.07.17	Poor service re continence supplies	Part upheld	Levenwick Health Centre indicates negative feedback on regular basis, will increase reporting	1
30	Bixter HC	04.08.17	(1) Attitude of locum GP (2) procedure for approval of patient escorts	Part upheld	response sent 24.08.17: GP apology and detail of new patient escort arrangements sent	13
31	Dental StOS	11.08.17	Length of time taken to complete denture work; let Dental Management know	Part upheld	Dental Director met with patient – satisfactory resolution	5
32	Dental StOS	16.08.17	Unhappy at not being able to get dental appointment	Not upheld	Explanation of changes to dental service	5
33	Dental GBH	19.08.17	Patient travelled from Yell with family member to find appt cancelled.	Part upheld	Staff updated mobile contacts for family and advised of Complaints Handling Procedure (i.e. escalation to Stage 2).	1
34	LHC	18.08.17	Annoyed by reception staff attitude	Not upheld	Complainant requested an emergency appt within the next 45 minutes so GP could approve Patient Travel Escort. Advised why this was not possible. Triaging GP concluded that emergency appt was not clinically necessary.	8
35	Ward 3	02.09.17	Patient unhappy with change in medication regime by both GPs and consultant	Not upheld	Patient offered chance to speak with consultant and declined; second opinion from NHS Grampian specialist (declined) and/or alternate local physician	1

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
36	Montfield dental	07.09.17	Patient unhappy with abrupt telephone attitude of receptionist when calling to make a payment	Upheld	Dental Director advised for information and any appropriate action	1
37	LHC	07.09.17	Clinician did not perform procedure patient booked in to receive	Upheld	Lerwick Health Centre Manager advised and followed up with patient and clinician	1
38	SHC	12.09.17	Unhappy with attitude of locum GP	Upheld	Note added to records that patient does not wish to see the locum GP again. Appt booked with preferred GP	1
39	Maternity	11.08.17	Unhappy with post natal care returning to Shetland from Aberdeen	Upheld	Patients met with Child and Family Health Manager 17.08.17; letter confirming outcome of discussions with staff in Shetland and Aberdeen sent 19.09.2017	5
40	Ward 3 re: A&E	25.09.17	Poor staff attitude in A&E reported by patient's relative on admission to ward	Upheld	A&E SCN met with patient and family whilst still on the Ward with a satisfactory outcome	9
41	Child Health	29.09.17	(1) GIRFEC meeting issues; no discussion about outcomes & planning (2) concerns about AHP treating child	Upheld	(1) Child and Family Health Manager to contact GIRFEC lead admin to make contact with parent re: forward planning (2) and to ask AHP Head of Service to arrange face-to-face meeting to discuss input.	1
42	A&E	03.10.17	Staff nurse had phoned wrong person re patient in A&E; potential breach of patient data	Upheld	To be discussed at as a training and development issue at next dept meeting	2
43	Dental	06.10.17	Unhappy with attitude of Dental Officer to other staff present in	Escalated to Stage 2	Apology given - patient decided to re-register with another dental practice	1

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
			front of patient			
44	Child Health	02.10.17	Parent unhappy with screening appo46intment	Upheld	Parent happy for Child and Family Health Manager to progress with Health Improvement staff and to look at pathway; School Nurse to follow-up after school break	1
45	CMHS	11.10.17	Concerns about support for suicidal patient admitted to hospital	Not upheld	CMHS Manager confirmed that appropriate care planning had taken place in conjunction with family members who had POA for patient	1
46	Dental	19.10.17	Unpleasant attitude of dentist	Upheld	Patient wanted management to be aware of poor staff attitude; patient indicated intention to escalate to Stage 2 (not forthcoming)	4
47	Continence service/Supplies	19.10.17	Problems with distribution of supplies	Part upheld	Patient satisfaction survey planned	2
48	Continence service/Supplies	19.10.17	Problems with distribution of supplies	Not upheld	Patient satisfaction survey planned	2
49	Consultant	26.10.17	Attitude of visiting consultant & rough handling of patient	Part upheld	Apology given - complainant did not accept offer to speak direct to clinician involved	2
50	CMHS	22.11.17	Patient unhappy with medication, seeking change	Not upheld	Concerns discussed with patient's CPN; patient advised of and satisfied with this; patient aware of an appointment scheduled	5

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
51	Child Health	04.12.17	Parent unhappy with way information shared between clinicians; information inaccurate and form not signed	Upheld	Child and Family Health Manager to identify who completed form for further discussion. Improvements to form discussed and agreed with changes to make it clearer	12
52	CMHS	11.12.17	Patient unhappy with CPN	Upheld	Patient changed to CPN they had seen previously	2
53	CMHS	14.12.17	Family unhappy with advice given by clinician. Requested second opinion.	Upheld	Appt arranged with Locum consultant for 19.12.17	2
54	Patient Travel	12.12.17	Unhappy about decision not to reimburse taxi journey to airport	Not upheld	EMT decision supported Patient Travel Manager's decision making	4
55	LHC Access	21.12.17	Unable to access an appointment	Not upheld	LHC manager spoke with the complainant and explained the system	2
56	Service change	22.12.17	Patient advised that Dermatology Service from NHS Grampian had been withdrawn	Upheld	Chief Executive responded - addressed concerns and advised the service would be continued	1
57	Service change	03.01.18	Query re dermatology appt	Upheld	Response based on above reply; advised patient to contact GP	2

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
58	Dental	05.01.18	Patient unhappy with attitude of dentist during consultation with regard to taking medical history in surgery and comments on smoking and general health. Also felt dentist rushed	Upheld	Patient satisfied to have discussed concerns with Dental Manager and accepted the apology given	1
59	Whalsay HC	04.01.18	Complainant unhappy with locum GP attitude towards family member	Upheld	Discussed with locum GP; letter of apology to patient by locum GP & covering letter sent to complainant	7
60	Child Health	18.01.18	Patient requested reassignment	Upheld	New HV arranged by Child and Family Health Manager	1
61	Dental	22.01.18	Orthodontic treatment follow-up	Not upheld	Dental Manager made contact directly to resolve issues	1
62	LHC	13.02.18	Unhappy with appts booking system and inability to see named GP	Not upheld	Difficulty with availability for one named GP – LHC manager suggested additional GP	2
63	LHC	15.02.19	Unhappy with delay in test results	Upheld	Investigated with labs & GP; found that test request had not been clearly labelled by clinician therefore not requested. Learning taken forward by clinician	30
64	Pharmacy	06.03.18	Frequency of prescription dropped from 3 months to 2 months	Part upheld	One month standard practice now the practice is salaried, however 3 months supply re-instated due to remote location of patient	3

	Department	Date logged	Summary of concerns	Outcome	Actions/lessons learned	no of working days
65	DXA scanning	20.03.18	Prolonged wait for DXA scan	Not upheld	Looking into where letter came from but advised re correct wait	9
66	LHC nursing	21.03.18	Vaccinations issue at LHC	Upheld	Agreed to share investigation summary briefing	1
67	LHC nursing	23.03.18	Vaccinations issue at LHC	Upheld	Advice given and apology	4
68	LHC nursing	27.03.18	Vaccinations issue at LHC	Part upheld	Meeting 06.04.18 clinician satisfied complainant understood risks; complainant chose not to sign the consent form	8
69	AAA Screening	20.03.18	Patient incorrectly identified as DNA	Upheld	Apology given. Lessons taken forward: operative to advise patients of reasons for delay; also to use electronic system to record patient arrival	22

NHS Shetland Annual Feedback and Complaints Report for 2017/18

Appendix B

Summary of Stage 2 Complaints in 2017/18

	Summary	Staff Group(s)	<= 20 wkg days	If not, why	Outcome	Actions
1	Escalated from Stage 1 complaint regarding wish to deliver baby out with the Board's Service Level Agreement	Board policy	Yes		Not upheld	• Explanation provided for why the policy exists and the requirement to adhere to this owing to financial constraints and the equitable use of resources • Maternity to undertake a review of cases as concerns noted about not being patient focussed **Case has been escalated to SPSO**
2	Staff attitude and lack of treatment	A&E	Yes		Partially upheld	• Apology provided for delay in receiving treatment • Explanation about services given that appeared to be lacking at the time (leading to poor communication) • Redirection of services raised with NHS 24 • Review of local documentation of the redirection of patients to other services from A&E to ensure there is an audit trail
3	Poor communication with patient	Consultant	No		Partially upheld	• Care not found to be lacking although communication difficulties acknowledged • Generic inbox for the ability to email appointments recommended for Medical Records
4	Staff attitude and lack of treatment	GP	No	Complaint was not logged by practice with Corporate Services correctly	Partially upheld	• Explanation for actions given and sincere apology offered for misinterpretation • Patient file note added requesting not to be seen by locum GPs

5	Inability to access appropriate support	Mental health	No	Annual leave of responder	Partially upheld	• Apology offered for delay in accessing support at a time of acute need • Service tasked with monitoring its routine and urgent waiting times so that they were better able to balance capacity with demand • Urgent referrals to be flagged and then treated as such, with those referrals being separated out and dealt with immediately after a decision was made by the team. • Exceptions to waiting times that fall outside the local target must be communicated to the patient's GP so they can consider if any other support needs to be made available
6	Staff attitude, poor communication, lack of ambulance transfer	Consultant / SAS	Yes		Partially upheld	• Meeting with Consultant Anaesthetist (as acting complaint investigator) to review medical records • Sincere apology for poor communication and misunderstanding • Response from NHS 24 and SAS included in final response • Staff to be reminded of the need for sensitivity when completing sharps questionnaires
7	Staff attitude	AHP	Yes		Upheld	• Investigation showed a clear difference of opinion between clinician and other professionals involved in patient's care. Second opinion expedited

8	Waiting time for appropriate support	Mental health	Yes		Upheld	• Referral route update to be better communicated to staff • Updating of the initial outcome letter to include advice to patients if circumstances change whilst on waiting lists
9	Non availability of fresh gluten free food in GBH canteen and reason given for this	Catering	No	Delayed to meet before response	Upheld	• Further explanation of original concern response provided regarding the definition of a safe environment for this food preparation • Signage to be optimised • Work with Coeliac UK to improve choice
10	Difficulty in accessing primary care appointments – GP and Dental	LHC/PDS	Yes		Not upheld	• Dental situation clearly explained in terms of choice of registering elsewhere • Access to clinician provided • Explanation of particular pressure points during the month and the mitigating actions taken
11	Suggested inappropriate request for note sharing between clinicians	Mental Health	No	Delay in making contact with two clinicians no longer in Shetland	Not upheld	• Explanation provided about why the request had been made • Confirmation no breach had occurred and safeguarding in place explained
12	Family not advised regarding patient transfer to care home	Ward 3	Yes		Upheld	• Full apology offered – staff error

13	Staff attitude at outpatient clinic	Consultant	No	Handover of Medical Director responsibilities	Partly upheld	• Apology offered as clinician recognised the appointment had not gone as well as either party would hope • Disagreement remains that the procedure requested by the patient was the appropriate one in the circumstances
14	Frequency of orthodontic appointments	Dental	No	Delay in response from clinician	Not upheld	• Length between appointments found to be reasonable for the care required
15	Staff attitude	Dental	No	Delay in response from clinician	Partly upheld	• Concerns not recognised by others witness to the treatment, however clinician also noted irreconcilable breakdown of relationship and requested patient removed from list • Communication misunderstandings were unfortunate
16	Discharge information and OOH care	Primary and secondary	Yes		Not upheld	• Care found to have been delivered appropriately, despite perception this was less good than it had previously been
17	Changes to patient travel rules with extended stay in between	Patient Travel	Yes		Not upheld	• Application of Highlands and Islands Travel Scheme explained including the definition of 'reasonable duration' between travel and appointments
18	Attitude of two medical staff	A&E and Ward 1	No	Meeting with complainant and changeover in MD	Upheld	• Apology given and commitment to see other consultant wherever possible to accommodate patient request

19	Lack of appropriate examination leading to delay in diagnosis for a poorly child	A&E	Yes		Upheld	• Discussion with staff involved that if the A&E department is busy on a weekend night and a similar situation arises in future to speak with parents about how they would like to proceed, for example continue to wait or organise a planned appointment for the following day with the walk-in (out of hours) clinics so that NHS Shetland does not fall short of clinical standards that everyone would expect to receive for emergency care
20	Poor communication of lab results leading to delay in surgery	Labs	Yes		Upheld	• Systems that NHS Shetland has changed in order to prevent these types of delays: anaesthetists based at GJNH and the pre-assessment team at GBH have put in place a tele-health consultation on a weekly basis to have joint discussions about patients waiting for surgery • Apology from GJNH shared with complainant

21	Misdiagnosis of child who was later transferred to RACH	A&E	No	Meeting held with parents	Upheld	• Unreserved apology • Induction training for locum clinicians to include a clear understanding of pathways for paediatric emergency care and that clinician decisions made in conjunction with paediatric colleague in Aberdeen • Primary and secondary care clinicians to jointly review paediatric emergency care pathways and agree acceptable, safe pathways across the health and care systems including clear lines of responsibility • All primary care clinicians to be aware of travel arrangements and procedures in similar circumstances and that appropriate transport arrangements (including approval of an escort) are made relative to the clinical needs of the patient and are clearly communicated to all those involved in making the arrangements
22	Staff attitude and lack of process for complaint handling	Corporate	No	Meeting with complainant	Upheld	• Explanation offered and apology given for miscommunication • Meeting offered with ND and MD to discuss clinical concerns
23	Staff attitude	Consultant	Yes	Meeting with complainant requested in future	Partly upheld	• Apology offered for offense caused and explanation that there was no indication of this at the time of the consultation offered
24	Staff attitude to patient and another member of staff	Dental	No		Upheld	• Treatment appropriate but notes supporting diagnosis were lacking in evidence • Dentist has reflected on the impact of their behaviour • Apology given for the experience

25	Perception of being blocked from seeing GP of choice	LHC	Yes		Not upheld	• Explanation offered about demand on clinical time and also that it would be safer to also establish a relationship with a further one or two GPs in the practice
26	Unhappy with management of ongoing care – second opinion requested	Consultant	No		Upheld	• Second opinion in place and encouragement to see GP as the key link between a patient and consultants who may be involved in different aspects of a care plan
27	Access to Public Dental Service for outer island residents	Dental	Yes		Upheld	• Pressure on PDS explained. Additional information included about adjusted skills mix within the team and the recent appointment of a dentist to work part of their week in the North Isles
28	Concern about consultation actions and referral to OT	GP	No		Partly upheld	• Actions not found to have breached professional protocol as MDT pathway clearly understood, but apology given for communication issues • Meeting offered with MD
29	Attitude and treatment of consultant	Consultant	No		Upheld	• Referral for a second opinion supported by MD both from a clinical point of view and in acknowledgement of loss of confidence • Apology given
30	Poor communication re x-ray result and clinic date	A&E / Medical Imaging	Yes		Upheld	• Review of options for ensuring staff communicate key contact details more effectively in future including resourcing a text messaging service

31	Communication issues	LHC	Yes		Partly upheld	• Apology offered that communication had been seen as lacking empathy and understanding • Explanation given that a clinician is now on stand by to speak direct to callers if a receptionist indicates clinical support is needed to clarify a caller's needs
32	Challenge to Patient Travel ruling re 48 hour window of return	EMT	Yes		Upheld	• Case review overruled previous decision in interests of patient centred care for individual • Information provided about potential future changes in service
33	Post-operative complications / communication with Ward	Surgery / Ward 3	No	Annual leave of key personnel	Upheld	• Meeting held to explain clinical decision making • Patient concerns re fitness for discharge should be brought to the consultant's attention • Post operative patients should be seen by GPs if requested • To be discussed at Consultants Group and disseminated to GPs
34	Delay for orthopaedic surgery	GBH/GJNH	No	Retrieval of old IT systems required at both hospitals	Upheld	• Apology given regarding delay to procedure. Information understood to have been sent by GBH but no evidence of receipt at GJNH. Investigation into system issues continued
35	Parents felt not being listened to about poorly child (subsequently to Glasgow)	Child and Family Health	Yes		Upheld	• Child and Family Health Manager met with parents prior to complaint response • Outcome of independent review to be shared with family once available

36	Staff attitude	Consultant	No	Delay in clinicians meeting to discuss	Part upheld	• Medical Director met with Consultant regarding the complaint who has reflected on the poor feedback • Stressed the importance of noting who is present in a consultation as a support measure for both the clinician and the patient
37	Parents felt not being listened to about poorly child (subsequently to Aberdeen)	Primary and secondary care	Yes		Part upheld	• Discussion with one staff member about how their attitude was perceived • Paediatric pathway review by Taskforce
38	Failure to diagnose	Community nursing	No	Delay in letter sign off	Upheld	• Additional training for staff member • Supervisory structure reviewed and strengthened
39	Delay to referral to psychologist	CMHT	Yes		Upheld	• Explanation of waiting list provided • Meeting with Head of Service to discuss concerns

NHS Shetland Annual Feedback and Complaints Report for 2017/18

Appendix C

Summary of Concerns received in 2017/18

	Department	Date	Summary of concerns	Outcome
1	Ward 3	16.04.17	Patient care and dignity issue; needs help feeding	Dignity issue noted; family can help with feeding and can visit at any time; medical and treatment notes discussed with family; family happy with outcome
2	LHC	24.04.17	Patient unhappy at receiving a written warning for unacceptable behaviour	Appointment system explained. Patient advised to go through GP for referral for other issues
3	OP referral	24.04.17	**in person**: patient angry at delay in receiving date for 2nd opinion requested in Jan 2017	Patient advised face-to-face of date & advised letter to follow. Patient very happy. Patient called following day to confirm letter had been received. Patient requested transfer to alternative practice
4	Dental	25.04.17	Dental patient seeking to understand why St Olaf St practice advised that they could not book appointments as she did not fall into priority group & advised her to re-register with LDP	Explanation given that there are 3 types of dental service currently available; private, independent NHS Dental Practice and Public Dental Service (PDS), with detail of PDS remit. Waiting lists at Montfield and St Olaf Street now closed; those on waiting list will receive letter advising them to register with Lerwick Dental Service (independent NHS practice). Existing patients may, in future, need to be advised to move to independent NHS provision in line with rest of the country
5	LHC	26.04.17	Inability to access appointments for long term chronic condition	GP call arranged for the following morning. Process for registration at alternative practice explained and email contact address provided. Temp transfer arranged for 3 months
6	LHC	25.04.17	Access to appointments; staff attitude	Patient advised of help available to complete 'pink form' (triage details); appointment with ANP secured (patient unwilling to engage with LHC manager)

7	Patient Travel	22.05.17	via MSP: travel escort for child aged 16	Parent annoyed at being advised that 16 yr old should collect own tickets from Patient Travel: Patient advised that children up to 16 will automatically be granted escort but that there is not compulsory after the 16th birthday; but can continue until child is 18 where agreed and confirmed by 16 yr old. Learning point to improve communication to 16 year olds and parents
8	Physiological measurements	23.05.17	Cover arrangements for physiological measurements and delay to OP appointments	Gap in provision of service for physiological measurements; understood cover had been arranged but not yet in place; concern at effect of OP clinic date; patient referred for 24 hr ECG monitor
9	LHC	25.05.17	Behaviour of locum GP during consultation	Lack of response from LHC following written concerns; unsatisfactory verbal explanation. Escalated to Stage 2 complaint
10	LHC	25.05.17	Transfer from LHC	Dissatisfied with service and attitude of staff at LHC re appointments system; request to transfer to alternative practice
11	CAMHS	25.05.17	CAHMS diagnosis	Dissatisfied with service and is requesting 2nd opinion via GP
12	ADTC	20.06.17	Delay to decision - request for unlicensed med prescription	Wishes to discuss with consultant earlier involved in discussions about using the medication. Favourable decision made
13	Audiology	19.06.17	Unacceptable delays in Audiology service	Explanation of staffing & recruitment issues causing delays; not appropriate to intervene in clinical prioritisation of patients
14	OP (Gen Surgery)	23.06.17	(1) OP Gen Surgery - unacceptable behaviour of consultant;(2) letter sent to direct to minor, not via parent/guardian	(1) became stage 2 complaint (2) became stage 1 complaint

15	Bixter HC appts	29.06.17	Patient unable to make regular book-ahead appt; concerned that this because practice had become salaried	September template had not been loaded due to resource issues since resolved
16	Surgery	26.06.17	Patient seeks to understand how to access private surgery; GJH refusing surgery until target weight achieved; patient in pain and able to pay for private treatment	GP agreed to see patient to discuss ways forward
17	Non-doctor islands cover	13.07.17	Cover arrangements for non-doctor islands	Concerns raised re Skerries and Fair Isle – responses from senior nursing staff
18	Dental	24.07.17	Query re appts for children registered at Montfield	Dental Director in contact to explain current situation
19	OP Rhematology	08.08.17	Service change - onward rheumatology care	Sent generic letter outlining ongoing arrangements for service provision
20	Community Nursing	09.08.17	Out of hours contact with community nurse	Confirmed 999 if emergency or NHS 24 was appropriate route (and not to make direct contact with nurse as this lacked resilience)
21	LHC	14.08.17	Patient in pursuit of definitive diagnosis in complex case; LHC not helpful	Interim Medical Director discussed with practice – GP identified for onward case co-ordination
22	LHC	21.08.17	Reception staff – poor attitude	Access issues explained
23	A&E procedure	17.08.17	Difficulties in getting needle aspirations through A&E – constructive feedback about how this could have felt better with appointment times	DN&AS spoken with appropriate staff to understand if this could be improved upon

24	Day surgery and generic waits	14.07.17	Not happy with generic waiting times given for DS appts	Anonymous feedback but learning point of instruction to be more explicit when patient arrives about how long expected wait will be and the reasons for this (clinical priority, emergency etc)
25	Dental SoS	28.07.17	Unhappy with St Olaf St and access to appointments	Dental Director met with patient
26	OP Rheumatology	18.08.17	Onward rheumatology care	DN&AS in direct contact
27	OP Rheumatology	28.07.17	Onward rheumatology care	DN&AS in direct contact
28	OP Rheumatology	28.08.17	Onward rheumatology care	DN&AS in direct contact
29	Travel Vaccs	29.08.17	Patient advised LHC no longer able to do travel vaccinations due to staffing issues	Being covered by community nurse – further discussion required
30	Travel Vaccs	28.07.17	Patient advised LHC no longer able to do travel vaccinations due to staffing issues;	Being covered by community nurse – further discussion required
31	Pain Clinic	21.08.17	Patient heard that Pain Clinic service is under threat	Response outlining challenges to service
32	CMHT	22.09.17	Family concerns about under provision/ communication from CMHT re family member's care	Service responded through DCH&SC

33	PC	25.09.17	In 2015 patient asked for his telephone number to be deleted; seeks reassurance that number has been deleted from all places in NHS Shetland system as he received a call from LHC	Original complaint investigation reviewed and appropriate action taken
34	GP	26.09.17	Patient unhappy with GP attitude but concerned they would be 'struck off' if concerns raised	Reassured patient that they would not be 'struck off' and that concerns would be noted
35	Levenwick HC	05.10.17	Patient 'told that the Board decided that fasting glucose tests are not to be performed (for diabetes)	Not a blanket NHS Shetland decision; Levenwick independent GP practice following national guideline recommendations. GP advised happy to speak to patient to explain
36	Opticians	13.10.17	Patient unhappy at not getting refund for second eye-test at different opticians	Letter reflects advice already given re eye test funding
37	GP/Physio	27.10.17	Unhappy with locum GP service & physio; why no referral to orthopaedics	Written response sent re care pathway
38	SC/PC	06.11.17	Patient concerns around competency of clinician in diagnosis (2013); ongoing care (GP) supporting therapies (CHSC, AHP)	Written response provided by Chief Executive and Interim Medical Director
39	OP referral	13.11.17	Patient not had VC consultation, expected in October; phoned Glasgow, told referral not received	Treatment clarified
40	CMHS	13.11.17	Patient seeking correct diagnosis	Closed in liaison with service directly
41	LHC	05.04.17	Access to appointments; staff attitude	Apology provided and assurance given regarding access

42	Rheumatology	03.11.17	Query re ongoing arrangements for rheumatology	CE responded directly
43	Pain Clinic	14.11.17	Query re ongoing arrangements for pain management	CE replied direct re ongoing arrangements
44	Anaesthetics	28.11.17	Concerns about outcome from day surgery procedure	Meeting with Medical Director. Became formal complaint
45	A&E procedure	14.12.17	Concerns about non-charging of non-EU patient in A&E (as seen on Island Medics 13.12.17)	Explained no charge in A&E for any patient (wherever domiciled) seen only in A&E. (Admission to ward is re-charged)
46	Pharmacy	15.12.17	Patient unhappy about prescription change which had unpleasant side-effects. Had been advised that change was to save money rather than general availability of previous meds.	Director of Pharmacy checked and confirmed shortage of previous meds; agreed that patient could revert to original meds for as long as available and that if not available, other meds to be considered as substitute as necessary
47	Rheumatology	18.12.17	Query re: rheumatology treatment pathway	CE responded directly
48	Orthopaedics	18.12.17	Query re: travel to ortho appts in Aberdeen rather than visiting consultant service	CE responded directly
49	Dental	09.01.18	Pursuit of apparently missing dental record	MJ gave assurance records being sought and re-examined. Subsequently dropped

50	GP	09.01.17	Concern over potential medical record breach by GP	GP named had not worked for NHS Shetland since 2016
51	Pharmacy	11.01.18	Concern over length of waiting time at hospital pharmacy & other concerns	Apology and explanation for delay given
52	OP Rheumatology	16.01.18	Concern re cortico-steroid injections	Patient to meet with Medical Director
53	Patient Transport	15.01.18	Concerns about poor service from SAS Patient Transport	Local SAS rep contacted for name of link person
54	OP Rheumatology	12.01.18	Update re OP Rheumatology	Reassured that arrangements are being put in place
55	Eye clinic ARI	19.01.18	Feedback for Grampian re cancelled OP clinic	Patient attended Aberdeen Eye clinic and appt was cancelled without reason. Wasted journey discuss with MD who arranged to see patient in Lerwick Eye Clinic
56	Follow-on care	30.01.18	Patient feels neglected by NHS Shetland services since leaving hospital	Post discharge arrangements and community health & care services reviewed
57	Rheumatology	05.02.18	Seeks clarity about rheumatology provision in NHS Shetland	Explanation about service plans provided
58	Contact for GP	04.02.18	Been told to contact GP but couldn't get able to get email address	Checked with GP and supplied email address
59	Audiology	04.12.17	Does not want to change hearing aid models	Written response issued - patient thanked respondent for letter

60	Rheumatology	16.02.18	Pain clinic injections: concerns over service disruption	Explained recruitment issues and service cover by locums including a Pain Specialist who will provide cover in the coming months while recruitment continues
61	LHC	13.02.18	Concern that GPs do not recognise CFS	Emailed with link to CFS website; GPs to get copy correspondence
62	LHC	22.02.18	Concerns about blood pressure medication	Ongoing discussions with Medical Director
63	Patient Travel	27.02.18	Escorted travel query	Ward 1 request made for patient travel; escort not approved. Review group agreed escort was appropriate and travel costs should be reimbursed
64	Patient Travel	02.03.18	Patient unable to find child care to attend ARI appt	Offered return boat trip to enable child to go at minimum cost – satisfactory outcome for patient
65	Psychological Therapies	06.03.18	Query over psychology therapy waiting times after referral	Current position explained

NHS Shetland Annual Feedback and Complaints Report for 2017/18

Appendix D

Complaint process experience results (key performance indicator at 4.2)

Description	2017/18	% (8 replies)
1. How satisfied were you that you were easily able to make your complaint?	Very Satisfied	25% (2 of 8)
	Satisfied	37.5% (3 of 8)
	Neither Satisfied or Dissatisfied	12.5% (1 of 8)
	Dissatisfied	12.5% (1 of 8)
	Very Dissatisfied	-
	Question Skipped	12.5% (1 of 8)
2. How satisfied are you with how you were treated when you were making your complaint?	Very Satisfied	25% (2 of 8)
	Satisfied	25% (2 of 8)
	Neither Satisfied or Dissatisfied	12.5% (1 of 8)
	Dissatisfied	25% (2 of 8)
	Very Dissatisfied	-
	Question Skipped	12.5% (1 of 8)
3. Do you feel that we showed empathy (an understanding of your feelings) when dealing with your complaint?	Yes	50% (4 of 8)
	No	37.5% (3 of 8)
	Question Skipped	12.5% (1 of 8)
4. Did we apologise for your experience?	Yes	75% (6 of 8)
	No	25% (2 of 8)
	Question Skipped	-
5. How satisfied were you that we responded to you in a timely manner?	Very Satisfied	12.5% (1 of 8)
	Satisfied	62.5% (5 of 8)
	Neither Satisfied nor Dissatisfied	-
	Dissatisfied	-
	Very Dissatisfied	12.5% (1 of 8)
	Question Skipped	12.5% (1 of 8)
6. Did the complaints response letter clearly detail the outcome of your complaint?	Yes	62.5% (5 of 8)
	No	12.5% (1 of 8)
	Question Skipped	25% (2 of 8)
7. Overall, how satisfied were you with the complaints procedure?	Very Satisfied	-
	Satisfied	25% (2 of 8)
	Neither Satisfied or Dissatisfied	25% (2 of 8)
	Dissatisfied	37.5 (3 of 8)
	Very Dissatisfied	-
	Question Skipped	12.5% (1 of 8)
8. Finally, do you have any other comments about how your complaint was handled or suggestions on how we may improve our service to customers?	Comments received relate to complaints outcomes rather than process issues	

Shetland Islands Health and Social Care Partnership

Agenda Item

3

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	13 March 2019
Report Title:	IJB Medium Term Financial Plan 2019/20 to 2023/24	
Reference Number:	CC-16-19-F	
Author / Job Title:	Karl Williamson / Chief Financial Officer	

1.0 Decisions / Action required:

That the IJB:

1.1 APPROVES the IJB Medium Term Financial Plan 2019/20 to 2023/24.

2.0 High Level Summary:

2.1 This is the first medium term financial plan (MTFP) for the IJB and will provide key information on the financial position of the IJB over the next five years.

2.2 The MTFP will provide the financial framework within which the Joint Strategic Commissioning Plan should evolve.

2.3 Taking into account costs, demands, estimated changes to funding and assuming nothing else changes the funding shortfall over the next five years will be £7.7m.

2.4 The proposed IJB MTFP draws on the assumptions made by the Parties to the Health and Social Care Partnership in Shetland. The Council and the Health Board both have medium term financial plans covering the period up to 2023/24, however, it must be recognised that these are subject to revision year on year to ensure they remain true to the circumstances in which they operate recognising that the levels of funding to each party are subject to changes out with their control from both the Scottish and UK governments as well as from uncertain future contexts arising for example from BREXIT. Therefore the IJB must also commit to at least an annual revision of its MTFP in order to reflect changing circumstances.

3.0 Corporate Priorities and Joint Working:

3.1 It is essential that the IJB develops and maintains a medium term financial plan to enable it to direct finances at the services which will deliver the greatest impact, support a shift in the balance of care, and will set the context for annual budgets.

3.2 The ability to plan based on the totality of resources across the health and care system to meet the needs of local people is one of the hallmarks of integrated care. Medium term financial planning is key to supporting this process and identifying the transformation which is required to provide sustainable services to the local community over the medium to long term.

3.3 Successful cross system planning and budgeting will benefit all partners by achieving better outcomes at lower cost. Aligned corporate priorities will be achieved through efficient integrated working practices which reduce duplication and waste.

4.0 Key Issues:

4.1 The IJB has a responsibility for the planning of integrated services in line with the agreed priorities set out in the Strategic Plan. The IJB must ensure that there are adequate financial resources to deliver services and the outcomes of the Strategic Plan. The MTFP enables the IJB to better plan for meeting future need and to ensure the sustainability of the services it commissions.

4.2 The need for a Medium Term Financial Plan has been further highlighted by the IJB's external auditors, Deloitte LPP, following their 2017/18 audit process and is now one of the main priorities for 2019/20 and beyond.

4.3 This document provides a set of financial parameters, over a five year timeframe, in which local plans can be developed.

4.4 The Scottish Government Medium Term Health and Social Care Financial Framework, Shetland Islands Council's Medium Term Financial Plan 2018/19 to 2023/24 and NHS Shetland's Local Operational Plan 2019/20 to 2023/24 have been used to inform this document.

4.5 Taking into account costs, demands, estimated changes to funding and assuming nothing else changes the funding shortfall over the next five years will be £7.7m.

4.6 The MTFP highlights the expected funding shortfall over the next five years. The solutions to closing this gap will have to be developed through the strategic planning process with full support from all key stakeholders.

4.6 The IJB MTFP will be updated annually in line with the budget setting cycle so it remains accurate and relevant.

5.0 Exempt and/or confidential information:

None

6.0

6.1 Service Users, Patients and Communities:	None arising directly from this report.
6.2 Human Resources and Organisational	None arising directly from this report.

Development:	
6.3 Equality, Diversity and Human Rights:	None arising directly from this report.
6.4 Legal:	The proposals in this report are consistent with the Public Bodies (Joint Working) (Scotland) 2014 Act and the Integration Scheme for Shetland's IJB.
6.5 Finance:	This report contains indicative funding allocations to the IJB from SIC and NHSS over a five year timeframe. These figures are subject to change and only provide reasonable estimates at this time. The funding shortfall over the next five years based on current assumptions will be £7.7m. The role of the IJB in planning and directing services is key to addressing the shortfall.
6.6 Assets and Property:	None arising directly from this report as the IJB doesn't own any assets or property. Both partner organisations have policies and procedures in place which govern their assets and property. However, in order to address the anticipated shortfall in funding over the medium term, the IJB will need to consider the revenue costs and implications arising from the accommodation currently used to deliver services and make strategic planning decisions in this regard.
6.7 ICT and new technologies:	None arising directly from this report, however, the use of new technologies will be a critical factor in developing sustainable models of service delivery going forward and the need for high speed connectivity throughout the isles is a key issue in this regard.
6.8 Environmental:	None arising directly from this report.
6.9 Risk Management:	Failure to agree a MTFP for the IJB will attract adverse criticism from external audit and other scrutiny bodies. The need for strong collaborative leadership has been highlighted in the recent reviews of health and social care partnerships by Audit Scotland and Scottish Government. The IJB MTFP is a required element of the strategic planning framework for the IJB, without it, the IJB cannot develop a viable 3 year Strategic Commissioning Plan.
6.10 Policy and Delegated Authority:	The IJB has authority from SIC and NHSS for the functions delegated to it as per the Integration Scheme. The IJB must direct service delivery, within its funding allocation, to deliver the outcomes of the Strategic Commissioning Plan.
6.11 Previously considered by:	The proposals in this report have not been presented to any other committee or organisation

Contact Details:
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11th February 2019

Appendix 1 - IJB Medium Term Financial Plan 2019/20 to 2023/24

Shetland Islands Integration Joint Board

Medium Term Financial Plan 2019/20 to 2023/24

March 2019

Review Date: March 2020

Contents

1. Executive Summary

1.1 The Shetland Islands Integration Join Board (IJB) is facing significant financial challenges and if nothing else changes spending would need to increase by 17% by 2023/24.

1.2 This Medium Term Financial Plan (MTFP) will provide the financial context for the Partnership, inform future decisions and start to identify a high level plan to bridge the financial gap moving forward and to deliver on the national commitment to shift the balance of care by 2023/24.

1.3 Taking into account costs, demands, estimated changes to funding and, assuming nothing else changes, the funding shortfall over the next five years will be £7.7m in total.

2. Introduction

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

2.2 The IJB has prepared management accounts and statutory annual accounts from 20 November 2015 when the first Joint Strategic Commissioning Plan was agreed.

2.3 The financial management of the IJB is governed by the Integration Scheme and the IJB's Financial Regulations. The Scottish Government established the Integrated Resources Advisory Group (IRAG) to consider the financial implications of integrating health and social care, and to help develop professional guidance. This guidance is used in conjunction with the Financial Regulations to assist on technical accounting matters.

3. Context

3.1 The IJB is responsible under the terms of the Public Bodies Act and the Integration Scheme for the planning and direction of integrated health and social care services in order to achieve Scotland's National Health and Wellbeing Outcomes for the local population. The IJB must ensure that there are adequate financial resources to deliver services and the outcomes articulated in a local Strategic Plan. The MTFP enables the IJB to better plan for meeting future need and to ensure the sustainability of the services it commissions.

3.2 The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are to achieve through integration and the pursuit of quality improvement across health and social care. By working with individuals and local communities, Shetland's IJB will support people to achieve the following outcomes:

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

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

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

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

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

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

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

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

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

4. Planning Assumptions 2019/20 to 2023/24

4.1 Shetland Islands Council (the Council) Medium Term Financial Plan 2018/19 – 2023/24 and Shetland NHS Board (the Health Board) Annual Operational Plan 2019/20 – 2023/24 provide background concerning each of the funding partners own planning assumptions and significant challenges. These detailed planning assumptions are consistent with the IJB's own situation and are therefore not duplicated in this document.

4.2 The documents in (4.1) will be updated on a regular basis and will inform the annual update of the IJB MTFP. The IJB MTFP is deliberately concise to avoid significant annual amendments.

4.3 The Scottish Government Medium Term Health & Social Care Framework has also been used to inform the IJB MTFP. This Framework supports the Health and Social Care Delivery Plan and sets out in more detail the potential approach and type of initiatives required to ensure continued delivery of a financially balanced and sustainable Health and Social Care system.

4.4 The Parties to the Integration Scheme for Shetland's IJB, i.e. the Council and the Health Board are required to allocate funding for the functions they have delegated to the IJB. Currently, the increasing pressure on health and social care from changing demographics, epidemiology and the increasing pressure on public finance

mean that it is becoming increasingly difficult to fully fund the current service model. It is recognised that transformational change is required in order to develop sustainable services that will meet the needs of the local population by achieving the desired outcomes articulated both at a national level and locally in the Shetland Partnership Plan and the IJB's Strategic Plan.

4.5 The allocation for each year is advised by each Party as it sets its budget for the incoming financial year. Currently, in line with national guidance, this becomes the control total on which future year funding allocations are based.
The IJB is required to develop its Strategic Commissioning Plan within the financial envelope provided by the Parties and to advise the Parties of any issues arising from funding constraints so that the relevant Party can assess the risk and adjust the funding allocation to cover any anticipated shortfall or accept the requisite change in service that will be Directed by the IJB as a consequence of the lack of funding. This allows each Party to address the issues and fulfil their continuing duty of accountability for the functions delegated to the IJB.
Further detail on this process is included in the Integration Scheme and Financial Regulations of the IJB and is not replicated here.

4.6 The Council's allocation for the period covered by the IJB MTFP is in line with its own Medium Term Financial Plan and is not expected to decrease over the timeframe of the IJB MTFP.

4.7 The Health Board allocation is expected to be increased each year in line with their own core baseline funding increase from the Scottish Government. NHSS allocation contains the Scottish Government Additional funding for Social Care.

4.8 In addition to the opening allocations, funding partners will pass any relevant in-year specific health and social care allocations across to the IJB increasing the IJB budget.

4.9 The MTFP is reviewed annually to ensure it remains aligned to the best information available at the time.

4.10 **Appendix 1** models these proposals over the 5 year timeframe.

5. Reserves

5.1 The IJB reserves will be managed in line with the IJB Reserves Policy.

5.2 With the extremely challenging savings targets over the term of the plan it is unlikely that the IJB will accumulate any material levels of reserves.

5.3 It is therefore not considered necessary to factor any reserve balances into this MTFP. Should this situation change the MTFP will be adjusted during the annual update process.

6. Recovery Plan

6.1 Longer term planning must be accelerated to enable safe, effective and sustainable services to be delivered within the funding available. The MTFP provides the financial parameters within which the Strategic Plan should be progressed.

6.2 Appendix 1 estimates that there will be £48.7m IJB funding available in 2023/24. The IJB must plan ahead to ensure that the outcomes of the Strategic Plan can be delivered, at that time, within the estimated funding allocation available.

6.3 The Joint Strategic Commissioning Plan 2019-2022 contains change programmes and projects which will provide the framework on which to develop longer term sustainable solutions for health and social care services in Shetland. As these projects progress the MTFP Recovery Plan will be updated to reflect the detailed plans expected to address the current funding gap.

6.4 The MTFP and Strategic Plan must be aligned so that there is a clear audit trail between the financial resources allocated by each Party and the desired outcomes of the Strategic Plan. Currently there is a high level of uncertainty with regard to timely achievement of the savings anticipated from planned service redesign projects. The IJB will provide regular updates to the Council and the Health Board regarding progress and any issues for the Parties in this regard.

Appendix 1 – Projected IJB Financial Position 2019/20 – 2023/24

	2019/20	2020/21	2021/22	2022/23	2023/24
Cost of Services	£48,181,541	£50,108,803	£52,113,155	£54,197,681	£56,365,588
IJB Funding					
SIC	£22,019,069	£22,093,249	£22,215,729	£22,395,022	£22,628,955
NHSS	£23,629,492	£24,220,229	£24,825,735	£25,446,378	£26,082,538
Total Funding	£45,648,561	£46,313,479	£47,041,464	£47,841,400	£48,711,493
Cumulative Funding Shortfall	-£2,532,980	-£3,795,080	-£5,071,080	-£6,355,280	-£7,652,680

Assumptions:

As per Scottish Government Medium Term Health & Social Care Financial Framework (4.3) *:

- Social Care costs expected to increase by 4% each year *
- Health costs expected to increase by 3.5% each year *
- SIC funding is not expected to decrease over the term of the plan
- NHS funding is protected and is expected to increase in line with inflation at 2.5%
- No savings are achieved over the period of the plan. This is the ‘do nothing’ scenario
- As with all assumptions these projections are indicative and subject to change over time.

Shetland Islands Health and Social Care Partnership

Agenda Item

4

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	13 March 2019
Report Title:	2019/20 Budget	
Reference Number:	CC-15-19-F	
Author / Job Title:	Karl Williamson / Chief Financial Officer	

1.0 Decisions / Action required:

That the IJB:

1.1 APPROVES the proposed budget for the Shetland Integration Joint Board (IJB) based on the conditions stipulated in 4.30 – 4.40.

1.2 APPROVES the proposed application of the Scottish Government Additionality funding as detailed in Appendix 2.

1.3 DIRECTS Shetland Islands Council and NHS Shetland to deliver the Joint Strategic Commissioning Plan within the funding available. This will include the delivery of the Recovery Plan (4.11) and further non recurrent savings measures (4.37).

2.0 High Level Summary:

2.1 This report sets out the proposals for the 2019/20 payments to the IJB from Shetland Islands Council (SIC) and NHS Shetland (NHSS) and the associated budget of the Shetland IJB.

2.2 SIC and NHSS have proposed payments to the IJB for 2019/20 which are in excess of their 2018/19 payments and meet the requirements of the Scottish Government.

2.3 The IJB has responsibility for the planning, resourcing and operational delivery of all integrated services. Decisions on integrated services are made by the IJB, which produces the Strategic Plan.

2.4 Ideally the IJB should produce the Strategic Plan to deliver services within the funding allocation available. However, since the formation of the IJB in 2015 the payments to the IJB have not been enough to fund services as they are currently delivered.

2.5 This theme continues into 2019/20 where there is again a significant gap between the payments made to the IJB and the cost of services it currently directs.

2.6 To enable the IJB to approve its budget by the end of March 2019 and to address key audit recommendations certain conditions and low risk savings proposals have been agreed between partners which reduces the IJB's financial risk to acceptable levels.

3.0 Corporate Priorities and Joint Working:

3.1 The proposals support the IJB's vision, aims and strategic objectives as set out in the Integration Scheme and the Joint Strategic Commissioning Plan 2018-21.

3.2 The payments to the IJB and the subsequent IJB budget provide the financial framework to which the Strategic Plan must be aligned.

3.3 Effective budget setting across the health and social care system and shared ownership of our significant challenges will support the redesign agenda and help achieve a sustainable model of healthcare for Shetland.

4.0 Key Issues:

4.1 **Payments to the IJB**

4.2 SIC and NHSS have both proposed payments to the IJB which are in excess of their 2018/19 payments and meet the requirements of recent Scottish Government guidance.

	SIC (£m)	NHSS (£m)	Total (£m)
2018/19	20.807	23.342	44.149
2019/20	22.019	23.629	45.648
Increase	1.212	0.287	1.499
SG minimum increase permitted	0.386	0.190	0.576
Compliant Y/N	Y	Y	

4.3 SIC and NHSS have both determined their payments based on the current cost of delegated services and in line with their own standing financial instructions.

4.4 Robust planning assumptions have been made by each partner which includes anticipated government funding levels, pay awards and changes to pension contributions.

4.5 A review of SIC and NHSS own financial plans suggests these figures are in line with expectations and are considered to be reasonable proposals.

4.6 **IJB Budget 2019/20**

4.7 The budget should be set to deliver services within the funding allocation above and in line with the Strategic Plan. With the challenging financial climate, reflected in both SIC and NHSS medium term financial plans, there is currently a £2.533m (5.3%) shortfall between the funding on offer and the cost of the current service model.

	SIC (£m)	NHSS (£m)	Total (£m)
Proposed payment	22.019	23.629	45.648
Current cost of services	22.019	26.162	48.181

Funding shortfall	0	(2.533)	(2.533)

4.8 IJB budgets continue to be predominately set by the funding partners based on the cost of the current service models. The IJB is kept informed through regular seminars but its influence in the process must be enhanced in future years.

4.9 The detailed 2019/20 budget is included at Appendix 1.

4.10 In addition to the operational budget the IJB has a general reserve balance of £364k going into 2019/20. Funding of £51k for a Falls Prevention Co-ordinator was approved in March 2018 so the remaining available reserve balance is £313k.

4.11 **Recovery Plan**

4.12 Management have identified several areas where they believe savings can be achieved in 2019/20. Service Managers are confident these savings can be achieved in-year and are therefore considered low risk. It is recommended that the IJB requests and monitors SMART business plans concerning each of the main projects below.

Proposal	£m	Recurrent (R) / Non-Recurrent (NR)
Pharmacy & Prescribing	0.300	R
Primary Care Review	0.100	R
Community Nursing	0.179	R
Mental Health SLA	0.100	R
Vacancy Factor	0.100	NR
Assumption of SG Additional Funding (Island Harmonisation)	1.200	To be confirmed
Total	**1.979**	

4.13 **Pharmacy & Prescribing**

4.14 Pharmacy has a good track record of delivering savings through specific strands of work that includes tackling polypharmacy; the use of generic medicines; and supporting clinicians with prescribing decisions. A new project to reduce the costs attached to nutritional supplements has a good potential to yield savings.

4.15 **Primary Care Review**

4.16 There is opportunity to streamline back office functions and make improvements to the public facing administrative functions, whilst delivering efficiencies. I.T are supporting this project, which will create better access to records across primary care to facilitate these improvements.

4.17 **Community Nursing**

4.18 The service has been working to create sustainability and resilience through a redesign project over the last couple of years. During that time additional health centres came into the health board managed portfolio, and considerable time and effort has been focused on incorporating practice nursing into the community

nursing service. The output of this work will culminate in efficiencies being identified for the start of the 19/20 financial year.

4.19 **Mental Health SLA**

4.20 Significant progress has now been made to develop the adult mental health service. The health board has committed additional funding to the mental health service for consultant psychiatry. The reduction in off island transfers of patients to Cornhill hospital is one demonstrable output from the way in which the service is now operating, managing more people on-island. The reduced activity off-island has led to a commensurate decrease in the money being spent off-island.

4.21 **Vacancy Factor**

4.22 In the region of £0.100m has been achieved in each of the last two years and there is nothing to suggest that a similar sum cannot be achieved in 2019/20.

4.23 **Assumption of SG Additional Funding (Island Harmonisation)**

4.24 With the receipt of £1.2 million as a non recurrent sum in 18/19, we are assuming at least a further non-recurrent allocation in 19/20. We will also be seeking agreement on a recurrent sum for future years to fully recognise the cost of primary care.

4.25 **Due Diligence**

4.26 SIC has approved its budget on 26th February. NHSS approved a draft financial plan and budget at its meeting on 19th February. NHSS has been asked to submit a draft budget to the Scottish Government in March with the expectation this will be formally agreed at the Board meeting on 16th April or 21st June. No material changes are anticipated between the proposals contained in this report and the final approved budgets. Any minor budget adjustments will be detailed in the quarterly management accounts during 2019/20.

4.27 Proposed payments to the IJB from both SIC and NHSS are compliant with recent Scottish Government guidance.

4.28 The IJB currently has two outstanding key audit recommendations concerning the budget setting process.

- The IJB should 'approve' its 2019/20 budget, as opposed to 'noting' it and should do so before the start of the 2019/20 financial year.

- The IJB should take ownership and financial risk for the budget.

4.29 The current funding gap of £2.533m poses a significant risk to the IJB and therefore the 2019/20 budget can only be approved as a result of the below conditions (4.30 – 4.40).

4.30 <u>SIC</u>

4.31 SIC has provided a fully funded budget to the IJB with an additional £0.386m contingency budget to cover any potential overspends. During the budget setting process some further cost pressures were identified which it is proposed will be

budgeted for within the Council Cost Pressures and Contingency Budget. The cost of these items is less certain, but estimation has been made of the expected costs.

4.32 Should SIC delivered services require further funding in addition to the core budget plus £0.386m contingency budget the Chief Officer and Chief Financial Officer will have to prepare a Business Case, as per the IJB Financial Regulations, requesting further funds from SIC. This request will have to be considered by SIC Policy and Resources Committee.

4.33 NHSS

4.34 The NHSS allocation to the IJB is £2.533m less than the current cost of NHSS delivered services.

4.35 NHSS has set aside a £0.800m contingency budget for cost pressures associated with temporary staff. This will help support any in-year overspends as a result of primary care and hospital locums. This will mitigate any overspends against 2019/20 budgets which has been a significant issue in recent years.

4.36 The NHSS savings proposals at 4.12 should also provide a degree of assurance to IJB members. If all these proposals are achieved the 2019/20 remaining funding gap will be reduced to £0.554m.

	£m
Opening Funding Shortfall	2.533
Savings Proposals (4.11)	1.979
Gap Remaining	**0.554**

4.37 It is anticipated that the remaining gap of £0.544m will be closed by additional non-recurrent actions. The NHS has a good track record of achieving non recurrent savings and it is expected that this will continue into 2019/20.

4.38 Should NHSS fail to address the Recovery Plan and deliver services within budget the Chief Officer and Chief Financial Officer will have to prepare a Business Case, as per the IJB Financial Regulations, requesting further funds from NHSS. This request will have to be considered by the NHSS Board.

4.39 NHSS has already agreed to provide extra funding to the IJB to balance the NHSS arm of the operational budget providing NHSS as a Board can achieve overall financial balance within its 1% flexibility.

4.40 Should NHSS fail to achieve financial balance within its 1% flexibility a funding mechanism will have to be agreed between all three partners which will likely result in less funding being available to the IJB in future years.

4.41 **IJB Medium Term Financial Plan (MTFP)**

4.42 The IJB budget should contain a three year indicative funding allocation to help support the strategic planning process.

4.43 The MTFP will provide a longer term indicative financial envelope in which the Strategic Plan can evolve. Funding commitments over a five year timeframe will allow the IJB to move towards a truly pooled budget where funding is directed towards best value outcomes.

4.44 A draft Medium Term Financial Plan will be presented as a separate agenda item at today's meeting.	
5.0 Exempt and/or confidential information:	
None	
6.0	
6.1 Service Users, Patients and Communities:	Changes to budgets will occur as efficiency schemes are developed to address the current funding gap. Service change will require a separate process for public and user engagement in line with NHSS, SIC and IJB policies.
6.2 Human Resources and Organisational Development:	Any service development proposals or changes affecting staff will be subject to full staff engagement and consultation with staff and their representatives through the Joint Staff Forum and other consultation committees in line with the relevant agencies policies and procedures.
6.3 Equality, Diversity and Human Rights:	None arising directly from this report. Any equalities impacts will be assessed and considered as part of any proposals for change and schemes for efficiency savings.
6.4 Legal:	The proposals in this report are consistent with the Public Bodies (Joint Working) (Scotland) 2014 Act and the Integration Scheme for Shetland's IJB.
6.5 Finance:	This report sets out the proposed budget for the IJB for 2019/20 of £45.648m. This is an increase of £1.499m on 2018/19 and ensures that both SIC and NHSS comply with the requirements set for them on the use of their Scottish Government funding allocations for 2019/20 as calculated at 4.2 above. The proposed funding allocations from the Parties include a £2.533m funding shortfall. A plan is presented at 4.12 above to address £1.979m of this shortfall, with the remaining £0.554m unidentified at this stage.
6.6 Assets and Property:	None arising directly from this report as the IJB doesn't own any assets or property. Both partner organisations have policies and procedures in place which govern their assets and property.
6.7 ICT and new technologies:	None arising directly from this report.
6.8 Environmental:	None arising directly from this report.
6.9 Risk Management:	Should there be year end overspends on IJB budgets and the Parties do not agree to provide additional funding there could be a financial risk to the IJB. Considering the fact that the SIC arm of the budget is fully funded and that NHSS has agreed to provide additional funding (4.39) the risk is considered low.
6.10 Policy and Delegated Authority:	The IJB has authority from SIC and NHSS for the services delegated to it as per the Integration Scheme. The IJB must direct service delivery, within its funding allocation, to deliver the outcomes of the Strategic Commissioning Plan.

6.11 Previously considered by:	The proposals in this report have not been presented to any other committee or organisation	

Contact Details:
Karl Williamson, Chief Financial Officer, karlwilliamson@nhs.net
28th February 2019

Appendices:
Appendix 1 – IJB Budget 2019/20
Appendix 2 – Proposed application of Scottish Government Additionality Funding

Appendix 1

IJB Budget 2019/20

Service	NHS	SIC	NHS Set Aside	TOTAL
	£	£	£	£
Mental Health	1,438,364	592,883	0	2,031,247
Substance Misuse	402,269	179,594	0	581,863
Oral Health	3,124,523	0	0	3,124,523
Pharmacy & Prescribing	6,073,749	0	571,761	6,645,510
Primary Care	4,430,563	0	0	4,430,563
Community Nursing	2,721,212	0	0	2,721,212
Directorate	92,990	957,082	0	1,050,072
Pensioners	0	79,845	0	79,845
Sexual Health	0	0	44,813	44,813
Adult Services	57,406	5,464,576	0	5,521,982
Adult Social Work	0	2,992,639	0	2,992,639
Community Care Resources	0	11,542,901	0	11,542,901
Criminal Justice	0	38,842	0	38,842
Speech & Language Therapy	89,116	0	0	89,116
Dietetics	116,280	0	0	116,280
Podiatry	235,962	0	0	235,962
Orthotics	138,329	0	0	138,329
Physiotherapy	593,382	0	0	593,382
Occupational Therapy	187,762	1,433,707	0	1,621,469
Health Improvement	0	0	224,174	224,174
Unscheduled Care	0	0	2,864,454	2,864,454
Renal	0	0	201,524	201,524
Intermediate Care Team	452,182	0	0	452,182
Reserve	463,874	0	182,021	645,895
SG Additionality	1,444,000	-1,278,000	0	166,000
IJB Running Costs	11,762	15,000	0	26,762
Total	**22,073,725**	**22,019,069**	**4,088,747**	**48,181,541**
Efficiency Target	-2,275,289	0	-257,691	-2,532,980
Grand Total	**19,798,436**	**22,019,069**	**3,831,056**	**45,648,561**

Appendix 2

Proposed application of Scottish Government Additionality Funding

Funding Streams	£000s	Description	Conditions	Current Status
1. Scottish Government Additional Funding for Social Care 1	1,024	Recurrent in nature and now in NHSS baseline funding – first received in 2016/17. Additional funding allocation paid to NHS Shetland and passed to IJB.	£512k Can be used by SIC to help cover existing pressures such as changing demographics and minimum wage compliance. The remaining £512k is to be used by IJB to fund 'additionality'.	
2. Scottish Government Additional Funding for Social Care 2	420	Recurrent in nature and now in NHSS baseline funding – first received in 2017/18. This funding has to be taken form NHS Shetland's baseline funding so no separate allocation received.	Up to £340k can be used by SIC to cover existing pressures such as changing demographics and minimum wage compliance. SIC has proposed to use the full £340k for this purpose. The remaining £80k is to be used by IJB to fund 'additionality'	
Total	**1,444**			
Proposed application of Funding				
Enhanced Intermediate Care Team	80	Full details of the enhanced Intermediate Care Team and funding can be seen in IJB paper CC-25-17 (13/07/17)	Current proposal is non recurrent for 2019/20 only. IJB should approve the use of these funds annually.	Seeking agreement in principle today
Self Directed Support	348	To fund increased demand in Self Directed Support Packages.	Current proposal is non recurrent for 2019/20 only. IJB should approve the use of these funds annually.	Seeking agreement in principle today
Social Work – Hospital Discharge Liaison	78	Specifically to focus on expediting timely hospital patient discharges, co-ordinating all agencies to ensure that rehabilitation is prioritised.	Current proposal is non recurrent for 2019/20 only. IJB should approve the use of these funds annually.	Seeking agreement in principle today
Reablement Programme to support Care Centres	86	To focus primarily on Montfield Support Services and develop the rehabilitation model further.	Current proposal is non recurrent for 2019/20 only. IJB should approve the use of these funds annually.	Seeking agreement in principle today
Used by SIC to offset overall Council settlement	512		Recurrent – Across all SIC budgets	Complete - As per SG guidance
Used by SIC to offset overall Council settlement	340		Recurrent – Across all SIC budgets	Complete - As per SG guidance
	1,444			

Shetland Islands Health and Social Care Partnership

Agenda Item

5

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board (IJB) NHS Board Policy and Resources Committee Shetland Islands Council	13 March 2019 16 April 2019 13 May 2019 15 May 2019
Report Title:	Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan 2019-2022	
Reference Number:	CC-14-19-F	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland on behalf of Simon Bokor-Ingram, Chief Officer of the IJB	

1.0 Decisions / Action required:

1.1 That the IJB approve the Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan, 2019-2022 (the Strategic Plan) at Appendix A.

1.2 That the NHS Board, SIC Policy and Resources Committee and Shetland Islands Council consider whether or not they are minded to consult with the other Party with a view to requiring the IJB to rewrite the Strategic Plan.

2.0 High Level Summary:

2.1 In March and April 2017, the IJB, NHS Shetland and Shetland Islands Council approved the Shetland Islands Health and Social Care Partnership's Joint Strategic Commissioning Plan for 2017-20. A web-link to the current Plan is included below under Background Documents.

2.2 It is best practice to regularly refresh the Strategic Plan, to make sure that it still addresses all the relevant issues and responds to need and demand in an effective way. In September / October 2017, the three partner organisations approved the process of updating the Strategic Plan. The timescale was delayed in order to take account of the outputs from the North of Scotland Regional Discussion Paper, the Shetland Partnership Plan and the knowledge gained from Scenario Planning workshops on the future of health and care services. The purpose was to address the agreed improvement actions, including to make sure that the Plan is:

- the 'backbone' of decision making;
- more explicit about the implementation plan and any specific changes which were planned;
- drawn up in consultation with stakeholders;

- aligned to the financial budget; and
- clear on the impact of change on service delivery / performance.

2.3 The health and care needs assessment has been reviewed, to take account of current activity levels and any emerging trends and issues being faced by each service area. The consensus is that, at a whole population level, the needs assessment which underpinned the current plan has not changed significantly enough to warrant any major shift in strategic direction.

2.4 The Clinical, Care and Professional Governance Committee sought and received reassurance that delivery of the Plan will provide safe, effective and quality services to meet the health and care needs of our population. That assessment is attached at Appendix B. The Impact Assessment has been strengthened to reflect the positive contribution to health and care that it is hoped can be achieved through delivery of the Strategic Plan.

2.5 The Health and Social Care Partnership Strategic Planning Group has supported the development of the Draft Plan and the consultation process and has endorsed the Draft Strategic Plan now presented for approval.

2.6 The consultation exercise has been predominantly internal at this stage. A Consultation Log has been maintained, and is included at Appendix C. The main changes to the draft plan presented for consultation are:

- the inclusion of a new section on Delivering the Best Start for Children and Families, in recognition that the plan is for all health and care services and children make up about 17% of our population;
- the inclusion of a new section on Our Approach to Mental Health at all Ages, in recognition of the Scottish Government revised strategy and investment in this service area; and
- an extended Public Health section to better reflect national policy direction.

2.7 There is a complementary exercise in hand to communicate the intention of the Strategic Plan, based on themes and stories and using a variety of tools and techniques.

2.8 The Chief Financial Officer to the IJB has developed a Medium Term Financial Plan for the IJB, which sets out the financial scenarios and forecasts. At this point, there remains a significant gap between the cost of the current model of service and the allocations made available from the funding parties.

2.9 If the IJB are content with the Strategic Plan and the proposed Budget for 2019-20, a report on updated Directions will be prepared for the next cycle of meetings.

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 Shetland's Partnership Plan, Shetland Islands Council's Corporate Plan and NHS Shetland's 2020 Vision and Local Operational Plan.

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

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

4.0 Key Issues:

4.1 The Strategic Plan is ambitious in its scope and intent and is built on current and evolving best practice, from national, regional and local sources. There is a recognition that health and care services need to constantly evolve, as they have always done, to meet changing demand, demographics and technology.

4.2 A formal communication and engagement framework has been established to make sure that the messages are clear and understandable. A variety of mechanisms will be adopted – written, visual and spoken.

4.3 Whilst change can be difficult, there are many positive aspects in the models of services we aim to deliver, for example around better health outcomes, choice, flexibility, access to specialists, resilience, appropriate use of technology, etc. We therefore need to build capacity to be able to think creatively and innovatively about new ways of working and support the resilience of staff to deal with constant change.

4.4 One of the underpinning principles will be to use an 'Asset Based' approach to working with individuals, families and communities. An asset based approach is one which builds on the assets that are found in the community and mobilises individuals, associations, and institutions to come together to realise and develop their strengths. The identified assets from an individual are matched with people or groups who have an interest in or need for those strengths by using what is already in place in each community. This approach sees health and care solutions being developed with communities and often outwith the formal health and care settings. In this respect, the Plan is closely aligned with the Shetland Partnership Plan.

4.5 A significant number of programmes and projects to deliver the Strategic Plan can best be described as 'business as usual' where managers continuously improve and evolve their ways of working to respond to changing needs and new technology. The one area where there is a specific programme of change is in response to the Primary Care Improvement Plan. There is also a requirement to address issues around Unscheduled Care and continue to support the investment in repatriating services back to Shetland where it is safe and appropriate to do so.

4.6 There is a continuing ambition to work to close the funding gap between the cost of the current models of service and available resources.

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 how services might change 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 overall objective of the Strategic Plan is to continue to provide safe, high quality and effective services to meet the needs of the population.
6.2 Human Resources and Organisational Development:	At this stage, there are no direct impacts on Human Resources and Organisational Development. However, any significant changes to existing service models and methods of delivery may, in time, affect staffing – both in terms of the number of staff and the skills mix required – in order that service costs can be accommodated within the total budget allocation. There are difficulties in being able to recruit to some posts, in some areas and several services rely on agency and locum staff to deliver the current service models. The need to support and train staff is an integral part of the Plan. Engagement with staff will be an integral part of the Communication Plan.
6.3 Equality, Diversity and Human Rights:	The Impact Assessment is included as an Appendix to the Strategic Plan (Appendix 5).
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. Section 29 of the Public Bodies (Joint Working) (Scotland) Act 2014 requires that: (1)The integration authority for the area of a local authority must prepare strategic plans in accordance with this section. (2) A strategic plan is a document— (a) setting out the arrangements for the carrying out of the integration functions for the area of the local authority over the period of the plan, (b) setting out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and (c) including such other material as the integration authority thinks fit. Section 38 of the Public Bodies (Joint Working) (Scotland) Act 2014 explains the circumstances which will ensue should the IJB, NHS Board and Local Authority not all agree the Strategic

	Plan. (2) If it appears to a constituent authority that the strategic plan is preventing, or is likely to prevent, the constituent authority from carrying out any of its functions appropriately or in a way which complies with the integration delivery principles and contributes to achieving the national health and wellbeing outcomes, the constituent authorities acting jointly may direct the integration authority to prepare a replacement strategic plan. (3) A direction under subsection (2) must— (a) be in writing, (b) include a statement summarising the reasons for giving it. (6)An integration authority must comply with a direction given to it under subsection (2).
6.5 Finance:	There is a significant current and forecast funding gap between the cost of services and available funding. Effort needs to be made to find sustainable models of service within the available funding levels. This is addressed in separate Reports by the Chief Financial Officer to the IJB.
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 Plan outlines the need to continue to modernise our working practices – both internally and with our patients / service users / customers – by maximising eHealth, Telehealthcare and Telecare opportunities.
6.8 Environmental:	Any changes to services models which result in changes to access points and transport arrangements may, in time, result in environmental considerations. On balance, the use of technology to support repatriation of services back to Shetland, and avoid unnecessary travel within Shetland, has a positive environmental impact.
6.9 Risk Management:	The risk of not updating the Plan to take account of best practice guidance and changing need and demand might mean that the Strategic Plan is not as effective as it might be in shaping the future health and social care service models, to best meet the needs of the community with the financial resources made available and availability of staff.
6.10 Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB assumed responsibility for the functions delegated to it

	by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting in November 2015. The delegated functions are set out in the Integration Scheme. The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the IJB sits wholly with the IJB as a statutory public body. Such decisions do not require ratification by the Health Board or the Local Authority, both of which are represented on the IJB. If both the Parties, ie the local authority and the health board, require the IJB to rewrite the Strategic Plan, then the IJB must do so. The Strategic Plan is therefore presented to the IJB for approval and to the Council and Health Board to consider whether or not they are minded to consult with the other Party with a view to requiring the IJB to rewrite the Strategic Plan. <u>IJB</u> The Integration Scheme states that, "The IJB has responsibility for the planning of the Integrated Services. This will be achieved through the Strategic Plan....The IJB will be responsible for the planning of Acute Hospital Services delegated to it....". Consideration and approval of the annual update of the Strategic Commissioning Plan is therefore within the authority delegated to the IJB. <u>NHS Shetland Board</u> NHS Shetland delegated functions, including planning for acute and hospital services, to the IJB. The NHS Board has the overall authority for consideration and approval of strategic planning, taking guidance from its Standing Committees, as appropriate. Consideration of the Strategic Commissioning Plan therefore rests with the NHS Shetland Board. <u>SIC Policy and Resources Committee</u> Shetland Islands Council delegated functions, including the planning arrangements, to the IJB. The Policy and Resources Committee is responsible for receiving reports on any matters relating to functions delegated to the IJB that require to be reported to the Council. Consideration of strategic policies, including the Strategic Commissioning Plan, falls within this remit. The <u>Joint Staff Forum</u> enables consultation on issues affecting the workforce within integrated services.	
6.11 Previously considered by:	Strategic Planning Group	13 February 2019

Contact Details:
Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland
hazelsutherland1@nhs.net
26 February 2019

Appendices:

Appendix A: Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan, Refresh 2019-2022
Appendix B: Assurance Process
Appendix C: Consultation Log

Background Documents:

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

Shetland Islands Health and Social Care Partnership Joint Strategic Commissioning Plan 2018-22 Draft for Consultation.
http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21384

Shetland Islands Health and Social Care Partnership

Joint Strategic Commissioning Plan

2019- 2022

For comments and queries, please contact:

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Foreword

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

Shetland, in keeping with other areas in the UK, is facing a period of unprecedented change in its public services. Investment in health and care services has been hugely successful, with people living longer and being able to live longer even though they may have more complicated health and care needs. Shetland has an excellent reputation for delivering high quality, safe and effective services. However, the pressures before us continue to grow and our financial challenges are significant, never mind dealing with increasing demand. We therefore need to set out clearly how we can deliver services into the future that meet need, and continue to be safe, effective and of quality. It goes without saying that individuals, families, unpaid carers, volunteers, staff and communities will be at the heart of the changes – after all that is why we are all in the business of public service. Our challenge is to genuinely change the way that we work to and make sure that services are integrated around the needs of individuals, their families and unpaid carers and are not built around the convenience of organisations.

It is a hugely exciting challenge to be at the forefront of modernising public sector service in Shetland and to help individuals enjoy a good quality of life. We want to grow a system where skilled staff and volunteers are trusted to do the best they can for the individuals that we serve within a safe and open learning environment and we look forward to working with the Shetland community to make that happen.

Marjorie Williamson
Chair of Shetland Islands Health and Social Care Partnership Integration Joint Board

Gary Robinson
Chair
Shetland Health Board

Steven Coutts
Leader
Shetland Islands Council

[1] Feedback from member of staff 2015

Contents

Executive Summary

In line with the Integration scheme this is a plan for the whole of the health and care system in Shetland which sets out the changing models of health and care services. The Plan is supported by more detailed plans and policies.

The partners are:

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

There are competing issues around increasing demand and diminishing resources which makes it not possible to continue to deliver services in the same way we do at the moment into the future. Our population is growing older and there are more people living with lifelong conditions, including people with learning disability, complex needs and autistic people. With that comes increasing demand for services associated with older age and throughout life.

Alongside that, our working age population is expected to decrease and there will not be enough working age people to maintain the same services models into the future. We also face particular challenges around the recruitment and retention of staff.

Health and care services will continue to face a real term restriction in resources over the next three years.

We therefore need to find a way, collectively, to develop the mix of hospital, primary care, community care and health improvement services that best meet the needs of our population.

We consider that there are opportunities to change how we deliver our services which may provide the same – and sometimes better – services, but at a lower cost. That might seem counter-intuitive but we believe by working together collaboratively to reduce the boundaries between all the different parts of the health and care system, we can find a way to make sure that citizens are seen by the right person, at the right time and in the right place.

The change projects that we want to work on to do this includes:

- working with individuals to help them to look after their own health and care needs;
- primary care;
- repatriation of care back to Shetland where it is safe to do so;
- unscheduled, or emergency, care;

- managing long term conditions, such as diabetes, respiratory disease and stroke; and
- working with people to maintain or increase independence and quality of life.

This Plans sets out why we want to make those changes. More details on any of these issues are included in supporting plans and documents, all of which are referenced at the back of this Plan.

Why do we need to change?

Health and care services in Shetland are delivered to a consistently high standard, in most areas. However, there are many factors which make the current models of service delivery difficult to sustain.

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 'National Clinical Strategy for the NHS in Scotland 2016', summarised the position as:

> "*Our population is growing older, and some older people will need increasing amounts of health and social care. More people are living with long-term conditions such as diabetes, high blood pressure, cancer and dementia, each of which requires ongoing treatment and care. And we still have a high level of health inequality – a person living in the most socially deprived community in Scotland can expect to live at least 10 years less than someone living in a well-off area. All of this means that demand for health and care services will increase over the next 15–20 years.* "

NHS Shetland recently facilitated a 'Scenario Planning' exercise to understand more fully the issues which we are facing and what we need to do about it. The participants identified the key variables that are likely to impact on health and care services in the future and the key themes and issues which emerged were:

- Demographics
- Workforce and Training
- Demand Management
- Whole System Approach
- Connectedness
- Communications
- Technology and Systems
- Prevention
- Money
- Self Care / Self Management
- Culture and Risk
- Decision Making
- Clinically Led Changes
- Stakeholder Involvement
- Politics

The key factors identified are explored in more detail below.

Demand

- The population is aging rapidly and it is therefore likely that demand for adult health and care services will increase.
- With advances in medical science, there is an increase in the number of people surviving birth issues and living with complex and lifelong conditions
- Longevity is improving for people with lifelong conditions, including people with learning disabilities, who now also experience age related issues, for example, learning disability and dementia.
- The Regional Discussion Paper estimates that the gap across the north of Scotland between demand and resources for outpatient referrals to be 9% per year and for inpatient and day case treatment to be 13% per year.
- Ageing can be an indicator for a potential associated rise in conditions

such as sensory impairments, mental ill-health, hypertension, asthma, diabetes, dementia and multiple chronic disorders.
- There is a trend towards more people living nearer to centres of population, making sustaining services in the more rural areas challenging.
- There is evidence of more people living longer, with long term conditions.
- Determining actual levels of future need is difficult, as there are so many factors at play, especially with a relatively small population.

Prevention
- There is a need to continue to invest time in helping people to help themselves in order to tackle the causes of ill health.
- Continued investment in preventive services is paramount to managing growth in demand, alongside supporting existing need.
- Many preventative services will be outwith health and care so we need to work with individuals, communities and partners to get better at early intervention and preventative services.
- There is a specific need to work with our partners in sign posting people to more appropriate services outwith health and care.

Economics
- The wider economic and political environment has restricted the availability of investment in the health and care system. This has led to a challenging financial environment and an ongoing need to identify efficiencies and savings
- The financial efficiency savings that need to be addressed over the next 5 years is £7.6m for the NHS.
- The Council has set out its financial aims in the medium term financial plan but there is no specific detail - as yet - in how the £15.6m savings target will be applied to individual service areas but it is expected that social care will not be exempt from the need to find savings.
- Opportunities and ideas for the NHS to work more efficiently have been identified by the Government (using national metrics) in line with the annual efficiency targets expected to be achieved.
- There are significant diseconomies of scale associated with the current service model which is compensated for, to some extent, by the financial support from the Government.

Workforce
- The working age population is predicted to reduce.
- There is difficulty in recruiting to some jobs, in some areas.
- A number of our services have been categorised as 'at risk' where either recruitment to key posts is difficult, the service relies on a single person or there is an aging workforce.
- It is likely that there will be insufficient staff to address future care needs, if the current models of service stay the same. In some areas, use of locum or agency staff is already required to meet current need.
- Our staff are highly skilled, often with skills beyond the job that they

actually do, so we need to find a way to build multi-disciplinary teams that work flexibly and makes the best use of everyone's skills so that people get seen by the 'right person' to meet their need.

Integration

- For any area, and especially for an area the size of Shetland, we need to find a way to progress a 'whole system approach'.
- There is a need to stop considering secondary care, primary care, social care, health improvement and the third sector as separate services and find a way to seamlessly wrap services, advice and support around the needs of individuals and families.
- Services often work in a 'fragmented' way so there is a need for staff to work more collaboratively – and avoid silo working.
- Our services users see one health and care system; there is a need for us to respond to that.

Technology

- We need to get better at using technology for routine appointments and advice.
- There is a need to accelerate the use of technology, to save people having to travel.
- Our data systems do not easily talk to each other so there is a need to work towards a series of compatible systems that wrap around the patients', staff and citizens' needs.
- We need to get better at using technology to support positive risk taking and risk enablement as a core part of placing people at the centre of their own care and support.
- Developing technology will provide new opportunities to change and redesign the way and type of service we provide

What we are trying to Achieve

This section sets out the various legislative and policy statements, to describe what we are trying to achieve.

Scottish Government 2020 Vision

The Government's overall Vision is that,

> "By 2020, everyone is able to live longer, healthier lives, at home or in a homely setting".

The National Health and Care Delivery Plan states that the Government's aim,

> "... is a Scotland with high quality services, that have a focus on prevention, early intervention and supported self-management. Where people need hospital care, our aim is for day surgery to be the norm, and when stays must be longer, our aim is for people to be discharged as swiftly as it is safe to do so".
>
> Where there is in place "a health and social care system that:
>
> - is integrated;
> - focuses on prevention, anticipation and supported self-management;
> - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
> - focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
> - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission".

Shetland Partnership (Shetland's Community Planning Partnership)

The overall purpose of the Shetland Partnership's approach is to work together to improve the lives of everyone in Shetland. The key focus will be to reduce inequality of outcome by tackling issues that mean some people and groups have poorer quality of life than others.

The shared vision of the Shetland Partnership, as set out in Shetland's Partnership Plan 2018-28, is,

> "Shetland is a place where everyone is able to thrive; living well in strong, resilient communities; and where people and communities are able to help plan and deliver solutions to future challenges."

Effective community planning focuses on where partner's collective efforts can add most value for their local communities, with particular emphasis on reducing inequalities. Shetland's Partnership Plan therefore focuses on a small number of local priorities where we will make the most difference for our most vulnerable individuals, families and communities and by moderating future demand for crisis services. The shared priorities are:

People	Individuals and families thrive and reach their full potential
Participation	People participate and influence decisions on services and use of resources
Place	Shetland is an attractive place to live, work, study and invest
Money	All households can afford to have a good standard of living

Whilst all areas need to continue to deliver effective services for the Plan to work as a cohesive whole, the focus of activity for health and care will be in the following areas.

For the 'People' dimension, the focus will be on:

- tackling alcohol misuse;
- healthy weight and physical activity;
- social isolation and loneliness; and
- reducing health and wellbeing inequalities

For the 'Participation' part of the plan, activity will be centred on:

- satisfaction with public services;
- community participation activity and impact; and
- people's ability to influence and be involved in decisions which affect them.

For the 'Place' priority, the focus will be on:

- service innovation;
- recruitment and underemployment; and
- balancing our working age population.

For the 'Money' priority, the focus will be on:

- households earning enough to have an acceptable standard of living.

Public Health Priorities

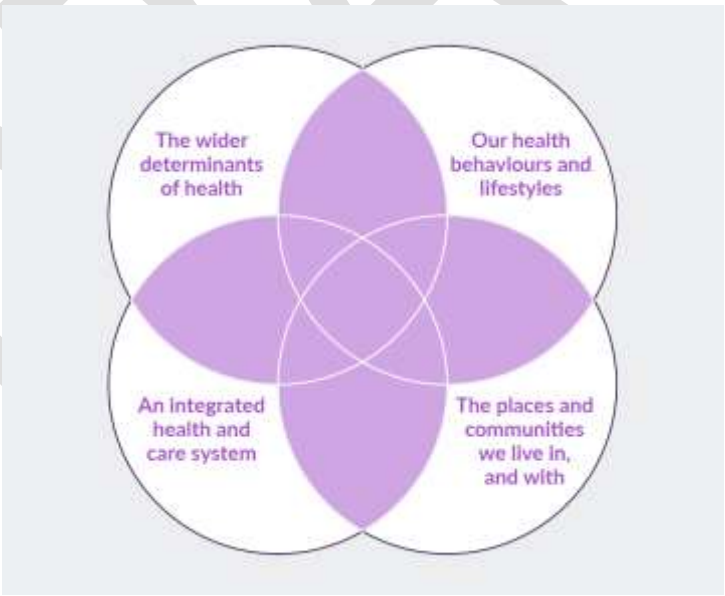
Substantial improvements in life expectancy over the past 100 years mean that people are living longer, healthier lives than ever before; however Scotland still has the lowest life expectancy in the UK. Within Scotland, Shetland has traditionally had a good life expectancy

and a level of health amongst the best in Scotland, reflecting the high quality of life in Shetland, as well as the quality of local services. Recently, the year on year improvements in life expectancy have slowed down across the UK, including Shetland. The reason for this slowdown is under investigation by universities and other academic institutions. For men the life expectancy at birth using the three year rolling average for 2013-15 was 77.6 years, down from 78 and for women was 81.9 years, down from 82.45.

Life expectancy (LE) is an estimate of how many years a person might be expected to live, whereas **healthy life expectancy (HLE)** is an estimate of how many years they might live in a 'healthy' state. HLE is a key summary measure of a population's health.

Men in Shetland have one of the shortest periods expected to be spent in 'not healthy' health (LE minus HLE); around 11-12 years. By contrast, the figure for Greater Glasgow and Clyde was 15.1 years. Women in Shetland can expect to spend the last 13.5 years of their lives in poor health compared to 17.8 in Greater Glasgow and Clyde and 11 in Orkney. (ScotPHO).

We recognise that NHS Shetland and the Shetland Health and Social Care Partnership cannot influence these outcomes alone. The King's Fund has developed a useful framework for planning actions to tackle population health (an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population).



- There is now a wealth of evidence that the **wider determinants of health** are the most important driver of health. In addition to income and wealth, these determinants include education, housing, transport and leisure.
- **Our health behaviours and lifestyles** are the second most important driver of health. They include smoking, alcohol consumption, diet and exercise. For example, while reductions in smoking have been a key factor in rising life expectancy since the

1950s, obesity rates have increased and now pose a significant threat to health outcomes.

- There is now increasing recognition of the key role that **places and communities** play in our health. For example, our local environment is an important influence on our health behaviours, while there is strong evidence of the impact of social relationships and community networks, including on mental health.
- Recent years have seen a strong focus on developing an **integrated health and care system**. This reflects the growing number of patients with multiple long-term conditions and the need to integrate health and care services around their needs rather than within organisational silos.

We are clear that work needs to be balanced across the four pillars and that work in one area alone will not be effective. A more balanced approach is required that distributes effort across all four pillars and, crucially, makes the connections between them.

The Scottish Government and COSLA, working with a range of partners and stakeholders, have developed a set of public health priorities for Scotland. The six priorities are:

- A Scotland where we live in vibrant, healthy and safe places and communities.
- A Scotland where we flourish in our early years.
- A Scotland where we have good mental wellbeing.
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
- A Scotland where we eat well, have a healthy weight and are physically active.

The agreed priorities reflect public health challenges that are important to focus on over the next decade to improve the public's health. Underpinning these priorities are health protection activities such as ensuring the safety and quality of food, water, air and the general environment and preventing the transmission of communicable diseases.

Regional Planning

The North of Scotland Health and Social Care Discussion Paper, Plans and Propositions for the future 2018-2023, sets out the strategic intent of the partners across the north of Scotland, the need for change, the model of care and the workstreams that will make the changes happen.

The partners in the North of Scotland Health and Care system are set out in the diagram below.

The key proposals for changing how we work – called 'propositions' - in the North of Scotland Health and Care Discussion Paper centre around:

- Changing Demand and Improving Efficiency – focusing on closing the demand and capacity gap for elective care
- Developing Effective Alliances – forging partnerships and focusing on improvement
- Transforming Care through Digital Technology – shrinking distances and improving access to services
- Developing World Class Health Intelligence - supporting change, quality improvement and efficiency
- Making the North the Best Place to Work – recruiting and developing the best staff

The proposed Model of Care for the North of Scotland is set out below.

- Create opportunities for the prevention of illness and promotion of health and wellbeing
- Support people to have the knowledge and skills to stay healthy
- Provide people with different ways of getting advice, treatment and care
- Provide as much support to allow people to live at home, or as close to home as possible, if ill, frail or living with long term health conditions
- Organise for diagnosis and treatment to be provided as locally as possible to minimise travel from home

- Ensure that the stay in, or visit to, hospital is as short as possible to give the best treatment outcome
- Ensure that the return home from hospital is organised and coordinated with community services
- Organise effective clinical networks of professional staff to provide support for those complex treatment and care needs
- Provide specialist services in the North of Scotland as far as possible
- Coordinate the treatment and care effectively if the condition or illness requires travel outside the North of Scotland

Working to improve people's wellbeing

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

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

The strategic outcomes[3] relating to the vision, values and goals of the *Scottish Strategy for Autism and the Keys to Life: Scotland's learning disability strategy*, contribute to all of the National Health and Wellbeing Outcomes and resonate strongly with the ambitions set out in *A Fairer Scotland for Disabled People.* The strategic outcomes are:

[2] Public Bodies (Joint Working) National Health and Wellbeing Outcomes (Scotland) Regulations 2014

[3] https://www.gov.scot/publications/scottish-strategy-autism-outcomes-priorities-2018-2021/ https://keystolife.info/

- A Healthy Life
- Choice and Control
- Independence
- Active Citizenship

How we will work

The following integration planning principles[4] "will underpin how we shape our services and find innovative solutions to meet our communities' needs and improve the wellbeing of service-users so that our services:

- are integrated from the point of view of service-users
- take account of the particular needs of different service-users
- take account of the particular needs of service-users in different parts of Shetland
- take account of the particular characteristics and circumstances of different service-users
- respect the rights of service users, whilst ensuring they understand and respect their responsibilities
- take account of the dignity of service-users
- take account of the participation by service-users in the community in which service-users live
- protect and improve the safety of service-users
- improve the quality of the service
- are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- best anticipate needs and prevent them arising
- make the best use of the available facilities, people and other resources".

Delivering quality services

We will deliver services in line with the Healthcare Quality Strategy for Scotland:

> Safe - There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all time
>
> Person-Centred - Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values

[4] Section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014

and which demonstrates compassion, continuity, clear communication and shared decision-making

Effective - The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated

We will deliver services in line with Scotland's Care Inspectorate standards as the national regulator for care services in Scotland. Care Inspectorate inspect the social work (and social care) services provided by local authorities and carry out joint inspections with partner organisations.

The Care Inspectorate[5] exists to:

- provide assurance and protection for people who use services, their families and carers and the wider public
- play a key part in improving services for adults and children across Scotland
- act as a catalyst for change and innovation
- promote good practice.

People have the right to expect the highest quality of care and their rights promoted and protected. It is the Care Inspectorate's job to drive up standards of care and social work services through regulation and inspection.

Shetland's Health and Care Vision

Our Vision is that by 2025 everyone is supported in their community to live longer, healthier lives and we will have reduced health inequalities.

[5] *http://www.careinspectorate.com/*

Developing the Future of Health and Care

NHS Shetland has facilitated a series of workshops to map out possible futures for health and care services in Shetland, using a management tool called Scenario Planning. This is one strand of our approach to making sure that the Strategic Plan is developed and owned by a range of stakeholders. There were representatives from:

- NHS Shetland Board
- Service user representatives
- NHS staff
- IJB Board
- Shetland Islands Councillors
- Council staff
- Third sector partners
- Community planning partners

Services being available at a local level is really important to people – and local can mean at home, in local communities or in Lerwick at the Gilbert Bain Hospital. The Scenario Planning exercise therefore placed 'local services' at the heart of the discussion on what the future should look like.

Two scenarios were explored in detail to determine what impact a change to where services might be delivered from, as follows:

- a lower level of local healthcare provision in 5-10 years than we have now on Shetland - a 'step down' from where we are now in terms of local service delivery.
- a higher level of local healthcare provision in 5-10 years than we have now on Shetland - a 'step up' from where we are now in terms of local service delivery.

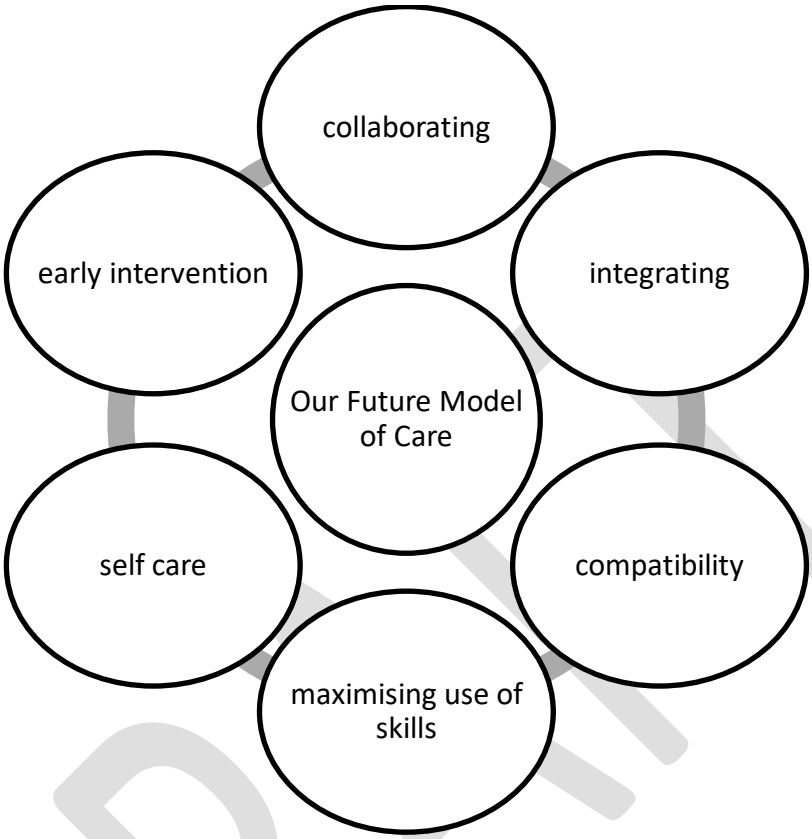
This was considered from the point of view of a continuum, from a more 'centralised' model, to a more 'locally based' model.

It was strongly felt that a 'step down' scenario of less local access (ie more care being provided on the Scottish mainland, with less local access across Shetland and a reduced emphasis on prevention and self care) was undesirable and likely to lead to poorer patient outcomes, reduced health in the population and less effective use of resources. It was recognised that if proactive steps are not taken, it would be perfectly possible for this scenario to become the reality.

However, there was a clear preference to work towards a future based on the 'step up' scenario where it would be possible to provide more services on mainland Shetland and reduce the need for patients to travel to the UK mainland. This scenario would reduce the need for care to be provided in hospital settings and there would be a significant increase in

focus on prevention and developing alternative approaches to support patients to control and improve their own health.

A description of that Model of Care is centred on a suite of enablers and principles:



The participants stated that what is important to them is an approach where we:

- put the person or service user at the centre of our decision making (person centred care);
- enable clinical leadership, based on evidence;
- maximise opportunities to support self care and self management;
- empower an early intervention and preventative agenda along with our service users and partner organisations;
- collaborate with each other to make sure that services are delivered by the right person, with the right skills;
- work to maximise how people can use their skills to best effect;
- integrate how we work to blur boundaries between organisations, buildings, systems and resources;
- create seamless systems – including ICT systems - for the purpose of data and decision making.

The Scenario Planning process helped to refocus thinking around the need for:

- clinical leadership;
- a whole system, or single system approach;
- communication and community engagement;
- seeing the wider impact of health and care from a community planning perspective;
- positive engagement of partners and the third sector; and
- opportunities through the Islands (Scotland) Act 2018.

What will our health and care services look like in future?

We will have in place seamless services, wrapped around the needs of individuals, their families and communities, which are not restricted by organisational or professional boundaries. Where possible we aim to deliver a 'one stop shop' approach to health and care.

Our underpinning principle will be to use an 'Asset Based' approach to working with individuals, families and communities. An asset based approach is one which builds on the assets that are found in the community and mobilises individuals, associations, and institutions to come together to realise and develop their strengths. The identified assets from an individual are matched with people or groups who have an interest in or need for those strengths by using what is already in place in each the community. This approach sees health and care solutions being developed with communities and often outwith the formal health and care settings.

We will support people to have the knowledge and skills to stay healthy. There is an increased emphasis on community-led health promotion and ill-health prevention, including at school. This is also supported by an increasing emphasis on self-care and self-management, alongside providing additional support to unpaid carers, including receiving training appropriate to the needs of those they care for.

All stakeholders use compatible Information Technology systems and share information and data easily and readily. This will be supported by robust but appropriate rules around how we use personal and health and care data. We will use technology to explore new ways of working, especially around: self care; advice and information; and virtual appointments to minimise travel and maximise access to services within Shetland and outwith Shetland for specialist treatment.

Services will share facilities and accommodation with less "names on doors". The concept of local "hubs" is developed that have a wider focus than just health. Service providers increasingly work out of shared buildings. Services will, where appropriate, share spaces, utilise shared reception and administrative staff, with teams co-located in some areas. Accommodation is being developed in the context of a wider public sector plan, with appropriate rationalisation and cost reduction but without any detriment on service delivery.

Training systems better reflect the needs of remote and rural practice, with at least some generalists available, supported by increased investment in rural training and local recruitment. Effective clinical and care networks of staff will be in place to provide support for treatment and care needs.

We will organise for diagnosis and treatment to be provided as locally as possible to minimise travel from home. There is faster and earlier intervention of the "right service" supported by effective" sign-posting - which includes social care and third sector services – so that people know where to go to access services. There is also a less obvious barrier between primary and acute care with staff coming together more where it is in the best interest of the patient or service user.

We will ensure that the stay in, or visit to, hospital is as short as possible to give the best treatment outcome. Out-patient, ambulatory and day care services will be the norm, and in-patient stays will be minimised.

We will support people with health and care needs to live and be cared for in their own home. Where people cannot be cared for in their own home, we will support them to live in a community setting that is not institutional.

Service delivery is characterised by improved collaboration with the "not my job" mentality largely gone.

This is further enhanced by policies that seek to remove barriers and a political dimension that increases the rural focus and voice in line with the principles of the Islands (Scotland) Act 2018.

Funding is increasingly spent on the core establishment – not supplementing it or filling gaps through expensive agency costs – with monies from all stakeholders increasingly seen as Shetland-wide resources rather than agency specific. The overall impact is to improve value for money and significantly reduce the recurring deficit.

Our Priorities for the next 3 years

The service models have changed over the years, as the population's needs have changed and new medicines and technology have evolved. This Plan represents a continuation of the approach to continually develop services to best meet our communities needs and make the best use of scarce resources.

Taking all the national, regional and local drivers for change, we intend to continue to evolve our service models to:

Develop a single health and care system - We will have in place seamless services, wrapped around the needs of individuals, their families and communities, which are not restricted by organisational or professional boundaries. Where possible we aim to deliver a 'one stop shop' approach to health and care.

Maximise population health and wellbeing – people will be supported to look after and improve their own health and well-being, helping them to prevent ill health and live in good health for longer

Develop a unified primary care service with multi-disciplinary teams working together to respond to the needs of local populations

Streamline the patient's journey in hospital – we will work to make sure that people get the right care in the right place at the right time by maximising outpatient, ambulatory, day care services and minimising in-patient stays

Achieve a sustainable financial position by 2023

Delivering the Best Start for Children and Families

Obstetric, Maternity and Neonatal Care in Shetland

The health, development, social, and economic consequences of childbirth and the early weeks of life are profound; and the impact, both positive and negative, is felt by individual families and communities as well as across the whole of society. Therefore, high quality maternity and neonatal care and services are vitally important to the health and wellbeing of Scotland's people. The importance of this is reflected in the Scottish Government 'Best Start: Five Year Forward Plan to improve maternity and neonatal care', which was published in January 2017.

The 'Best Start' plan focuses on developing models to support continuity of care, locally delivered services, person centredness and keeping families together. Thus, recognising the relationship between these factors and the impact on positive health and socio-economic outcomes for women, their babies and the wider family.

In 2017-18, 219 live births were registered in Shetland that year (National Records Scotland, 2018), 50% of women delivered their baby out with Shetland. The birth rate in Shetland is in line with the national average and has remained static over the last 10 years with 217 births registered in 2008.

The delivery of the plan is a key priority for local services over the next five years. NHS Shetland employs a team of Midwives who provide an integrated midwifery service (i.e. the same midwives work in the hospital and the community setting) offering support from pre-conception through to postnatal care.

NHS Shetland has used the funding made available so far to implement the Best Start plan to:

- Further extend the telemedicine options available so fewer women and their families need to travel to Aberdeen for ante-natal or post natal care;
- Continue to train senior Healthcare Support Workers (HCSWs) to provide ante-natal health improvement advice and signposting to other services and support including welfare advice e.g. Best Start Grants;
- Support Midwives to develop expert skills in a range of disciplines e.g. sexual health, obstetric sonography and public health so that more services can be offered locally;
- Support Midwives to develop enhanced skills to support neonatal care, working in a multi-disciplinary team which does not have a Neonatal Unit on site;

- Worked with NHS Grampian to ensure that families who are separated are able to stay in contact e.g. using technology to link in with the nursing team on the Neonatal Unit;

- Supporting volunteers to provide breast feeding support and advice to new mothers.

The Maternity Service is part of the wider obstetric care model in Shetland, which includes medical staff based in Shetland and Aberdeen, multidiscplinary Theatre and A&E teams as well as the Scottish Ambulance Retrieval services. The extant model for obstetric care in Shetland has been a 'GP with special interest' (GPwSI) approach. However, due to the changing landscape in medical training over last 15 years and the need to implement Keeping Childbirth Natural and Dynamic (KCND) published in 2009; there has been a greater emphasis placed on the role of the Midwife in leading maternity care for low risk women.

In 2010, we formally reviewed the obstetric model recognising the growing challenge for GPs to maintain obstetric skills and in line with our need to implement (KCND) which set out the pathway for normal maternal care.

The conclusion of the review was that the GPwSI model provided the best degree of fit for us as an Island Board. The rationale for this was the continued need to provide a safe model of care for low risk women; but also the recognition that our geographical distance from Aberdeen Maternity Hospital means that we also need to be equipped to manage obstetric emergencies and the needs of high risk women. Between 2010 and 2018, we have maintained a model including GPwSI, albeit that we have found it difficult to recruit and train new doctors as others have left during that time.

However, the other Island Boards have now shifted to a Consultant Obstetrician led model of care because of the difficulty in recruiting GPwSI and so now NHS Shetland is also transitioning to that model. We are looking at options for developing an intra-Board or regional model to help sustain access to Consultant Obstetricians in Shetland.

We have opted for this approach because developing a model that would shift services away from Shetland is counter to the local and national policy context of promoting choice, person centred care, delivering care close to home, tackling health inequalities and improving outcomes, providing the best possible start in life for our children. It is also inconsistent with the priorities Vision in Shetland's partnership plan that "Shetland is a place where everyone is able to thrive; living well in strong, resilient communities; and where people and communities are able to help plan and deliver solutions to future challenges" or the priority agreed in this plan that "Shetland is an attractive place to live, work, study and invest".

Developing a model with Consultant Obstetricians is a key priority for NHS Shetland over the next 2-3 years in order to:

- Ensure we are able to provide safe and sustainable obstetric care in Shetland;
- Reduce the number of higher risk women who need to travel to Aberdeen for obstetric care and continue to provide surgical interventions such as c-sections safely in Shetland;
- Ensure that we continue to provide a sustainable model for neonatal care, recognising the change in roles and responsibilities in the team and the new skills that are needed to maintain safe practice.

Supporting Early Years

'Getting it right for every child' (GIRFEC) aims to improve outcomes for all children and young people. It is a multi-agency practise model that puts the wellbeing of children and young people at the centre. A common coordinated framework for holistic assessment, planning and action across all agencies is used to address needs, including the development of a Childs Plan. GIRFEC recognises that children, young people and their parents/carers have the right to be consulted about decisions that affect them.

It promotes a shared approach that:

- Builds solutions with and around children and families;
- Enables children to get the help they need when they need it;
- Supports a positive shift in culture, systems and practice;
- Involves working together to make things better;
- Getting it right for every child is the foundation for our work with all children and young people, including adult services where parents are involved

The Joint Strategic Plan for Children develop by partner organisations in Shetland utilises GIRFEC principles to improve outcomes for children and has commissioned projects to:

- Develop multi-agency approaches to support psychological wellbeing and resilience, especially around early intervention and prevention e.g. Incredible Years and ANCHOR projects;
- Further developing transitional pathways for young people with complex health needs transitioning into adult services including mental health;
- 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 Schools, GPs, and Child Health e.g. reducing Adverse Childhood Experiences (ACES).

In recognising that the Early Years have a profound impact on an individual's future experience of health and wellbeing; health professionals, particularly Health Visitors, have a vital role to play in supporting children and families in the first few years of a child's life and ensuring that GIRFEC principles are reflected in day to day practice . In order to provide a consistent approach to Health Visiting roles and services across Scotland, The Scottish Government published the Universal Health Visiting Pathway in Scotland: pre-birth to pre-school in 2015.

Fundamental to the changes in the pathway are: the utilisation of public health approaches in responding to all families; an emphasis on reducing inequalities by increasing access to appropriate interventions; responding to vulnerable groups and importantly, ensuring that the right number of Health Visitors are in post to support the delivery of the pathway across Scotland.

Since 2016-17, NHS Shetland has received incremental increases in funding to support the implementation of the Universal Health Visiting pathway. The funding has been used to increase the number of Health Visitors in post in Shetland and implement a programme of role development to ensure that we can support and train Health Visitors who have the specialist and generalist skills necessary to practise in a remote and rural setting.

Integral to the Health Visitors role is the requirement to:

- Build strong relationships with women (and families) from pregnancy;
- Promote, support and safeguard the wellbeing of children;
- Offer support during the early weeks and planning future contacts with families;
- Promote person-centeredness; and
- Focus on family strengths, while assessing and respectfully responding to their needs.

In 2017-18, the proportion of children receiving a Health Visitor led development review at 24-30 months was in line with the national and peer group averages of 88%. As a positive outcome, 6.3% of children had one or more developmental concerns identified (lower than) rates in our peer group (9%) and across Scotland (15.3%).

NHS Shetland priorities for Health Visiting services are to:

- Ensure that we prioritise workforce planning so that we continue to sustain our Health Visiting workforce and support our practitioners to grow and develop;

- Ensure that we sustain the requirements of the pathway and increased emphasis on home visits, in particular supporting pre-school checks and developing innovative ways to increase the uptake of these checks;

- Ensure that Health Visitors have the capacity to work across all agencies and contribute to the development of multi-disciplinary/agency models of care in Shetland e.g. through local services to strategic planning level.

School Nursing and Children's Nursing

Over the last four years considerable work, nationally and locally, has been undertaken to refocus and maximise the School Nursing contribution in response to current policy directives, population need and service requirements. This includes:

- Ensuring the focus is on prevention, early identification and intervention
- Consistently providing evidenced based assessments and interventions for 5-19 year olds and their families based on the GIRFEC practice model
- Reducing inequalities and increasing focus on vulnerable groups and populations.

There are 10 priority areas under these overall headings which ensure focus is on vulnerable children and young people, mental health and wellbeing and risk taking behaviour. They are:

- Emotional Health and Wellbeing
- Substance Misuse
- Child Protection
- Domestic Abuse
- Looked After Children
- Homelessness
- Youth Justice
- Young Carers
- Transitions
- Sexual health/pregnancy

These ten areas were initially identified based on public health need, research and evidence of what factors contribute to poor health and wellbeing outcomes in later life. It is anticipated that the establishment of a robust foundation of assessment, will significantly improve identification of children, young people and families who will benefit from additional support and resource.

The redesign of the school nurse role incorporates the health assessments of all Looked After Children, looked after at home or in kinship care children and young people, thus

enabling greater reach in assessment and routine screening for the most vulnerable children and young people.

The team remains very small with an increasing remit and there is significant support needed to ensure the team have the education and resilience to support this programme of work.

As part of the wider child health remit the school nursing team work with the practice nursing team in delivering the immunisation and vaccination programmes in schools. This programme has expanded and continues to expand with no additional resources to support the team. This is a risk both for the school nursing pathways and the immunisation programme.

The wider children's nursing team comprises of a community children's nurse and a hospital children's nurse who support children with long term and complex condition both in an acute and community setting. The hospital children's nurse supports children from emergency to routine surgical admissions to the hospital. The community children's nurse supports children with complex needs and takes on the Lead Professional role within the GIRFEC process to support children and their families manage their complex conditions.

Child and Adolescent Mental Health Services (CAMHS)

Child Health services include Child and Adolescent Mental Health Services (CAMHS) in Shetland which are also linked to specialist services provided in Dundee for children and young adults with complex care needs. Children referred to CAMHS may have depression, anxiety, eating disorders, obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD) or self-harm.

Over the last three years the multi-disciplinary CAMHS team has implemented 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. Funding made available by Scottish Government in 2016-17 to improve access to CAMHS service has been used to increase the Consultant Psychologist and Consultant Psychiatrists clinical capacity in the team.

More recent funding has been used to increase the nursing establishment to support young people who need more intensive CAMHS input and children with Learning Disabilities.

NHS Shetland is one of only three Boards to have achieved the 18 week referral to treatment target for CAMHS access in 2018. The priority for the team is to continue to manage increasing demand for CAMHS service and maintaining access so that children with clinical need are assessed and supported in a timely way.

Child Health and Emergency Paediatric Care

Children make up approximately 18% of the total population of Shetland. NHS Shetland provides a range of emergency paediatric care (in the hospital and general practice) and planned Child Health services, including Child and Adolescent Mental Health Services (CAMHS). Due to the specialist nature of paediatric care, then we have close links with specialist services particularly in Aberdeen and Glasgow that provide both inpatient care and visiting services for Children in Shetland. There are also a number of regional networks for children's care and clinicians visit Shetland to provide highly specialised input e.g. Orthopaedic Consultants, Child Development Specialists and Consultants who specialise in Diabetes in Children.

In 2017-18, 60 children had paediatric surgery in Shetland and 964 had outpatient appointments. Children and families also travelled to the Royal Aberdeen Children's Hospital (RACH) for elective care, where 116 outpatient appointments, 33 inpatient episodes of care and 29 Day Case procedures were performed. Wherever possible, we are looking at opportunities to deliver care locally, reducing the requirement for patients to travel and using technology to bridge the gap between local services and specialist care on mainland Scotland.

Children who need emergency paediatric care are triaged at the Gilbert Bain Hospital where either treatment is provided and completed, or the child is transferred to a specialist children's hospital out with Shetland. In the majority of cases care is delivered locally by multi-disciplinary teams with support from Consultant Paediatricians based in Aberdeen. Between December 2017 and December 2018, 44 children were admitted to the Royal Aberdeen Children's Hospital for emergency care.

The table below shows the number of children aged 0-19 who attended A&E in 2018. It shows that we have a higher rate of A&E attendances compared with our peer group. The reasons for this are multi-factorial and include the fact that A&E is our formal hub Out of Hours for care in Shetland and we have a 24/7 Consultant led model of care; which means that more children can be treated locally (compared with other some of the Rural General Hospitals that transfer higher numbers of children to specialist centres).

A Table to show the A&E attendance rate for children and young people in Shetland (age 0-19 years), December 2017-December 2018

Age Range (years)	A&E Attendance (number of cases)	Population (number of children in age range	Shetland Rate per 1,000 population	Peer Group Rate per 1,000 population
0-4	665	1,279	519	273
5-9	360	1,349	267	154
10-14	411	1,558	303	207
15-19	545	1,279	426	259
Total	2,011	5,465		

Approximately 11% of children are admitted to hospital from A&E in Shetland (n=220) which is higher compared with peer groups and is again likely to be attributable to our geographical distance from specialist centres (i.e. local surveillance is provided instead) and the level of Consultant input that is available locally.

Sustaining safe and effective paediatric care is a priority for NHS Shetland and a local paediatric taskforce was established in 2018 to review the current pathways for emergency care, skill mix in our teams, supervision and models of support for decision making and training.

The taskforce has helped to put in place shared guidelines for paediatric care with NHS Grampian. Work has also been undertaken to provide enhanced induction to doctors and other health professionals who will be providing emergency paediatric care in the hospital setting.

Our strategic priorities for emergency paediatric care include:

- Working with NHS partner organisations to ensure that we continue to be part of the strategic planning and decision making for paediatric care across the region;
- Clarifying the clinical pathways for children so that as much care can be provided locally as is safe to do so and there are robust arrangements in place for the transfer and discharge of children from specialist care;
- Agreeing the skill mix in our local teams in order that we can sustain our emergency paediatric care requirements (supporting practitioners who are responsible for neonatal care and through to critical care/stabilisation);

- Ensuring that we support our multi-disciplinary teams to develop and sustain the necessary skills to provide emergency paediatric care, in collaboration with specialist, off island services;
- Ensuring that we develop approaches to reduce patient travel and increase access to services through the use of technology.

Our Approach to Mental Health Across All Ages

The Scottish Government's Mental Health Strategy[6], gave a commitment to,

> " prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems".

The Shetland Health and Care Partnership shares that commitment. This will mean working to improve:

- Prevention and early intervention;
- Access to treatment, and joined up accessible services;
- The physical wellbeing of people with mental health problems;
- Rights, information use, and planning.

Local priorities cover:

- Ensuring people can access information to maintain their own mental health
- Promoting resilience and mental health promotion to prevent mental illness
- and distress.
- Early recognition and treatment of mental illness and disorder
- Providing person centred care which can only be achieved through well integrated services focussing on an individual's needs including their carer(s) and families.
- Ensuring service users are at the centre of care and treatment
- Effective engagement of families and carers to support care and treatment
- Embedding recovery approaches within services

A review of our Mental Health Services is progressing which aims to:

- Ensure people who require services achieve better outcomes;
- Assess service users needs, outcomes and recovery plans;
- Ensure that services are integrated, flexible and responsive to people's assessed need;
- Assess the extent to which services are supporting people to live safely and independently through a focus on recovery and / or maintenance of long term conditions / preventable relapse;
- Ensure resources are used effectively and wisely.

The work is linked to the Primary Care Improvement Plan. The Mental Health Strategy will also be updated in line with the national Strategy and guidance.

[6] https://beta.gov.scot/publications/mental-health-strategy-2017-2027/

What will change about our services?

We have used the 'Scenario Planning' workshops to help us to shape the new models of care. While we have some work to do yet to design exactly what our services might look like in the future, we think it will be helpful to describe how we see the services developing.

Develop a single health and care system

Our overall ambition is to move away from seeing health and care services as single services organised across departmental managerial lines. We all recognise the intrinsic relationships between all aspects of health and care services, as people move through and between services. We want to continue our approach towards a single health and care system, which is seamless from the point of view of the service user ie it doesn't matter which service or organisation is delivering the service, the service is determined by the patient / service user's needs. This approach is the under-pinning philosophy of the work we already do through the auspices of the Integration Joint Board. We want to accelerate that philosophy to find a way to deliver a 'one system, one budget' approach for Shetland. This will involve changes, with a need to implement data systems which will support this way of working and to invest in staff to support them to respond and innovate in an ever changing environment. We want to do this through collaboration, building trusting relationships to give staff and partners permission to try to do things differently. Technology will help us to improve access to services – and equity of access – and where people live should not be a barrier to access.

This 'whole system' approach is shown diagrammatically below in the health and care system adopted by Canterbury in New Zealand. The system is built around the question of 'What Does it Mean for Agnes' (the lady in the red cardigan at the centre of the diagram).

The idea that the diagram conveys is based on the layers of input and interventions into health and care and that really it is the whole community working together that makes for an effective health and care system.

From the centre, it starts with the individual person; their own health and care needs and their motivation to look after their own wellbeing through lifestyle and other choices.

The next step is to think about friends and family and the contributions that others around us can make to our health and wellbeing, including the support of unpaid carers. We can also think about community services (those available to all of us) and how those services help us to live our lives.

The next stage is to think about how services help us with specific issues – for example going to the dentist for a check up, going to the pharmacy for medicines, seeking help from a GP or nurse for a specific illness on a one-off or ongoing basis.

The next layer is the specialist services which come into play when a particular intervention is required, for example calling an ambulance in an emergency, having an appointment to see a consultant for a specific illness or attending a specialist mental health service.

At the outer rim of the diagram are the specialist treatments centres where people will go if they are medically unwell and that will usually be a hospital setting.

People will move in, out and through these services on a changing basis as their health and care needs change. Our focus will be on making sure that all the services are aligned and co-ordinated around people's needs - and that is why we call it the 'whole system' approach.

We will deliver this through the following principles and projects:

- ✓ Clinical leadership
- ✓ workforce development and integrated teams, enabling people to work to the maximum of their skill set
- ✓ technology enabled, working to remove organisational and system boundaries around data

Maximise population health and wellbeing

We will continue to invest in a wide range of early intervention and preventative measures to minimise, and sometimes avoid, the need for health and care needs to occur. It is our ambition that a significant proportion of preventative services will be provided outwith the

statutory health and care framework, through voluntary, community and third sector provision and from people investing in and looking after their own health and wellbeing. Health improvement and ill health prevention is not just a function of Public Health; it is a fundamental role of all health and care professionals to support people to take control of their own lives and their health.

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

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

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

This will be an underpinning philosophy in all the service redesign models.

A key recommendation from the Commission for the Future Delivery of Public Services was that we need to work closely "with individuals and communities to understand their needs, maximise talents and resources, support self reliance, and build resilience". We do this by moving away from a paternalistic approach of doing things to people, to working out ways to work with people to help them to look after their own health and wellbeing.

We will deliver this through the following principles and projects:

- ✓ we will update and implement a Welfare Reform Outcomes Focused plan to ensure that our NHS Board continues to support the working-age population to move into, remain in and progress in good quality employment, and access the social security supports that they are entitled to
- ✓ we will work in partnership with the local authority to deliver a Child Poverty Action Plan which makes a difference to the outcomes and life chances of children and young people in Shetland
- ✓ We will implement the Diabetes Prevention Plan
- ✓ Further develop opportunities to increase physical activity for people who are least active through the implementation, with our partners, of the Active Shetland Strategy
- ✓ Continue to develop and deliver the smoking cessation service
- ✓ Increase the capacity of our weight management services
- ✓ Continue work to increase wellbeing and mental health

Developing a unified primary care service

Investment in community based services and strengthening primary care are two key elements of making the 'whole system' approach work by keeping activity out of the acute and hospital sector. We recognise that this shift in emphasis may put pressure on community resources, including GPs. There is a need to make sure that we make the best possible use of GP time and resources and get better at further developing a team approach to meet people's needs. These teams will be multi-disciplinary and can include any health care professionals appropriate to meet health and needs, such as social care staff, nursing staff, allied health professionals, pharmacists, health improvement practitioners, therapists, third sector support, etc.

We will be supporting more people – and more frailer people - to remain living at home for as long as possible. People with care needs living in the community will have even higher levels of support needs than at present.

The main aim is to support people with health and social care problems to stay in their own communities, help them to learn to manage their conditions and, whenever possible, reduce the chances of them having to be admitted to hospital. This will mean that some services traditionally supplied in hospitals will be provided in community settings.

The teams can by physically located in one place and work out of any of the health and care buildings, in people's own homes, or be 'virtual' in nature and supported by technology to take place through Video Conferencing, telephone or other technology enabled solutions.

It might mean that people do not necessarily need to see a GP first to arrange health and care needs; people might see, for example, a nurse or a pharmacist or a physiotherapist. This might mean that staff have to travel and move around a bit more. It might mean that service users have to wait a little while longer, so that there are enough people to see to make it an efficient use of staff time. It might mean that we have to share scare resources throughout Shetland, to make better use of all our staff resources and skills. Much of this is in place at the moment, through permanently located and visiting services, but we want to formalise the arrangements; the Primary Care Improvement Plan provides us with the opportunity to do this.

An exercise has been carried out to start to describe in detail what our future service models might look like. We have explored 'what will success look like for our patients / service users' and how will we evidence that. An extract of this work is included below, as an indication of what services are working towards.

Service name/project	What will success look like	Outcomes what evidence of success
Primary care	Single point of access for queries Better access to the right person Parity of service Full utilisation of all staff No locums	Reduced demand Healthier population More self-service One system Non premises led service
Virtual Services	No door is the wrong door Easier and more immediate access to services Reduced need at higher levels People are responsible for directing their own care	Reduction in frequent attendees Reduction in frustration in getting appointments Increased self care Reduction in emergency care
Adults with Learning Disabilities and Autistic Spectrum Disorder	Support people to live independently Support people to stay at home Right support at right time whatever age (child, young person, adult, lifelong) Asset based approach to assessment of need Support for transitions Reducing barriers Community support Focus on equality	Communities are empowered Access is equal Opportunity is equal
Pharmacy and prescribing / effective prescribing	Patient / Service User is safer and more in control of their health Better use of resources Medicines needed on time	People know why they are taking medicine Reduce variation in prescribing Morbidity and Mortality Rates
Mental health	Support people to live at home Individuals with mental health conditions are able to live as independently as possible Be active and have a purpose To be accepted and participate Step up and step down care	Focus on Recovery Services are responsive
Community nursing	Access to right professional, right time, right place Autonomous Practitioners Working at advance levels	Nursing care and support provided in timely appropriate way Sustainable workforce
Allied Health Professionals	Support people to live independently Appropriate use of skills Self care Self directed treatment First point of contact	Maximise use of Independent Living Centre (increased access and services on offer)

We will deliver this through the following change projects:

- ✓ Management of Long Term Conditions
- ✓ Primary Care Improvement Plan

Changing Models of Care:

If you are a patient who is remote from your health care professionals, and have a condition they are supporting you with, you can use 'Attend Anywhere' from any smartphone, tablet, laptop or computer which is connected to the internet to connect with them. Whenever you have an appointment with a health care professional, Attend Anywhere has the potential to allow you to have it at a time to suit your: work commitments; mobility; remoteness from health centres and hospitals; so you can receive care where you are. There's no need to log in, you just go to the NHS Shetland website and click the link to enter the "Waiting Room" on the device you have, or follow the link on an email. When you're in the waiting room, the health care professional supporting you will "call you in" to start the appointment. You'll both be able to see each other face to face, and provide updates and get advice on your condition. The connection is secure and private, from you to the professional. An appointment, which used to take you a day to travel to/from the Gilbert Bain Hospital to physically see someone for a brief appointment could maybe be carried out remotely from your own home. There are a number of different scenarios where this can be beneficial for those involved, ranging from seeing your specialist, to seeing your local practice nurse – at a distance and in a way convenient for all.

Social Care

The overall objective is to work with people to enable them to live independently in their own home, or in a homely setting within their community and to be centred on helping people maintain or improve quality of life. There is in place a range of care services including nutritional support, care at home, respite care, short breaks, supported vocational activity and residential care.

A recent review of the social care service concluded that an enhanced care at home service was the preferred option. In order to fulfil that ambition, many other services and support need to be in place, as described below.

The elements of services that need to be in place for an enhanced care at home service to be delivered include:

- the 'asset based' approach to needs assessment, whereby the assessment of need starts from the premise of what a person is able to do for themselves, then works outwards to statutory provision;
- encourage 'Self Directed Support' which allows people to choose how their support is provided, and gives them as much control as they want of their individual budget;
- support for unpaid carers through the implementation of the Carers Act (Scotland) 2016;
- extended approach to falls prevention;
- Supporting the further development of integrated local teams, building resilience and cover especially around single handed practitioners and out of hours arrangements;
- Maximising the use of Anticipatory Care Plans;
- Supporting staff to be mobile, flexible, and working to their maximum skill set and where staff with a general skill set are able to work across services;
- Supporting the Effective Prescribing project, where it focuses on care homes and community settings;
- Accelerated campaign to support home owners to make investments now to plan for future care needs (accessible ramps, showers, etc, etc);
- Positively promote a range of ill health prevention and good health promotion initiatives and messages (around activity, diet, lifestyle, etc);
- Stepping up post diagnostic support for people recently diagnosed with dementia;
- Maintaining the strong partnership arrangements around winter planning specifically and business continuity planning in general to manage unusual peaks in demand;
- Continue to explore with Shetland Charitable Trust how best to focus support on improving people's quality of life, with an emphasis on early intervention and preventative services and tackling inequality;
- Apply, where appropriate, emerging technological solutions to support people to live independently at home;
- Support for financial wellbeing, fuel poverty and social isolation / loneliness
- Working with partners to explore community transport arrangements to support people being able to be connected within and between communities.

Some areas for improvement have been identified to help to continue to support people to live at home around:

- access and participation;
- anticipate needs and prevent needs arising;
- service users being in control of the decisions affecting how they live, have flexible and responsive services and choice;
- making best use of all resources; and
- the model of health and care is able to be adequately staffed.

The specific improvement plan will include consideration of:

- Support for unpaid carers through the implementation of the Carers Act (Scotland) 2016, specifically to extend day services to provide extended respite opportunities.
- Carry out a needs assessment of Levels 1 and 2 care needs in one locality, map those to existing resources and services, identify gaps and develop arrangements to best meet those needs (including preventative services outwith the formal health and care sector including voluntary, community, third sector and housing services and support).
- Explore further geographically dispersed models for supporting care at home in one locality, including respite at home where appropriate and exploring different contractual staffing models to best suit client's needs.
- Investigate a 24-7 responsive service to further support care at home and out of hours arrangements. This will involve exploring partnership arrangements with other statutory and third sector partners.

These projects are currently being worked up as Spend to Save Projects within the Shetland Islands Council as additional funding will be required from outwith proposed joint delegated budgets to provide initial investment for these tests of change

Alongside this, Housing services will continue to invest in all housing stock, to increase overall supply and support a range of housing choices. Working with housing colleagues to enable people with care needs to remain living at home will remain a priority. There is a presumption against having to move house in order to receive a care package, where it is practicable and feasible to do so. Technology enabled will continue to be a key component of that ambition. More detailed is included in the Housing Contribution Statement, which supports this Plan, at Appendix 3.

Criminal Justice Service

The Strategy for Justice in Scotland sets out the Government's approach to make the Scottish justice system fit for the 21st century. The second phase of the Reducing Reoffending Programme which began in 2012 is focused on making sure that the right

services and support are provided so that prolific offenders can address their reoffending and its causes.

The Community Justice (Scotland) Act 2016 sees the responsibility for community justice transferred to 'community justice partners', with oversight and assurance to Ministers being given by a new national body, Community Justice Scotland. In Shetland, a local Community Justice Partnership has been established and reports to the Shetland Partnership. The Partnership will be responsible for producing a strategic plan that will address local and national priorities. Criminal justice social work services are statutory partners in ensuring effective community justice in local communities.

Shetland Islands Council has had a statutory duty to provide criminal justice social work services for individuals awaiting sentencing; subject to community based disposals or custodial sentences. The Service ensures that all people who are referred to the service are appropriately assessed, supervised and risk managed. The service works predominantly with individuals over the age of 16 years and is responsible for the delivery and development of all criminal justice social work services throughout Shetland. This includes the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences. The service also offers support and advice to family members.

Right Place Right Time – Providing Hospital Based Care and Specialist Services

Over the last 10 years we have increased investment in community based services and developed new ways of delivering care that means less people need to go into hospital and if they do require care in hospital, their length of stay will be shorter. Between 2014 and 2018, we saw a 39% reduction in the number of occupied medical bed days.

This 'shifting the balance of care' has been possible due to a number of factors which includes enhancing the skills of our local teams, using technology to support people at home and enable remote monitoring and advancements in medical practice.

For example, 30 years ago the average length of stay in hospital to recover from an uncomplicated myocardial infarction (heart attack) was 9 days and by 2017 the average length of stay had reduced to between 2-3 days. This has been driven by enhancements in interventional treatments, medications, cardiac rehabilitation and active changes that people have made to their lifestyles e.g. reduction in smoking. Work is being driven at both a national and a regional level to develop clinical pathways that are streamlined and mean that patients are able to leave hospital as soon as it is safe to do so. This driven by a number of factors, some are relate to ensuring that we effectively design services which can cope

with increasing demand and others are more focussed on ensuring that we redesign services so that we can support patients to have the best possible clinical outcomes.

There is good evidence available, which shows that older people who have an admission to hospital which is 10 days or longer will experience muscle ageing and functional decline and people who are medically fit for discharge but are delayed in hospital, are at greatest risk of this with over 40% of people developing loss or decline in their potential to regain independence and leave hospital (NHS Improvement, 2018).

Over the last five years we have been working closely as an integrated health and social care service to ensure that we effectively discharge plan together (and with patients and their families). This includes ensuring that we offer early supported discharge whenever possible; through the combined efforts of hospital based staff, carers, community and social care teams. In that timeframe, we have invested in multi-disciplinary teams to provide community based rehabilitation, falls prevention care, enhanced dementia services, prescribing advice and community based pharmacy teams as well as technology to assist people to live at home safely.

This has led to an increase in the range of care that can be delivered in the community and an increasing focus on prevention and rehabilitation. We have seen over that time a decrease in the length of time that people wait in hospital for community care input.

The recently published Draft Discussion Paper entitled 'Delivering Health and Social Care to the North of Scotland 2018-21', includes some important commitments to treatment being carried out as close to people's homes as is possible. The commitment is to decentralise access to treatment and care as much as possible with the aim of providing local access.

In response to this plan and implementing improvement approaches set out in the Modernising Outpatients programme; we have redesigned planned care services, which means that a greater range of services are now provided at the Gilbert Bain Hospital rather than specialist off island services. These changes have included investment in training and equipment for local staff, developing new roles and using technology to bridge the gap between Lerwick and Aberdeen services. For example, patients requiring biologic medications can now access treatments in Shetland, previously having to travel to Aberdeen on a regular basis.

Since 2014, we have reduced outpatient activity by 18% and we have increased Day Surgical activity by 27%. In the last three years we have increased the number of tele-health consultations from 600 in 2016 to over 2,000 in 2018, significantly increasing the number of patients who can access care locally and reducing unnecessary travel.

These changes have all helped to contribute to a position where we have been able to ensure that hospital services in Shetland have been able to adjust to increasingly complex

patient care and frailty and also offer more services locally (previously only available on the mainland).

Therefore our focus over the last 10 years which is carried through into this strategic plan is to:

- Utilise the principles of realistic medicine to ensure that we challenges historical norms and episodic care and instead offer more individualised approaches;
- Continue to identify ways in which we can bring together teams to streamline the patient journey and offer safe alternatives to hospital care;
- Continue to invest in role development to ensure that we can maintain and grow specialist care in our Rural General Hospital setting;
- Continue to invest in technology to support improved access to specialist care, particularly to bridge the gap with services previously only available in mainland hospitals;
- Continue to grow the number of services which can be offered 'in outpatients' or as 'day care' to aid speedy recovery and reduce likelihood of complications;
- Continue to invest in equipment and the Hospital infrastructure to ensure that it is fit for purpose and able to deliver the clinical strategy set out in this Strategic Plan. This includes medium and longer term planning for the provision of the Gilbert Bain Hospital over the next 10 years and beyond

Changing Models of Care...

You have been in hospital due to a minor heart attack; the Specialist Cardiac Nurse sees you in hospital and gives you support and advice about recovery. The Nurse invites you to attend the cardiac rehabilitation class that she organises. At the class you are able to meet other people with heart conditions and share experiences, make friends. You are also able to access advice about changing your lifestyle, you had been thinking about it anyway after the shock of being in hospital. At the class you are able to get advice about making healthy meals, find out about ways to stop smoking and look at ways to get fitter. The class is at the Leisure Centre so you are able to try out different sports and activities.

In this model of care, the approach is person centred and everyone is working together to minimise the number of different places people need to go to get advice and support to change their lifestyle as well as making key clinical advice available to support recovery from a heart attack.

Changing Models of Care...

Your GP has referred you for sleep studies. Instead of travelling to the Sleep Clinics in Aberdeen or Edinburgh, you are asked to attend a clinic at the Gilbert Bain Hospital.

You are fitted with monitoring equipment and you return the data to the hospital and it is sent electronically to a Specialist Nurse, who is based on the mainland. The Nurse analyses the results of the sleep studies remotely and agrees a treatment plan with the Consultant.

You return to the Outpatient clinic at the Gilbert Bain Hospital to discuss the results which may mean lifestyle changes, a dental appliance or airway pressure device is recommended.

Travel is minimised and the pathway has less steps.

Our overall approach is shows diagrammatically below.

Enablers

Alongside day to day service delivery and the change programmes, there needs to be in place a range of 'enabling' activity. These are the support services, systems, skills and knowledge that we need to have in place to help keep delivering high quality services and implement any changes. Often, the support services arrangements can be aligned to the Regional Planning approach, as we work towards an environment of sharing resources and skills across the North of Scotland, and the 'Once for Shetland' approach where partners in Shetland work hard to find ways to streamline how we work together. We recognise the inherent tension between working out how best to do things for Shetland's Health and Care Partnership at a local level whilst also responding to the challenges for the NHS of working better at a regional and national level.

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

Alongside the support to staff, there will be a programme to redesign business and organisational systems, integrated insofar as they possibly can be, so that our staff can focus on tasks which support front line service delivery and are not wasteful. This might also involve working locally with partners in Shetland to make the best use of systems and resources, where it might be possible to develop a common approach, or working across the North of Scotland region, or working at a national level on a 'Once for Scotland' approach.

We will deliver this through the following established programmes of work

- ✓ Delivery of the Joint Organisational Development and Workforce Protocol which includes:
  - Developing new and efficient ways of working
  - Implementing organisational capacity and resilience building initiatives
  - Establishing locality working arrangements
  - Developing participative approaches that involve communities / the public in service re-design
  - Creating a shared culture based upon shared values and expectations

- Developing collaborative and authentic leadership as the norm

✓ Supporting staff to:
  - continue to develop their skills and knowledge and work to maximum of their skill set
  - Develop opportunities to work in more generic roles
  - Continue to develop opportunities for specific remote and rural training and practice

✓ Participating in the Delivery Arrangements for the North of Scotland Health and Care Discussion Paper

✓ Delivering the NHS Board and North of Scotland Region and local E'Health Plans, including:
  - Working towards shared data systems (a portal approach)
  - A Joint approach to Records Management
  - Supporting technology enabled appointments
  - Providing evidence in support of investment in infrastructure

✓ Developing our Asset Investment Plan to put in place the assets and infrastructure to deliver the strategic objectives set out in this plan.

✓ Participating in developing the 'island proofing' issues for health and care in line with the Islands (Scotland) Act 2018.

Working with Others

The Commission On The Future Delivery Of Public Services (2011)[7], stated that,

> "A first key objective of reform should be to ensure that our public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience. Research evidence and our submissions suggest strongly that our public services can become more efficient and effective in working collaboratively to achieve outcomes. To do this, they must focus clearly on: the actual needs of people; energising and empowering communities and public service workers to find innovative solutions; and building personal and community capacity, resilience and autonomy".

We will do this is three specific ways:

- Working with our patients and service users
- Working with our staff
- Working with our partner organisations
- Working with communities

Self Care is the actions that individuals take for themselves, on behalf of and with others in order to develop, protect, maintain and improve their health, wellbeing or wellness. We will support people to look after their own health and well-being, through advice, support and interventions.

We will put the person receiving health and social care at the centre of decisions made about their care. We will encourage shared decision making between the person receiving care and the member of staff providing care.

NHS Shetland and Shetland Islands Council are the two key employers for health and care service, as well as a range of third sector providers and unpaid carers. We are committed to working with staff in an open, honest and transparent manner to reach the decisions on how best to meet the health and care needs of the community.

The third sector, which includes charities, social enterprises and voluntary groups, delivers essential services, helps to improve people's wellbeing and contributes to economic growth. It plays a vital role in supporting communities at a local level. Their contribution is

[7] https://beta.gov.scot/binaries/content/documents/govscot/publications/publication/2011/06/commission-future-delivery-public-services/documents/0118638-pdf/0118638-pdf/govscot:document/

recognised in our strategic approach – at an individual care pathway level and at the broader community level.

Community Planning is the name given to how public, private and third sector organisations work together to improve the overall wellbeing of people living in Shetland. An effective health and care systems relies on many other services and support being in place to help people to thrive and reach their full potential. Examples will be: housing; education; employment; transport and leisure. Working in partnership with other organisations and professions will become the norm.

With our Shetland Partnership partners, we want to help people in communities actively participate with public service providers to improve the lives of people in Shetland. We will do this by changing the way we work. We want to find ways to help people to be more closely involved in shaping the future of their communities. This will include supporting people and communities to develop their skills and knowledge in order to participate fully in community life and meet health and care needs.

Financial Position

NHS Shetland

The amount of funding which NHS Shetland is expected to receive to pay for services is set out in the Table below. The key assumption made is that Board's baseline funding will increase by 2.5%.

Table : Shetland Health Board Funding 2019-2024					
	2019-20	2020-21	2021-22	2022-23	2023-24
Opening Core Balance	49,611	50,851	52,122	53,425	54,761
Inflation Funding	1,240	1,271	1,303	1,336	1,369
Closing Balance	50,851	52,122	53,425	54,761	56,130
Percentage Increase	2.5%	2.5%	2.5%	2.5%	2.5%

The funding will not meet the projected growth in costs (as a result of inflation and the impact of demographics and innovation).

To address this gap NHS Shetland will need to deliver around £7.6m in savings to re-invest in these increased costs.

The Scottish Government's has a 3% efficiency target for the public sector. The funds released from the achievement of the target are re-invested in services to meet cost pressures and to offset the gap between funding and health inflation. Without the delivery of at least this level of efficiency there are no funds to address cost pressures and to ensure the Board's Income and Expenditure is balanced. The board's financial plans assume the continuation of this policy over the next five year planning cycle.

The implication of these new efficiency targets, over the five year period is outlined in the Table below, totalling £7.6m.

Table : Shetland Health Board New Savings Targets 2019-20 to 2023-24						
	2019-20	2020-21	2021-22	2022-23	2023-24	Total
Funding	48,167	49,407	50,678	51,981	53,317	
New Savings Target	-1,445	-1,482	-1,520	-1,559	-1,600	-7,606
Target as a Percentage	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%

Shetland Islands Council

The amount of funding which Shetland Islands Council is budgeting to contribute to community health and social care services in 2019-20 is £22m.

Longer term, the Council has in place a medium term financial plan. There is an expectation that the Social Care service will need to find a fair proportion of the overall savings target but there is no specific monetary value placed on it at this stage.

IJB

The Shetland Islands Integration Join Board (IJB) is facing significant financial challenges.

Taking into account costs, demands, estimated changes to funding and, assuming nothing else changes, the funding shortfall over the next five years is estimated to be £7.7m in total, as shown in the Table below.

	2019/20	2020/21	2021/22	2022/23	2023/24
	£	£	£	£	£
Cost of Services	48,181,541	50,108,803	52,113,155	54,197,681	56,365,588
IJB Funding					
SIC	22,019,069	22,093,249	22,215,729	22,395,022	22,628,955
NHSS	23,629,492	24,220,229	24,825,735	25,446,378	26,082,538
Total Funding	45,648,561	46,313,479	47,041,464	47,841,400	48,711,493
Cumulative Funding Shortfall	**-2,532,980**	**-3,795,080**	**-5,071,080**	**-6,355,280**	**-7,652,680**

Reliance on one-off initiatives to balance the books becomes increasingly difficult as opportunities have already been taken over the years.

The change programme will therefore need to be of a scale to address the underlying financial challenge to make sure that the cost of the service models can be accommodated within the overall funding made available.

While the programme is progressed, short term decisions will also be required so that NHS Shetland and Shetland Island Council continue to meet their immediate financial obligations and service issues. As far as possible any immediate decisions should be consistent with the aspirations set out in the Strategic Plan.

Longer term planning must be accelerated to enable safe, effective and sustainable services to be delivered within the funding available, through the change programmes set out in the next section.

Ultimately, the Financial Plan and the Strategic Plan should be aligned so that there is a link between the financial resources allocated by each funding partner and the desired outcomes of the Strategic Plan.

The IJB budget for 2019-20 is set out below. This is part of the NHS Budget, and all of the Council's Social Care budget and totals £46m.

2019-20 Budgets	NHS Delegated	SIC Delegated	NHS Set Aside	Total
Service Area	**£**	**£**	**£**	**£**
Mental Health	1,438,364	592,883	0	2,031,247
Substance Misuse	402,269	179,594	0	581,863
Oral Health	3,124,523	0	0	3,124,523
Pharmacy & Prescribing	6,073,749	0	571,761	6,645,510
Primary Care	4,430,563	0	0	4,430,563
Community Nursing	2,721,212	0	0	2,721,212
Directorate	92,990	957,082	0	1,050,072
Pensioners	0	79,845	0	79,845
Sexual Health	0	0	44,813	44,813
Adult Services	57,406	5,464,576	0	5,521,982
Adult Social Work	0	2,992,639	0	2,992,639
Community Care Resources	0	11,542,901	0	11,542,901
Criminal Justice	0	38,842	0	38,842
Speech & Language Therapy	89,116	0	0	89,116
Dietetics	116,280	0	0	116,280
Podiatry	235,962	0	0	235,962
Orthotics	138,329	0	0	138,329
Physiotherapy	593,382	0	0	593,382
Occupational Therapy	187,762	1,433,707	0	1,621,469
Health Improvement	0	0	224,174	224,174
Unscheduled Care	0	0	2,864,454	2,864,454
Renal	0	0	201,524	201,524
Intermediate Care Team	452,182	0	0	452,182
Reserve	440,674	0	182,021	622,695
SG Additionality	1,444,000	-1,278,000	0	166,000
IJB Running Costs	11,762	15,000	0	26,762
Total	**22,050,525**	**22,019,069**	**4,088,747**	**48,158,341**
Efficiency Target	-2,275,289	0	-257,691	-2,532,980
Grand Total	**19,775,236**	**22,019,069**	**3,831,056**	**45,625,361**

Change Programme and Projects

We will take a whole organisation approach to achieving the Plan. Looking after our day to day business is as important as focusing on any service changes. How all the elements will come together is show in the diagram below.

How the Whole Organisation Works

<table>
<tr><td colspan="6">Governance and Decision Making</td><td rowspan="7">Supported by:

Realistic Medicine</td></tr>
<tr><td colspan="6">Main Purpose: Delivering Services Day to Day to Patients and Service Users</td><td rowspan="5">Assured and Monitored through:

Performance Data,

Clinical Governance

Risk Management</td></tr>
<tr><td colspan="6">Leading and Managing Change: Changing and Developing Services to meet changing need</td></tr>
<tr><td colspan="6"><u>Supported by: Enablers - Services and Activities which support front line services</u></td></tr>
<tr><td>Workforce Recruitment and Retention</td><td>Workforce Training and Development</td><td>Budgets and Finance</td><td>Systems and Technology</td><td>Assets and Equipment</td><td>Data and Information</td></tr>
<tr><td colspan="6">Underpinned by communication and engagement with all stakeholders</td></tr>
<tr><td colspan="6">Reinforced through positive leadership, culture and behaviours</td></tr>
</table>

The elements of the programme of work to implement the Plan are outlined below and included in more detail at Appendix 1:

Vision and Strategic Context
Preventative Services
Sustainable Services
Enabling Services
Communication and Engagement

Many of the change projects for the IJB sit within the auspices of the Primary Care Improvement Plan, approved by the IJB on 6 June 2018. The overall timeline is included at Appendix 2.

Delivering ongoing day to day services is an equally important part of delivering the objectives of this Strategic Plan. Having a stable base and good performance provides a platform upon which the change projects can be built. The detail of service delivery, and service improvements, is outlined in the Board's Annual Operational Plan 2018-19[8].

How will this impact on the Board's Performance?

We already have a comprehensive approach to performance management and that will continue.

We will focus on specific strategic and high level performance indicators to help us to keep track of progress and to make sure that, in the medium to long term, we achieve what we set out to do. The high level indicators are:

- Number of people actively and successfully managing their own condition
- Unplanned admissions
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
- Community Participation activity and impact (also a Shetland Partnership Plan indicator)
- People engaging in physical activity (also a Shetland Partnership Plan indicator)
- People drinking at harmful levels (also a Shetland Partnership Plan indicator)

The current performance and the target we aim to achieve are set out in the table below.

[8] https://www.shb.scot.nhs.uk/board/documents/OperationalPlan-20182019.pdf

Strategic Indicator	Current Position Baseline	2021 Target	2028 Target
Percentage of adults able to look after their health very well or quite well.	95% [Peer Group average 95%] 2015-16	Maintain position	Maintain position
Unplanned admissions	2016-17 9,566 / 100,000 2016-17 First in Scotland	Maintain position	Maintain position
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	84% (2015-16) Peer Group average is 87%	87%	90%
People who feel they can influence decisions affecting their local area	27% of people feel they can influence decisions affecting their local area	At least 35% of people feel they can influence decisions affecting their local area	At least 50% of people feel they can influence decisions affecting their local area.
People engaging in physical activity	77% of people engage in some form of sport and physical activity (2018)	At least 80% of people engage is some form of sport and physical activity	At least 90% of people engage in some form of sport and physical activity
People drinking at harmful levels	20% of people drink at harmful levels (2018)	No more than 18% of people drink at harmful levels	No more than 15% of people drink at harmful levels (or in line with the National Average, whichever is lower)

Appendix 1 : Action Plan

Area	Item	Comment
Vision & Strategic Context	**Update Shetland Health & Care Vision & Objectives**	Progress as part of Joint Strategic Plan refresh ; Involve stakeholders and Strategic Planning group
	Develop detail on "step up / Step down" scenarios	Progress as part of Joint Strategic Plan refresh ; Involve stakeholders and Strategic Planning group
Preventative	**Long term conditions**	
	Prevention /Self care	Build on 10 year PH Plan
	Realistic Medicine	Work beginning to be developed by Realistic Medicine group
	Effective Prescribing	Build on current work; Requires clinical leadership
Sustainable Services	**Unscheduled Care**	Project team to be developed;
	Primary, Community & Social care Services	Building on current work (including work on sustainable Social care services and North isles project); project team developing
	Hospital Services & workforce sustainability	Need to link to previous 2 work streams.
	Elective Model (repatriation)	Build on current work; supports reduction in cost of service provision
Enablers	**Information (analytics)**	Link to National / Regional work
	eHealth	
	Workforce development	Build on Workforce plan
	Recruitment and Retention	Develop current approaches to sustaining recruitment / existing staffing
	Financial Framework	
Communication & Engagement	**Key Community leaders**	Include SIC, Community planning / NHS Board members / IJB
	Clinical / professional leaders	Ensure continued clinical / professional involvement. Use Professional advisory committee structure alongside management meetings
	Unpaid Carers	Link to formal and informal unpaid carers
	Staff / service providers	Progress at work stream / project level
	Communities / Service users	Progress at work stream / project level

Appendix 2 : Primary Care Improvement Plan Action Plan

Key Priority Area	Year 1	Year 2	Year 3
Vaccination Transformation Programme	• Identify the main Governance issues for immunisation services (informed by Incident Report). • Implement SIRS call recall for all practices / treatment centres (currently only 20% use it) • Develop a training framework for staff, based on a training needs analysis that has been undertaken. • Develop a local model for delivering travel health services (in light of national work that is ongoing) • Develop a model for a 'virtual' immunisation team for vaccination in schools (comprising school nurses, practice and community nurses) • Begin to develop a model for immunisation teams within primary care and the community • Audit BCG immunisations to inform planning for a sustainable model • Develop a plan for seasonal flu immunisation for social care staff (informed by a recent Care Centre flu outbreak).	Fully develop and agree immunisation team model within primary care and the community, to include staffing and travel considerations Audit SIRS call recall system following implementation Audit travel health services service delivery model to ensure it is meeting local requirements Develop BCG immunisation model	Implement immunisation team model within primary care and the community

Key Priority Area	Year 1	Year 2	Year 3
Pharmacotherapy Services	Directors of Pharmacy to develop consistent approach across North of Scotland	Funding permitting, additional 2 Practice Pharmacists to be employed	Pharmacist time in practices embedded
Community treatment and care services	Implement Skill Mix Practice Nursing team at all 8 of the Board provided Health Centres by August 2018. Implement Phlebotomy service at each Health Centre/ Practice area by August 2018 Conduct workload analysis across the service by October 2018 Develop general practice nursing workforce in alignment with future service model by March 2019 Host training for nursing workforce as per outcome of NES funding bid by June 2018 Review leadership /management of general practice nursing by 31 March 2019	Bid for further NES funding to support development of general practice nursing workforce by August 2018 Implement leadership structure for general practice nursing from 1 April 2019 Consider further refinement of service provision across Shetland to ensure capacity meets demand with appropriately skilled practitioners available to deliver to service model by 31 March 2020	Skill mix General Practice Nursing team in place providing a safe and sustainable service delivery model, appropriate to local service design.

Key Priority Area	Year 1	Year 2	Year 3
Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care	Recruit Practice Educator for Advanced Nursing Practice by July 2018 Participate in the development of the regional Advanced Practice Academy (as per regional timescale) Review current unscheduled care weekend clinics to determine future	Continue to support ANP (development) posts – ongoing Bid for further NES funding to support development of Advanced Practice workforce	In collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design.
Multi-disciplinary team: Mental Health Workers	Redesign of services currently underway to implement an integrated service	Development of Mental Health Plan	Implementation of agreed actions from Mental Health Plan
Multi disciplinary team: Occupational Therapy	Exploration of vocational rehabilitation within General Practice	Implementation of vocational rehabilitation	Multi disciplinary team: Occupational Therapy
Multi disciplinary team:	Scoping exercise for roll out of Physiotherapy provision to General Practice	Implementation of additional Physiotherapy support to General Practice	Multi disciplinary team:
Community Link Workers	Continue existing Health Improvement input to GP Practices	Audit of workload, demand and potential requirements for expansion of service	

Housing Contribution Statement

March 2019

Introduction

The Housing Contribution Statement (HCS) is a statutory requirement, as set out in the Government's Housing Advice Note, 'Statutory Guidance to Integration Authorities, Health Boards and Local Authorities on their responsibilities to involve housing service in the Integration of Health and Social Care, to support the achievement of the National Health and Wellbeing Outcomes'.

The HCS sets out the contribution of housing and related services in Shetland towards helping achieve priority outcomes for health and social care. It serves as a key link between the Strategic Commissioning Plan and the Local Housing Strategy and supports improvements in aligned strategic planning and the shift to prevention.

As a local housing authority, the Council has a statutory duty and a strategic responsibility for promoting effective housing systems covering all tenures and meeting a range of needs and demands.

The Council's strategic housing plan is articulated in the Local Housing Strategy[9] which is underpinned by the robust and credible evidence from the Housing Need and Demand Assessment (HNDA)[10]. Both these key documents are in the process of being revised and the Housing Contribution Statement will be updated in line with published versions.

Health & Social Care Partnership

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care to ensure joined-up, seamless services. In 2015 the Integrated Joint Board (IJB) was established as a separate legal entity.

The Executive Manager – Housing is represented on the Strategic Planning Group to actively promote the housing sector's role in health and care integration. The Chief Executive of Hjaltland Housing Association is also a member of the Strategic Planning Group.

National Outcomes

The national health and wellbeing outcomes to be delivered through integration set out 9 specific outcomes. Outcome 2 is of particular relevance to setting out the housing contribution.

[9] http://www.shetland.gov.uk/housing/policies_housing_strategy.asp

[10] http://www.shetland.gov.uk/housing/policies_housing_need.asp

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

Locality Planning

Locality planning has been established and unified in Shetland at a Community Planning level. This means that strategic documents such as the LHS reflect the same 7 localities. This will allow for integration of services operationally as the local implementation plans develop.

Delegated Function

The Act sets out a range of health and social care functions, including functions under housing legislation which 'must' or 'may' be delegated to the IJB. These are contained in the Health and Social Care Integration Scheme approved in June 2015.

The housing functions that are delegated to the IJB are:

- Housing Adaptations (General Fund and Housing Revenue Account) – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living. The General Fund adaptations are carried out by Hjaltland Housing Association through their One-Stop-Shop and are for owner occupiers and tenants of private landlords. The Housing Revenue Account is where any adaptations for tenants of Council houses are funded.

Other housing functions which have a close alignment with health and social care outcomes but are not part of any delegated functions are:

- Housing support services and homelessness
- Other broader strategic functions to address future housing supply, specialist housing provision and measures to address fuel poverty.

Local Housing Strategy

The Local Housing Strategy (2011-2016) sets out the vision for Housing in Shetland:

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

The Local Housing Strategy sets out 5 key themes/priorities:

- Future Housing Supply
- Fuel Poverty

- Housing Support/Housing for an Ageing Population
- Homelessness
- Private Sector Housing

All of the key themes of the LHS are relevant to the HCS.

Key Issues for Shetland

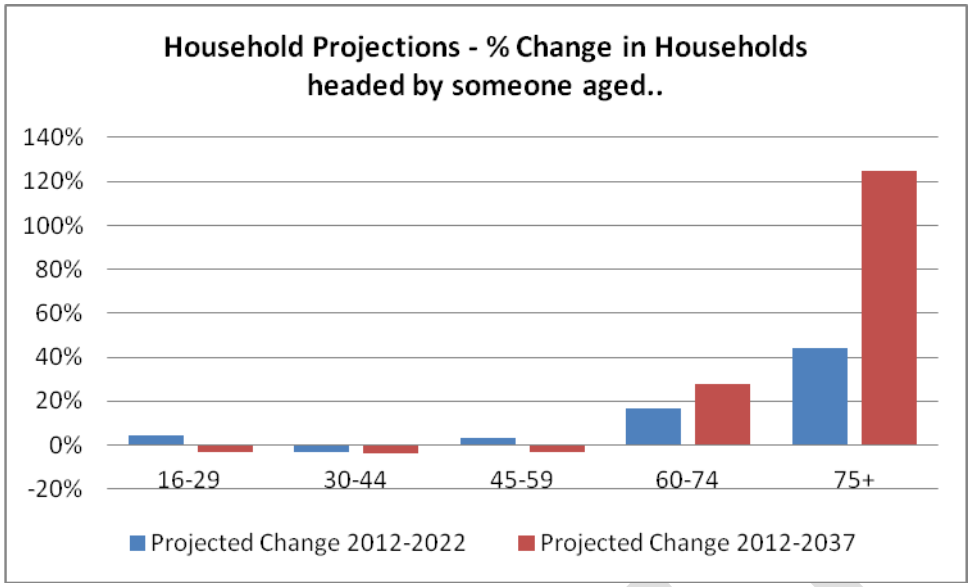
Housing Profile

Population	• 23,230[11] • 3,946 (17%) aged over 60 years
Households	• 10,201 • 9.8% increase 2004-2014 • Average household size 2.26 • 3.8% decrease 2004-2014
Household Composition	• 33% single adult households[12] • 58% small family households • 8% large family households
Dwellings	• 10,950 • 8.2% increase 2004-2014
Completions	• Annual average 94 (2010-2015) • 47% Affordable housing • 53% Private housing
Tenure	• 65% Owner occupied • 24% Social rented • 9% Private rented • 2% other
Specific needs	• 83% of the population do not consider that they are limited by a disability[13]
Specific Housing Provision	• 273 sheltered houses (social rented) • 25 extra care units (social rented) • 15 Homes for Life units (social rented in pipeline)
Adaptations	• 223 adaptations to private sector properties through Scheme of Assistance since 2011 • 70% to provide level access shower • 15% to provide ramped access • 8% both shower and ramp provision • 3% to provide WC upstairs/downstairs • 3% extension/conversion • 1% driveway/external access • Adaptations to Council properties in graph below

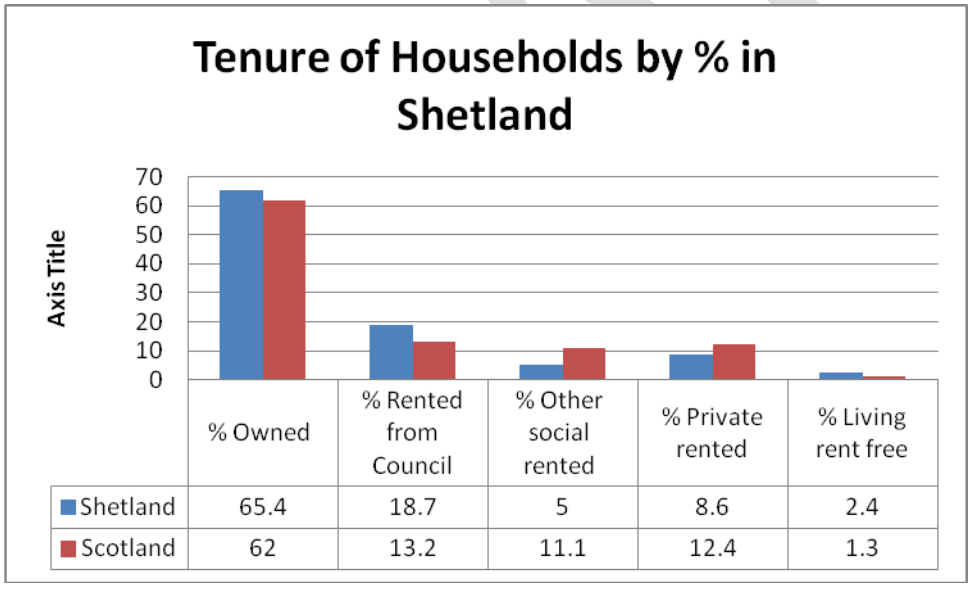
[11] GRO Scotland mid-2014

[12] National Records of Scotland 2012

[13] Census 2011



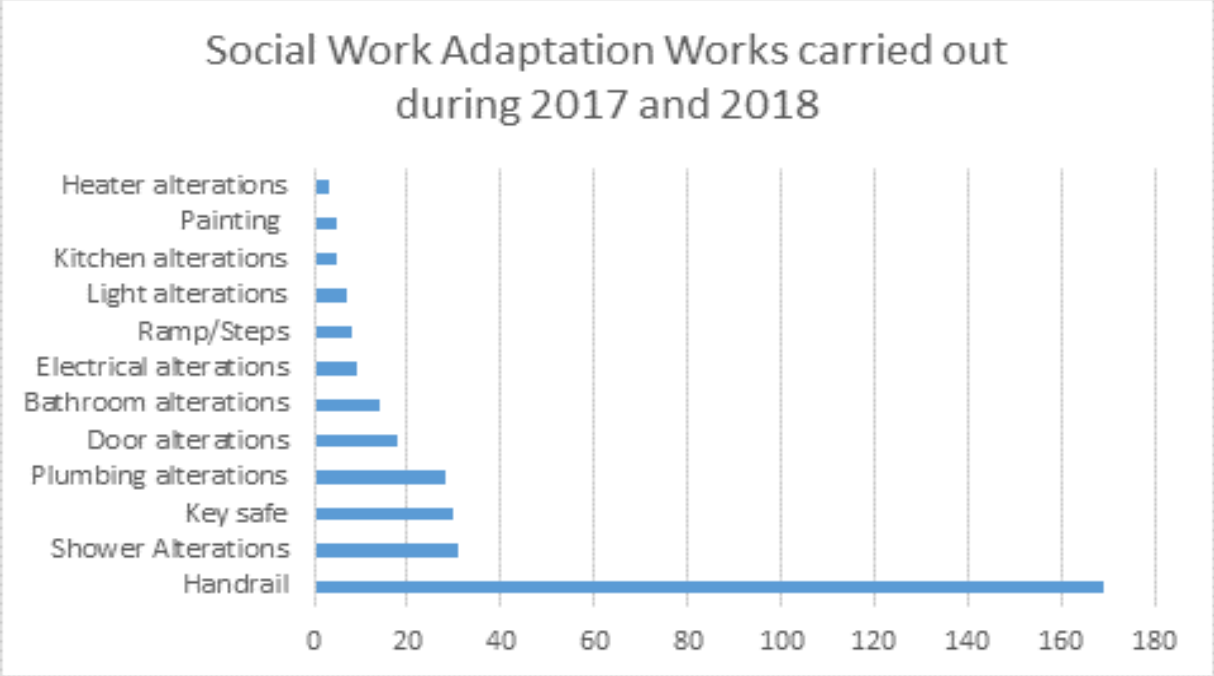
Source National Records Scotland



Source: Census 2011

Age group	Total no.	Day to day activities limited a lot	Day to day activities limited a little	Day to day activities not limited
65-74	2143	266 (12%)	505 (24%)	1372 (64%)
75-84	1178	337 (29%)	398 (34%)	443 (38%)
85 and older	456	265 (58%)	123 (27%)	68 (15%)

Source 2011 Census



Housing Contributions to Integration

- Encourage future housing supply that is the right size and in the right location across all tenures; built to modern standards and future-proofed design, mainstreaming of barrier-free, dementia friendly design and promoting provision for the use of assistive technologies.

- Moving away from ‘sheltered housing’ and ‘very sheltered housing’ labels to provide more flexible solutions through accessible housing, homes with support and homes for life.

- Developing better shared assessment processes with health and care teams in localities to link with housing support plans and housing allocation process.

- Reviewing the housing allocations policy to ensure that it continues to match people with housing that is suitable for their needs.

- Developing a housing options approach which would assist with longer term planning and anticipating future needs by fostering a prevention/early intervention approach to housing need. This will include developing a range of information and advice access points in partnership with a range of agencies in all localities.

- Providing a flexible and adaptable housing support service in all localities.

- Anticipate an increase in the number of adaptations required. The range and flexibility of adaptations should be reviewed to enable choices and to allow for future planning to happen as early as practicable. Timescales and priorities for adaptations to be kept under review.

- Increase the number of accessible houses in the Council's housing stock. There is a template for this from the North Isles pilot project.

- Integrating telecare and telehealth technology with provision of adaptations

- Review and develop the Handyman service for all tenures

- Recording and analysing a range of data and indicators on housing need, demand and provision to provide a robust baseline of future and anticipated needs.

Challenges

Demographic – projected rapidly ageing population will present a universal challenge in terms of delivering services to meet projected increased demands.

Financial – continued financial pressure on public sector budgets will present a number of challenges going forward. Changes to welfare benefits will continue to impact on the housing sector.

Knowledge – there is a real need to develop better, shared baseline information about the housing and support needs of people with long term, multiple health conditions and complex needs.

Support needs – demographic change suggests that there will be a small but significant number of people who will require intensive levels of support and care. This will bring challenges in a small, mainly rural local authority where availability of specialist services may not always be locality based. There is also likely to be an increase in the demand for lower level housing support to enable people to sustain their own tenures and allow them to continue to be supported at home as far as is practicable.

Housing Stock – Shetland has an imbalance in its housing stock with a prevalence of larger sized properties whereas demand is currently for smaller properties. There are also more 'sheltered' properties in landward areas and a lack of such provision in the town. Work has been done on a pilot project to demonstrate that accessible conversions can be carried out to stock in a cost effective way.

Resources

Housing Adaptations General Fund	£355k
Housing Adaptations HRA	£104k
Total	£459k

There are no plans for any staff with responsibility for housing functions to be transferred to the health and care partnership. Close partnership working will be essential, both strategically and operationally to ensure that housing's contribution can be achieved.

The General Fund adaptations are delivered through an agreement with Hjaltland Housing Association through a 'one-stop-shop'. This model has successfully provided a range of adaptations. With projected increased demand for adaptations to enable people to stay in their own homes, resources for aids and adaptations are likely to require close monitoring and review.

Programmes of maintenance and investment in housing stock has ensured that tenants in social rented sector have homes that meet the Scottish Housing Quality Standard. Continued planned investment will focus on energy efficiency which makes a significant contribution to health inequalities.

The Council and Hjaltland Housing Association (HHA) work in partnership to deliver the Strategic Housing Investment Plan which is the development of a new build programme to meet the needs and priorities identified through the LHS. The current new build plan contains provision for the proposed Homes for Life development at King Harald Street, Lerwick. HHA have completed a master-planning exercise on thesite at Staneyhill, Lerwick and there may be opportunities to include specialist provision in the planned development as that takes shape.

Monitoring and Review

This statement forms the link between the LHS and the SCP. Actions will be reviewed jointly through monitoring arrangements for both documents.

Anita M Jamieson

Executive Manager – Housing March 2019

Appendix 4, Schedule of Services and Directions

The pooled budget envelope for each theme in the Strategic Plan will be prioritised and detailed budget allocation will be made for the services to be delivered by the Parties under the direction of the IJB in line with the agreed priorities set out in the Strategic Plan and any associated strategic planning documents. The existing Directions will be updated to reflect the priorities and expected outcomes of this Strategic Plan.

Service	Direction	Reference
Mental Health	January 2019	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=23531
Substance Misuse	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Oral Health	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Pharmacy & Prescribing	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Primary Care	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Community Nursing	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Sexual Health	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Adult Services	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Adult Social Work	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Community Care Resources	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Criminal Justice	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Speech & Language Therapy	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Dietetics	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833

Podiatry	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Orthotics	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Physiotherapy	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Occupational Therapy	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Health Improvement	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Unscheduled Care	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Renal	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Unpaid Carers	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Domestic Abuse and Sexual Violence	January 2019	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=23530

Appendix 5, Impact Assessment

Part 1 – Background Information

Name of Responsible Authority	**Shetland Integration Joint Board, NHS Shetland and Shetland Islands Council**
Title of Plan, Programme or Strategy (PPS)	Joint Strategic Commissioning Plan 2019-2021
Contact Name, Job Title, Address, Telephone Number and email	Simon Bokor-Ingram Director of Community Health and Social Care NHS Shetland Board Headquarters Burgh Road Lerwick, Shetland ZE1 0LA Telephone: 01595 743087 Email: simon.bokor-ingram@nhs.net
Signature	
Date of Opinion	February 2019
Purpose of PPS. Please give a brief description of the policy, procedure, strategy, practice or service being assessed.	The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.
Why PPS was written What is the intended outcome of this policy, procedure, strategy, practice or service?	Joint Strategic planning document for Integrated Joint Board (IJB) business. Statutory requirement for IJB when planning services.
Period covered by PPS	3 financial years from 2019 to 2022.
Frequency of Updates	Annual
Area covered by PPS (geographically and/or population)	Shetland
The degree to which the PPS sets a framework for projects and other activities, either with regard to the location, nature, size and operating conditions or by allocating resources.	The Plan will set a framework for all service activities including planning change and delivery within localities and decisions on resource deployment.
The degree to which the PPS influences other PPS including those in a hierarchy.	Overarching strategic planning document for integrated health and care services, and for NHS Service Planning. The overall objective of the Plan is to set out how to best deliver safe, high quality and effective services to meet the needs of the local community.
Summary of Content	It is a strategic commissioning plan which is structured around the client groups / services that are included within the delegated authority of the IJB. In addition, it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

Part 1 – Background Information (continued)

Objectives of PPS	To improve national health and wellbeing outcomes for people in Shetland through the joint commissioning of services that are included within the delegated authority of the IJB, and as a single system approach to health and care service planning through NHS Shetland. The overall objective of the Plan is to set out how to best deliver safe, high quality and effective services to meet the needs of the local community.
What are you trying to achieve?	Service delivery and redesign to improve health and wellbeing outcomes.
Is this a new or an existing policy, procedure, strategy, practice or service being assessed?	Existing strategic plan updated.
Please list any existing documents which have been used to inform this Integrated Impact Assessment.	Draft Ethnic Minorities Health Needs Assessment for Shetland 2017 The needs assessment and consultative elements of Older People's Strategy and Primary Care Strategy.
Has any consultation, involvement or research with people impacted upon by this change, in particular those from protected characteristics, informed this assessment? If yes, please give details.	Yes in relation to specific client groups. For example, a health needs assessment for Minority Ethnic People in Shetland is underway. Initial findings show an increase in numbers of people from ethnic minority backgrounds in Shetland. Health Improvement: ongoing consultation / dialogue with people with learning disabilities, lower paid men in mainly manual type work, people of ethnic minorities, people with mental health issues. Adult Services for Learning Disability and Autism – Progression of the Day Services New Build (Eric Gray Resource Centre) Stakeholder engagement has taken place in the form of regular meetings and consultation with the Eric Gray Users Group; the new Eric Gray Resource Centre Working Group which includes nominated family, carers and users. Occupational Therapy Informal feedback from clients and stakeholders has helped us to define areas for improvement. Primary Care Issues of importance to local communities have been identified through the round of locality planning meetings. Additional service specific information has been held by engagement with various groups eg patient satisfaction survey for Advance Nurse Practitioner service at Lerwick Health Centre. General satisfaction survey across all of District Nursing and Continence Service. Discussions with community councils on health issues. Podiatry Services produce annual patient satisfaction surveys for a% of caseload. Feedback from survey enables service to produce and implement action plans.

Is there a need to collect further evidence or to involve or consult people, including those from protected characteristics, on the impact of the proposed policy? (example: if the impact on a group is not known what will you do to gather the information needed and when will you do this?)	Ongoing process of needs assessment in Health Improvement. It is clear from the Ethnic Minority Health Needs Assessment that statutory services in Shetland do not routinely collect enough data on protected characteristics, such as ethnicity, to be able to judge the accessibility and appropriateness of current services, let alone proposed changes to services. The EMHNA will recommend further work to fill this gap in future. The audit of Adult Service Learning Disability and Autism service included engagement with people with learning disability, autism spectrum disorder, families and carers through meetings and gathered feedback. The implementation of the findings includes service user input and family representation on the project team. Further engagement work will be undertaken with island communities to explore / discuss sustainable service models for the future. The PPF will be used to discuss changes in nursing services based on the outcome of the national review of District Nursing services. Podiatry service will continue to use both formal and informal feedback from service users to redesign and develop service provision.

Part 2 – People and Communities

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Economic	No impact / positive. In Health Improvement all our programmes are adapted to suit individual circumstances as far as possible. For Primary Care; not known at this stage – potential negative impact if reduction of employment in small communities through changes in service provision / increased use of technology.	Discussions with partner agencies / other stakeholders as part of service review. We will use the recommendations contained in 'On Da Level' (the report of the Shetland Inequalities Commission, 2016) in assessing the impact of proposed service changes.
Cultural	Primary Care – potentially negative; communities may perceive changes in service provision as having negative impact on their culture. It is possible that significant changes in service provision may encourage community activism and an increase in communities taking ownership of and responsibility for health and social care.	Discussions with stakeholders as part of service reviews and engagement with communities in any major service change. Support for community initiatives and 'capacity building' in conjunction with Community Development and Learning and the Third Sector.
Environmental	There may be an increase in travel required if services are delivered further away from local communities. However the programme to return services to Shetland from Grampian and elsewhere may counterbalance this, alongside the increasing use of technology for routine appointments and checks.	We will ensure that all changes in service provision are considered with regard to impact on environment.

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Poverty	No impact / positive. Primary Care – not known, may have negative impact if changes in access to services rely on car ownership or availability of public transport.	We will use the recommendations contained in 'On Da Level' (the report of the Shetland Inequalities Commission, 2016) in assessing the impact of proposed service changes. We recognise that services may need to be adapted to individual circumstances to ensure that fewer people in Shetland live in poverty. Engagement with communities in any major service change.
Health	No impact / positive. As services are more targeted in their approach to the provision of services to those in greatest need.	
Stakeholders	No impact / positive. Primary Care	Discussion with partner agencies / other stakeholders as part of service review.

Equalities

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Ethnic Minority Communities (consider different ethnic groups, nationalities, language barriers)	We are not aware of any impact – positive or negative – at present.	Completion of EMHNA may allow an assessment of impact. It is likely that more complete data recording and engagement with people from ethnic minorities will be required to properly assess the impact of changes to services
Gender	No impact / positive	
Gender reassignment (consider transgender and transsexual people. This can include issues such as privacy or data and harassment).	No impact / positive	
Religion or Belief (consider people with different religions, beliefs or no belief)	No impact / positive	
People with a disability (consider attitudinal, physical and social barriers)	No impact / positive	
Age (consider across age ranges. This can include safeguarding, consent and child welfare)	No impact / positive	
Lesbian, Gay and Bisexual	No impact / positive	
Pregnancy and Maternity (consider working arrangements, part-time working, infant caring responsibilities)	No impact / positive	
Other (please state)	No impact / positive	

Part 3 – Resources

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Staff	Positive / Negative. Staff in some services will have to spread themselves more thinly with few resources	
Finance	Positive / No impact. We will continue to deliver within current or available resources. Some services identify that savings still need to be identified.	Investigating alternative methods of service delivery
Legal	Positive / No impact.	
Assets and Property	Not known currently but potentially opportunities for sharing assets and property through integration, especially at locality levels.	Consider as part of all developments being progressed.

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https://www.kingsfund.org.uk/audio-video/nicholas-timmins-canterbury-new-zealands-quest-integrated-care

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https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska

Health Foundation, 10 Things you need to consider when building a healthcare workforce in remote areas
http://www.health.org.uk/newsletter/10-things-you-need-consider-when-building-health-care-workforce-remote-areasTBC

Draft North of Scotland Plans including E'Health and Workforce

(not yet published)

The Kings Fund: A vision for population health: Towards a healthier future
https://www.kingsfund.org.uk/publications/vision-population-health

ENDS

Appendix B,
Timeline and Process of Updating the Strategic Plan 2019-22

Overview

The 'Commissioning Process'

The process that we are going through is trying to make sure that we use all the resources at our disposal (staff, assets, information, treatments, etc) to best meet people's outcomes. In IJB terms it is called the 'commissioning process'.

The 'Commissioning Process' has 5 key stages:

- assessing and forecasting needs
- linking investment to agreed outcomes
- considering options
- planning the nature, range and quality of future services
- working in partnership to put these in place

as shown in the diagram below.

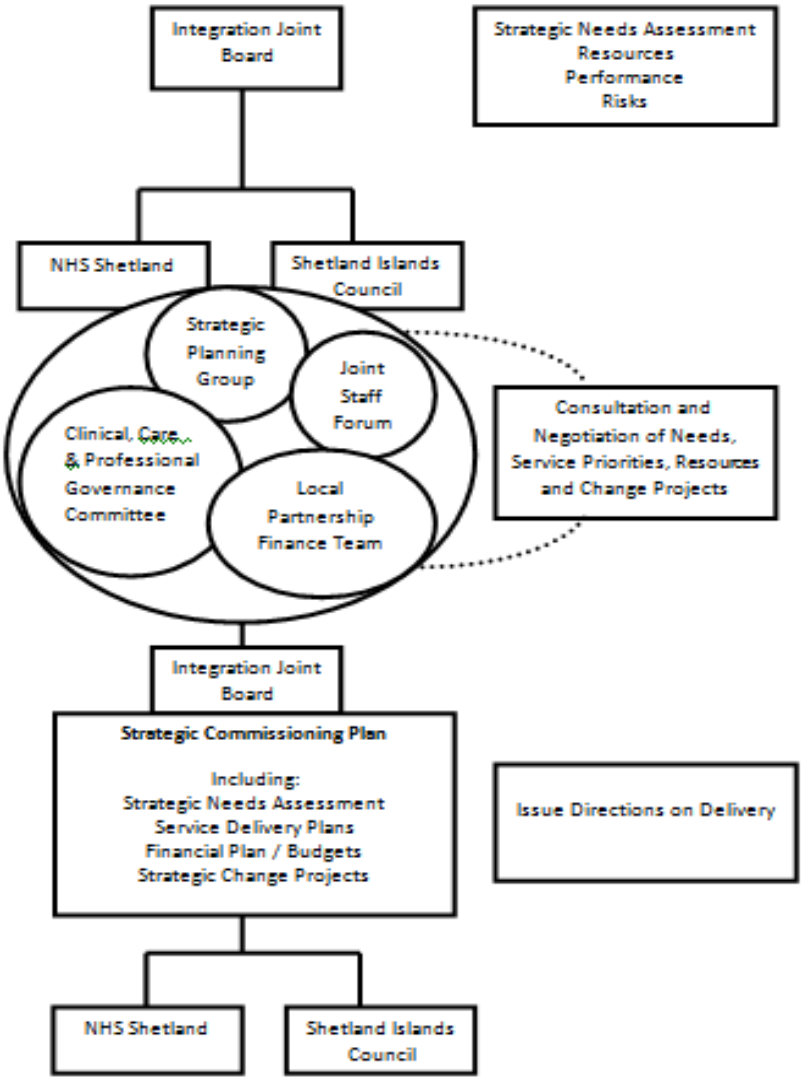
The Timeline and Process

The Public Bodies (Joint Working) (Scotland) Act 2014 Section 33 sets particular requirements for the preparation of a strategic plan for health and social care integration. It states that integration authorities must:

- prepare proposals for what the strategic plan should contain and seek the views of the Strategic Planning Group
- take account of the views of the Strategic Planning Group and prepare a first draft of a strategic plan for further consultation
- prepare a second draft of the strategic plan taking account of views expressed and further consult with persons it considers appropriate
- when finalising the plan, take account of any views expressed during consultation.

NHS Shetland has delegated responsibility for strategic planning for all services to the IJB.

The diagram below shows the relationship between the IJB and its funding partners, NHS Shetland and Shetland Islands Council. The relationship can best be described as an iterative process of collaboration between the partners, to get the best balance of resources, service performance and risk to meet identified need.



An overview of the process and timeline of developing the Plan is outlined below.

	Quarter 1 May – June	Quarter 2 August – September	Quarter 3 October – December	Quarter 4 February - March
	Looking back on what's actually been done and learning from that.	Planning for the year ahead, what do we want to achieve and why.	Resourcing the plans through budgets, workforce plans, asset plans, etc.	Approval of the Plans and Resources for the year ahead.
Strategic Planning	Annual Performance Report Needs Assessment Update	Draft Plan for Consultation	Consultation on Draft Plan	Approval of Strategic Plan

This forms part of the overall approved Planning and Performance Framework (Appendix

A).

The stage by stage process of developing the Strategic Plan is set out below.

Timeframe	Element	Task	Responsibility
Quarter 1	Annual Performance Report	Annual assessment of performance, gaps and changing demands.	Head of Planning and Modernisation
	Needs Assessment Update	The Needs Assessments are done at Locality Levels and kept up to date on an annual basis	Senior Planning & Information Officer
		An overview of the Needs Assessment is prepared to inform the update of the Plan.	Head of Planning and Modernisation
		The Needs Assessments are checked for significant change / variation	Public Health Principal
Quarter 2	Draft Plan	Prepare Draft Plan for Consultation, with the Strategic Planning Group	Head of Planning and Modernisation
		Seek approval on Draft Plan from IJB, NHS Board and SIC Policy and Resources Committee and Council	Head of Planning and Modernisation
Quarter 3	Consultation Phase	Draft Plan subject to consultation with groups, committees as approved.	Head of Planning and Modernisation.
		Maintain Consultation Log	Head of Planning and Modernisation
		Maintain Version Control of Draft Plan and amendments	Head of Planning and Modernisation
		Prepare Final Draft Plan for approval, with the Strategic Planning Group	Head of Planning and Modernisation
Quarter 4	Approval Phase	Final Draft of Plan presented for approval to IJB, NHS Board and SIC Policy and Resources Committee and Council.	Head of Planning and Modernisation.

Stakeholders

In broad terms, it is best practice for the Plan to be co-produced with a range of stakeholders, including:

- patients / service users
- unpaid carers and their families
- staff
- partner organisations
- communities / localities

The formal structure of the IJB governance arrangements ensure that all these groups are represented within the decision making arrangements, in particular:

- the Strategic Planning Group

- the Joint Staff Forum and
- the Clinical, Care and Professional Governance Committee

The key group for the development of the Strategic Plan is the Strategic Planning Group. The Strategic Planning Group includes a wide membership from:

- Users of health care
- Users of social care
- Carers of users of health care
- Carers of users of social care
- Commercial providers of health care
- Commercial providers of social care
- Non-commercial providers of social care
- Non-commercial providers of social housing
- Non-commercial providers of health care
- Health professionals
- Social care professionals
- Third sector bodies carrying out activities related to health or social care
- Members nominated by the Local Authority or the Health Board, or both
- Representatives of the interests of each locality
- Other persons the Integration Authority considers appropriate, such as Local Authority housing colleagues

The main role of the Strategic Planning Group is to shape, influence and review the Strategic Plan.

The Group has been involved at each stage of the process of developing the Plan and has 'signed off' each of the stages before the documents were presented to the IJB (and others) for formal approval.

The consultation stage sought input and feedback from the groups listed in the table below, which also provides a note of the key purpose of that group and their involvement in the strategic planning process.

Entity	**Purpose**
Area Clinical Forum	• Professional Advice from all the professional staff groups • Engagement and involvement of the professional staff groups in the decision making arrangements
Area Partnership Forum	• Provide the main forum where representatives of trade unions, professional organisations and management of Shetland NHS Board work together to have early input into, and influence over the strategic decision making affecting service planning, change and development.
Public Focus Patient Involvement Steering Group	• Patient Focus Public Involvement (PFPI) is about everyone working together to improve the way local health services are planned and delivered.
Shetland Public Engagement Network	The Public Engagement Network will exist to support and inform the work of the PFPI Steering Group and the Patient and Service User Representatives on the IJB. This will be done by ascertaining and expressing the views of the Shetland Public on current and

	proposed health and social care services.
Staff Governance Committee	• The role of the Staff Governance Committee is to support and maintain a culture where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the Board and is built upon partnership and collaboration.
The Strategic Planning Group	• How will the proposals improve people's lives (Health and Wellbeing Outcomes)? • How will the proposals contribute to the Strategic Commissioning Plan's objectives? • Have all appropriate delivery mechanisms been considered? • Do the proposals represent the best mix of service, quality and cost?
The Joint Staff Forum	• That appropriate consultation and engagement with affected staff (direct and indirectly affected) has taken place at all stages • That effective engagement with staff has informed the proposal • That all relevant employment law and policies have been considered in the development of the proposals
The Local Partnership Finance Team	• Is the proposal in line with the Strategic Financial Plan, including any savings plans / efficiencies? • Have all the financial risks been identified and addressed? • Has the funding mechanism been agreed by all parties? • Does the proposal represent value for money?
The Clinical Care and Professional Governance Committee	• That the proposals are based on sound evidence that best meet the identified needs • That the proposals are safe and will secure appropriate levels of quality • That all the relevant risks have been identified and managed • That effective engagement with service users and staff have informed the proposal

The Process in Detail

The first of the Strategic Plans presented and approved in response to the requirements of the Public Bodies (Joint Working) Act 2014 consisted more of an amalgamation of service plans, rather than an overarching strategic plan. An NHS Shetland Internal Audit Report in 2016 recorded the following improvement actions:

> *There are a number of strategies in place, such as the Clinical Strategy, that cover the same activity as the service plans, but at a more strategic level, these strategies are not considered during the strategic planning process;*
> *NHS Shetland has not identified where they will document the actions required to achieve the strategic objectives and how these will be monitored by management and the Board;*
> *No financial context has been provided for NHS Shetland or the IJB, and limited financial information was available during planning; and*

No performance measures were identified within the SCP, which has resulted in there being no mechanism in place for NHS Shetland to measure and demonstrate achievement against the strategic objectives.

In February 2017, approval was given to the current version of the Strategic Plan. The main outstanding matter related to the extent to which the Strategic Plan was aligned with the Financial Plan.

A self assessment against the Government's best practice was undertaken in the summer of 2017.

In September 2017, approval was given for an annual refresh to the Strategic Plan, in line with best practice. The key improvement areas were highlighted as:

- use the Plan as a communication and engagement tool, to all stakeholders;
- be clearer on implementation plans;
- be produced under the principles of coproduction, including with localities;
- have better clarity on the service impact of resourcing decisions.

At this point the Strategic Plan and Financial Plan remained unaligned.

The process of refreshing the Plan was then put on hold as NHS Shetland arranged to carry out a series of Scenario Planning workshops, to help shape future services.

From the Scenario Planning process, we were able to include a clear statement of the Future Service Models.

At the same time, the North of Scotland regional plan (now Discussion Paper) was being developed.

Recently, the Shetland Partnership has approved a Shetland Partnership Plan.

The outputs from those discussions and plans have been included in the update of the Strategic Plan.

In the autumn of 2018, approval was given for a Draft Strategic Plan for consultation with key stakeholders.

Summary of Key Findings

An overview of the key issues highlighted during the development of and consultation on the Draft Strategic Plan is set out below.

Criteria	Evidence
Evidence Based	Built on National and Regional Policy Direction
	NHS Shetland Scenario Planning 2018
	Public Health Needs Assessment
	Plan evaluated by Public Health Consultant (Volunteer)
Safe Services	Focus on changes to 'ways of working' rather than service delivery models
	Well aligned to relevant national policy documents and direction
	Outcome focused, rather than inputs
	Health and Wellbeing Outcomes and Integration Principles founded in law
	Change Projects managed through formal groups / committees
	Request to include sections on Child Health ('Getting the Best Start in Life') and on Mental Health to make sure the Plan covered all health services.
Risk	Risk Register presented in support of 2017-20 Plan, which have not significantly changed, are around: - governance - partnership working - finance The Risk Register was developed in a workshop with IJB members and is reported regularly to the IJB (annual update, quarterly performance)
Engagement	Focus on internal consultation
	Scenario Planning was attended by 50-70 people, from a broad range of services and stakeholders
	The consultation draft has been submitted to a range of groups and committees
	The Shetland Partnership Engagement Network, supported by the Scottish Health Council, are actively supporting the communications team to develop material to describe the themes of the plan (using a project approach, eg Diabetes) and videos of clinicians, where appropriate.
	Formal approval sought at all stages
	No formal public engagement to date

Evidence Base

The Strategic Plan 2017-20 includes details on population needs assessment, by locality areas - http://www.shetland.gov.uk/Health_Social_Care_Integration/Localities.asp

The purpose of the analysis was to determine if the service model needed to flex to respond to different needs in each locality.

There are issues around completeness and robustness of the data (often relying on how individual services record data) and small number variation.

The response from Public Health colleagues was that there were no significant issues which would require any adjustment to the current service models and there were no 'outliers' of need which would require a different service model.

The Report in September 2017 included a summary Needs Assessment, an overview of the data included in the Locality Profiles.
https://www.shb.scot.nhs.uk/board/meetings/2017/1003/20171003-2017_48.pdf

The conclusion again (checked by Public Health colleagues) was that the needs assessment did not highlight any significant issues which might influence the strategic direction.

In 2018, we made use of the Consultant in Public Health Volunteer to undertake an assessment of the Draft Plan. We asked him to consider if a formal whole population needs assessment would alter the direction of travel set out in the Draft Strategic Plan. His conclusion was that a formal needs assessment would not add value to the form and content of the Draft Plan.

For the most part, the Strategic Plan has been developed with reference to national and regional policy documents. We rely on those being evidence based as they are official policy documents.

Recently, there has been an opportunity to align the Strategic Plan with the Shetland Partnership Plan, which was developed from an evidence base of local indicators, highlighting improvements in outcomes to tackle inequality.

Safe Services

The purpose of the national policy statements is to ensure that health and care services achieve 'Better Care' and, through the Public Bodies (Joint Working) Act 2014, to deliver 'Better Integrated Care'.

The Strategic Plan has a focus on delivering to National Health and Wellbeing Outcomes and the Integration Principles, which is a legislative requirement through the Public Bodies (Joint Working) Act 2014.

The Strategic Plan is aligned with the Institute of Medicine's six domains of Healthcare Quality as set out in their document Crossing the Quality Chasm: A New Health System for the 21st Century. The six domains of quality healthcare are:

- Safe
- Effective
- Patient / Person Centred
- Timely
- Efficient
- Equitable

The definitions are set out below.

- Safe: Avoiding harm to patients from the care that is intended to help them.
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

- Patient/Person-centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Services are delivered in line with Scotland's Care Inspectorate standards as the national regulator for care services in Scotland. Care Inspectorate inspect the social work (and social care) services provided by local authorities and carry out joint inspections with partner organisations.

The Care Inspectorate exists to:

- provide assurance and protection for people who use services, their families and carers and the wider public
- play a key part in improving services for adults and children across Scotland
- act as a catalyst for change and innovation
- promote good practice.

Delivery of the Strategic Plan is supported by a whole range of related policies and strategies which address the specific needs, services and improvements required for specific service areas.

Specifically, this Plan develops the concepts set out in NHS Shetland's Clinical Strategy, "Creating Sustainability, Ensuring Resilience, Securing the Future", 2011-2014. The clinical strategy included the following themes, which are still relevant today:

- Reduce unnecessary patient journeys, particularly to Aberdeen;
- Integrate community and hospital services especially nursing;
- Develop a one stop shop approach to making appointments, starting with the hospital;
- Develop a more responsive mental health team;
- Strengthen resilience of healthcare on non-doctor islands;
- Remodel clinical staffing to respond to the national shortage of junior doctors and challenges to the recruitment and retention of staff.

The Draft Strategic Plan will also help to shape the approach to Realistic Medicine, which aims puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to service users so that the care of conditions fits people's needs and situation. 'Medicine' includes all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness. This includes professions such as nursing, pharmacy, counsellors, physiotherapists and social work.

The policy concept diagram was included in the 2017 Plan and is replicated below.

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

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

Delivering Health and Wellbeing Outcomes

Using Integration Principles</td><td>In partnership with

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

The Board has in place a ’Transformational Change Programme Board’ under the Chair of the Chief Executive to oversee the implementation of projects.

Any service change projects are supported through the normal clinical committees and advisory groups to ensure that any changes to service models or ways of working are assessed for Quality, Safety and Effectiveness.

Lead Executives are encouraged to undertake the work using formal project management documentation, systems and processes. This will include specific risk assessments for each project.

Arrangements are being developed to implement a Clinical Alliance to support the philosophy that changes to service models should be 'clinically led, management enabled'.

There can be lack of clarity on the purpose of the 'reviews' within the Strategic Plan. There can be tension between pace of change, the requirement to deliver financial savings and the ambition to do change using co-production techniques.

Risk

The 2017 Strategic Plan included a Risk Assessment section, set out below.

This has been taken into a formal Risk Register, which is reported to the IJB in the quarterly performance reports.

The Risks are updated on an annual basis.

It is considered that the risks, as set out in 2017, remain valid.

> *"The things which might go wrong and mean that we are unable to, or are less successful in being able to, deliver what we are trying to achieve include:*
>
> - *the governance arrangements detracting from rather than supporting a journey towards 'single system' working across health and care services;*
>
> - *the scale of the financial challenges and extent of the Government's ambition to modernise public services not being well understood when decisions about changes to specific service areas are required;*
>
> - *the individual needs of each of the partner organisations being greater than the partnership agreement in influencing how services are designed and delivered;*
>
> - *this Strategic Commissioning Plan not adequately reflecting the transformational change required to build sustainable and affordable health and care services for Shetland;*
>
> - *the need for transformational change not being effectively understood or communicated to all stakeholders;*
>
> - *the pressure to address short term needs is greater than planning what needs to change to create a sustainable future;*
>
> - *spending decisions being based solely on historical service models rather than those we need to develop for now and into the future;*
>
> - *insufficient staff, or ability to recruit and retain staff with the necessary skills;*

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

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

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

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

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

- *there may be insufficient staff time to undertake all the strategic projects in the timeframe suggested as staff have to balance their time between operational matters and development work and day to day service delivery matters will always take priority;*

- *the underpinning requirement for resilient and complete broadband coverage to take advantage of technological solutions might not be secured within the timescale of this Plan."*

Engagement

The focus of the consultation has been internal; there has been limited direct engagement with localities and communities in the development of the Strategic Plan.

The Scenario Planning workshops did, however, generate interest from a broad range of stakeholder interests.

A Communications Plan is being developed to support the explanation and implementation of the Strategic Plan.

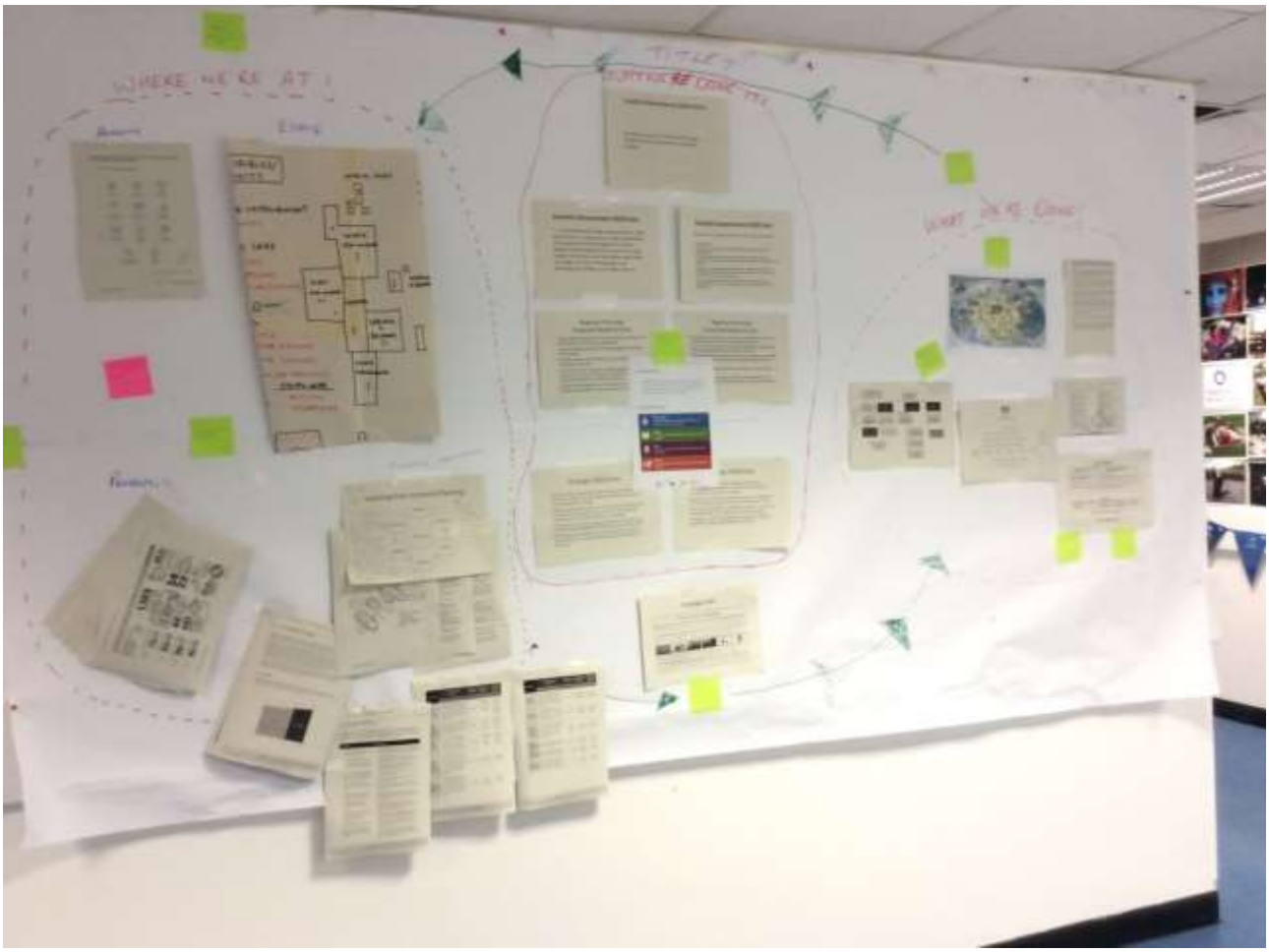
In 2017, there was a specific proposal to undertake a co-production project with the isles of Yell, Unst and Fetlar on the future of their health care services but this has not been progressed as a full co-production exercise (as yet). Specific pieces of work are being taken forward across community health, social care and health improvement.

[A separate co-production exercise is underway in Bressay, led by the Chief Nurse (Community) which is exploring innovative solutions to care on a non-Doctor island].

A consultation log has been maintained and is included in a separate Appendix.

A separate meeting has been held with the Third Sector Forum, whose members are keen to make links and be seen to be a more integral part of the health and care service offering.

The themes of the Plan were put up on the wall in the Board HQ offices at Montfield (photo below).



Comments were sought from staff and recorded on Post It Notes and a log of issues raised was maintained.

Appendix A, Planning and Performance Reporting Schedule

Topic	Report	Frequency	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Meeting			NHS Board		NHS Board		NHS Board		NHS Board		NHS Board		NHS Board	
Development Session								Dev		Dev		Dev		Dev
Strategic Planning	Joint Strategic Plan	3 Year, annual refresh							Process		Draft		Final Approval	
	Operational Plan	Annual			Approval								Draft	
	Local Outcome Improvement Plan	10 Year, 3 year refresh			Approval									
	Regional Delivery Plan	NEW			Approval									
Performance	Key Performance Indicators	Quarterly[1]			Jan-March Q4		April – June Q1				July-Sept Q2		Oct-Dec Q3	
	Progress Reports on Action Plans	Quarterly			Jan-March Q4		April – June Q1				July-Sept Q2		Oct-Dec Q3	
	Annual Report: LOIP	Annual					Review							
	Annual Report: IJB	Annual			Review									
	'Focus In On...'	Ad Hoc,												

[1]The indicators which are available annual will be reported at the first opportunity following publication

Entity	Date	Purpose	Comments
TCPB	20 September	Review	Amend diagram of Whole System to include 'Acute and Specialist Services' and re-order the streams to put 'Agnes' at the centre.
IJB	21 September 2018	Approval	JG page 17, add in at paragraph 2, "including receiving training appropriate to the needs of those they care for". Include an explanation of 'Agnes' and what that means in a Shetland context, from a Person Centred Care position.
NHS Board	2 October 2018	Approval	Agreed for consultation. (As identified by Hospital Management Team) Include a section on Children's Services. Acknowledged that the document will change as it goes through the consultation process. There needs to be more detail on Finance and an Implementation Plan, for the short, medium and long term.
SIC P&R	8 October 2018	Approval	Agreed for consultation. Suggested amendments to introductory remarks from Chairs of three partner organisations. Political Leader supportive of an approach of working together for the overall health and wellbeing of people and communities.
Area Clinical Forum	13 December 2018	• Professional Advice from all the professional staff groups • Engagement and involvement of the professional staff groups in the decision making arrangements	No specific issues raised.

Entity	Date	Purpose	Comments
Area Partnership Forum	1 November 2018	• Provide the main forum where representatives of trade unions, professional organisations and management of Shetland NHS Board work together to have early input into, and influence over the strategic decision making affecting service planning, change and development.	There is a need to align the Strategic Plan with the Financial Plan. There is a need to get communication out to front line staff (for example, through an annual event). Specific query on Housing for workers (availability, supply, affordability, specific areas with specific pressures). Looking for detail on how the Plan will be delivered, the change projects and what support will be needed.
Public Focus Patient Involvement Steering Group		• Patient Focus Public Involvement (PFPI) is about everyone working together to improve the way local health services are planned and delivered. • This includes patients, carers, the public, NHS staff and local partners, such as the local authority, voluntary and community groups.	Supportive of an approach which provides clear communication on how the Plan will be implemented and what changes people are likely to experience.

Entity	Date	Purpose	Comments
ANMAC	16 October 2018		Agreed to put in the extra section on Children and Young People, around 'Getting the Best Start in Life'. Suggest holding workshops to explore different ways of working from a 'whole system' perspective.
Shetland Partnership Engagement Network	22 October 2018	The Public Engagement Network will exist to support and inform the work of the PFPI Steering Group and the Patient and Service User Representatives on the IJB. This will be done by ascertaining and expressing the views of the Shetland Public on current and proposed health and social care services.	Discussion on methods, tools and timescales for public engagement. Suggested an idea to focus on a Shetland 'Agnes'. Make full use of SPEN's social media page and presence to pose questions and generate debate. Suggested start with a discussion on the principles. Agreed to set up a meeting with the communications team. The idea explored at that meeting was to focus on Diabetes (especially preventative approach).

Entity	Date	Purpose	Comments
Staff Governance Committee	15 November 2018 (meeting cancelled, response received by email to papers submitted).	The role of the Staff Governance Committee is to support and maintain a culture where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the Board and is built upon partnership and collaboration. The Committee will ensure that this is achieved by ensuring robust arrangements are in place around the implementation and delivery of the Staff Governance Standard, entitling staff to be, amongst other things: • well informed; and • involved in decisions;	- Since the Scenario Planning Event (February 2018) we have not seen much progress in the work strands (a high level report on repatriation has now been shared which will be forwarded to Unison members). We understand the need for detail, but at this stage we are asking for the vision statement to link to clear programme aims which link to workforce and financial planning so we can share this with our members. - The Board has invested in the Management Bundles / SIFT to create capacity for existing managers and to support succession planning. There is also project LIFT to identify existing and potential leaders in the organisation. We would like to know how we plan to use these programmes and the existing will/skill in the workforce to support the delivery of the strategic plan. - Although Service Planning was approved by the SGC this has not progressed. It would be good to understand the alternative to determine workforce direction linking to scenario, workforce and training planning and finance. - Scenario Planning: Unison staff side are waiting to be informed of the costs.

Entity	Date	Purpose	Comments
The Strategic Planning Group	13 February 2019	• How will the proposals improve people's lives (Health and Wellbeing Outcomes)? • How will the proposals contribute to the Strategic Commissioning Plan's objectives? • Have all appropriate delivery mechanisms been considered? • Do the proposals represent the best mix of service, quality and cost?	Supportive of Draft Plan, with amendments, to be taken to formal decision making. Agreed the description of Future Service Models.
The Clinical Care and Professional Governance Committee	12 February 2019	• That the proposals are based on sound evidence that best meet the identified needs • That the proposals are safe and will secure appropriate levels of quality • That all the relevant risks have been identified and managed • That effective engagement with service users and staff have informed the proposal	Requested a formal paper to set out the processes and evidence used to develop the Strategic Plan to provide reassurance to the IJB that delivery of the Plan will secure safe, quality and effective services. See Appendix B for details. Impact Assessment updated accordingly.

Shetland Islands Health and Social Care Partnership

Agenda Item

6

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board (IJB)	13 March 2019
Report Title:	Carers Eligibility Criteria and Directions	
Reference Number:	CC-11-19-F	
Author / Job Title:	Claire Derwin / Self-directed Support (SDS) Implementation Officer/ Carers Lead	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board:

i. AGREE the local Carers Eligibility Criteria for determining the level of support offered to Carers, set out at Appendix 1; and

ii. DIRECT the Community Health and Social Care Partnership to deliver the services contained in the Direction, at Appendix 2.

2.0 High Level Summary:

2.1 This report relates to Unpaid Carers as defined in the Carers (Scotland) Act:

"An individual who provides or intends to provide care for another individual (the "cared-for person)".

Throughout the rest of the report Unpaid Carers will be referred to as Carers.

2.2 In November 2018, the IJB considered and approved a Report on the Carers Strategy Update and Action Plan. There are two outstanding issues from that Report (Minute Reference 36/18), as follows:

- to consider a Direction to implement the Action Plan and resourcing decisions; and
- (at the request of the Chair) that the future report would include census data and information on types of care, age and demographic.

2.3 This Report also sets out a proposal to approve the new Eligibility Criteria (at Appendix 1). Not all carers will require support to continue in their caring role

but the purpose of the eligibility criteria is to set in place a systematic way of offering support to those who need it. Carers will be eligible for support at a 'substantial or critical' level of impact on their health and wellbeing. In that respect, the criteria is aligned with the assessment levels for other care needs. This eligibility criteria will ensure that support is provided to those Carers most in need of achieving a good balance between caring and other aspects of their lives and also reduce negative impacts on their health and wellbeing.

2.4 Those Carers whose level of need does not meet the threshold for support (i.e. is moderate or low) will be signposted to alternative support, in line with existing practice.

2.5 The IJB has a legislative requirement to provide Directions to the operational bodies - NHS Shetland and Shetland Islands Council - on delivery the services as detailed in its Strategic Commissioning Plan. A Direction in respect of Unpaid Carers, specifically about the implementation of the Carer's Strategy was approved in July 2017 (Minute Reference 36/17). Now that the Carers Information Strategy and the Action Plan have been approved, it is appropriate to provide an updated Direction on continued delivery of services for Carers. The detail is set out in Appendix 2.

2.6 Forecasting the level of future need for carers support is difficult from two perspectives. Data is not always available on which to base a good assessment of need and, as the legislation is relatively new, there are no national trends as yet developed upon which reasonable assumptions on the likely uptake of services might be made. Various scenarios have been developed and costed, the detail of which is included at Appendix 3, as follows:

- growth at current prevalence of uptake;
- growth at an increase of activity to the mid-point in meeting all carers needs; and
- growth to meet the estimate of all carers needs.

2.7 The Table below sets out the possible additional assessments – and plans – which might be required to be prepared to meet the requirements of the legislation. The value has been costed using nationally provided data of the average likely staff cost of undertaking an assessment and preparing a plan. The Scenarios identify a potential increase in demand and services of between £10,000 and £66,000 per annum.

Scenario	**No of Additional Plans per annum**		**Estimated Additional Cost per Annum per Scenario (£000)**					
	Adults	**Young People**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Current Rate	60	0	10	10	10	11	11	53
Mid-Point	120	26	26	26	26	26	26	132
All Support Plans	320	58	66	66	66	66	66	333

2.8 During the 2019-20 budget setting process, direct carers costs of £121,971 were identified. Beyond that there is no robust evidence of need upon which a proposal for service redesign can be based at this point. In that respect 2019-20 will be a year of getting in place robust data collection systems to prepare for actual and likely uptake of services and how current services might need to flex and change to respond to the requirements of the new legislation.

3.0 Corporate Priorities and Joint Working:

3.1 The 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 Partnership 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. There is a significant investment in in-house services to support carers, which is complemented by the work of the local third sector.

4.0 Key Issues:

4.1 Section 21 of the Carers (Scotland) Act 2016 sets out a duty to set local eligibility criteria. Eligibility criteria are the criteria by which each local authority must assess whether it is required to provide support to carers to meet carers' identified needs.

4.2 The Eligibility Criteria has been developed by Carers groups across Scotland consulted on locally, and is aligned to the existing assessment criteria e.g. With You For You (WYFY) in that it focuses prioritising resource/support for those individuals most at risk. Resources provided to carers, some of it through self-directed support, aims to improve outcomes for those requiring support and to ensure better value for money. An eligibility criteria gives us a framework for ensuring we support those individuals who have critical or substantial needs that impact on their ability to live an ordinary independent, inclusive life. For Carers this means those individuals whose caring role has a significant impact on their ability to have an ordinary life outside of their caring role, whilst continuing to offer care.

4.3 The revised Direction for Carers services is included at Appendix 2. This references the broad range of provision already in place to support carers needs, approved within other Directions to the operational bodies . Whilst specific national and organisational outcomes for carers are still being developed, the local WYFY personal outcomes framework allows us to focus

on what is important to individuals. Other strategic frameworks and the Carers Act sets out outcomes which are already in place and there are others which we would wish to develop. The Direction makes specific reference to the direct costs in respect of carers support identified in the IJB 2019/20 budget setting process of £121,971 and sets out how this should be utilised.

4.4 Information on the number of carers and their likely needs is well established at a national level, but data is limited at a local Shetland level. Arrangements are being put in place to better capture local data on the numbers and needs of carers – across children and adult services. Appendix 3 sets out a number of scenarios as to how services may evolve and develop over the next few years. This will be evaluated on actual data captured during 2019-20 and the needs assessments - which informs the strategic commissioning plan, service plans and budgets - will be updated accordingly in the autumn as part of the annual planning cycle. This is part of ongoing budget setting processes.

5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	There is in place significant investment in services which will support carers in Shetland. However, there is a degree of uncertainty on the number of carers in Shetland so the accumulated assessed needs are not yet fully understood. Systems for better recording data have being put in place to capture data which will inform a needs assessment for future planning (autumn 2019).
6.2 Human Resources and Organisational Development:	There are no specific issues with regard to Human Resources and Organisational Development.
6.3 Equality, Diversity and Human Rights:	Decisions made in relation to this paper will have an impact on the rights and equality for Carers to have opportunities to a life outside of caring, to reduce stigma, isolation and discrimination.
6.4 Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act") established the legislative framework for the integration of health and social care services. That Act requires the IJB to issue Directions in writing, which must set out how each function is to be exercised and the budget associated with that function. Guidance is in place on the form and content of Directions, which Appendix 1 meets. The Carers (Scotland) Act 2016 will ensure better and consistent support for carers and young carers so that they

	can continue to care, if they so wish, in better health and to have life alongside caring.
6.5 Finance:	During the 2019/20 budget setting process, direct expenditure related to the support of Carers was identified of £121,971. The IJB budget for 2019/20, which will be presented today as a separate agenda item, makes provision for these costs. The Shetland Islands Council approved the expenditure in February 2019 as part of the Community Health & Social Care Directorate budget be delegated to the IJB in 2019/20. The impact of increased demand for carers support plans and Self-directed Support resources is as yet unclear. This will be monitored during 2019/20 and any significant unbudgeted cost will be reported to the Board through its quarterly monitoring reports. The IJB has a legislative requirement to provide Directions to the operational bodies on the delivery of services as detailed in its Strategic Commissioning Plan. A Direction (Appendix 2) in respect of specific carers support allocating budget of £121,971 will be issued to the SIC, if approved. There is a broad range of provision available to Carers which has already been approved in other directions to the operational bodies. This includes respite and day care support for the cared for person which is provided for the benefit of the carer.
6.6 Assets and Property:	There are no issues with regard to Assets and Property.
6.7 ICT and new technologies:	Improvements in recording and using meaningful data regarding outcomes and Self Directed Support expenditure for Carers is vital to understanding need and commissioning more flexibly.
6.8 Environmental:	There are no specific environmental implications to highlight.
6.9 Risk Management:	Shetland Health and Social Care Partnership carries a number of risks in not addressing the actions of this report: – failure to meet the Carers (Scotland) Act 2016 with regard to setting and applying eligibility criteria; and – failure to allocate funds to carry out the duties and meet assessed needs – failure to properly identify and record Carers needs may limit access to resources for support and understate actual service need

6.10 Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. The IJB assumed responsibility for the functions delegated to it by the Council and the Health Board when it (the IJB) approved and adopted the joint Strategic (Commissioning) Plan at its meeting in November 2015. The delegated functions are set out in the Integration Scheme and Carers Services is a delegated function. The Integration Scheme also states that, 'the detailed commissioning and operational delivery arrangements will be set out in the Strategic Plan'. The IJB can therefore decide on any investment and disinvestment recommendations, as required, in respect of the allocation of additional funding.	
6.11 Previously considered by:		

Contact Details:

NAME Claire Derwin
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DATE 22 February 2019

Appendices

Appendix 1 Draft Eligibility Criteria for Approval
Appendix 2 Draft Amended Direction
Appendix 3 Forecasting and Scenarios of Future Need

References

NHS Shetland and Shetland Islands Council Joint Strategic Commissioning Plan 2017-2020
http://www.shetland.gov.uk/coins/viewDoc.asp?c=e%97%9Dd%96p%81%8E

Directions, July 2017
http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151

Appendix 1, Draft Eligibility Criteria for Approval

Implementation date: 1st April 2019

Introduction to Eligibility Framework

Background

Unpaid carers are the largest group of providers of care in Scotland and should be recognised as equal partners in providing vital care and support. Carers should be supported and not be worse off by caring.

Carers, and the people they support, must be at the centre of care planning. They should have the opportunity to define their contribution to the care of the person, know what to expect and be clear about the support they are entitled to.

In the case of young carers, they are entitled to be children first and foremost, and should be aware that frameworks like 'Getting it Right for Every Child' are also likely to be relevant to them.

The Carers (Scotland) Act 2016, implemented from 1 April 2018 is designed to support carers' health and wellbeing. It puts a duty on Shetland Island Health and social Care Partnership Integration Joint Board to provide support to carers, where identified needs meet agreed eligibility criteria.

To achieve this, a framework of eligibility criteria has been developed covering two aspects:

1. the definition of levels and types of need for support.
2. the thresholds that must be met to be eligible for support.

What our eligibility framework will achieve

Preventative support will be the norm and a firm part of our policies and practice. The framework creates a fair and transparent system for determining eligibility and carers with different needs will be treated equally in accessing support and services.

Assessments for support should identify steps to prevent deterioration in the carer's health or the caring situation. By defining clear personal outcomes for carers at different levels of support, the benefits from accessing both preventative and intensive support will be outcome focused. This will allow change to be measured.

Staff will work jointly with carers to complete a personal Adult Carer Support Plan or Young Carer Statement (ACSP/YCS) that identifies their individual needs and personal outcomes. These will then be assessed in line with the agreed local eligibility criteria to ensure that the right level of support is delivered at the right time
All questions about needs and outcomes will have a clear purpose for carers. The ACSP/YCP will complement and relate carers' information and advice service covering issues such as emergency and future care planning, advocacy, breaks from caring, support services for carers, ensuring carers know where to go for help, income maximisation and carers' rights.

Policy Statement
The Carers (Scotland) Act (from April 1st, 2018) is designed to support carer's health and wellbeing. It places a duty on the local partnership to provide support to carers based on their identified needs, which meet the local eligibility criteria.

Shetland Islands Health and Social Car Partnership Integration Joint Board has set its own eligibility criteria framework but this must meet the national guidance and secondary legislation.

Definitions
Meaning of "carer"
(1) In this Act "carer" means an individual who provides or intends to provide care for another individual (the "cared-for person").
(2) But subsection (1) does not apply—
(a) in the case of a cared-for person under 18 years old, to the extent that the care is or would be provided by virtue of the person's age, or
(b) in any case, to the extent that the care is or would be provided—

(i) under or by virtue of a contract, or
(ii) as voluntary work.
(3) The Scottish Ministers may by regulations—
(a) provide that "contract" in subsection (2)(b)(i) does or, as the case may be, does not include agreements of a kind specified in the regulations,
(b) permit a relevant authority to disregard subsection (2)(b) where the authority considers that the relationship between the carer and the cared-for person is such that it would be appropriate to do so.
(4) In this Part "relevant authority" means a responsible local authority or a responsible authority (see section 41(1)).

Meaning of "young carer"

In this Act "young carer" means a carer who—

(a) is under 18 years old, or

(b) has attained the age of 18 years while a pupil at a school, and has since attaining that age remained a pupil at that or another school.

Meaning of "adult carer"

In this Act "adult carer" means a carer who is at least 18 years old but is not a young carer.

Our Principles

Carers

Carers will be recognised as equal partners in providing care and support.

Outcomes

Good quality outcome focused assessment continues to be central to developing effective carer support plans. This aims to achieve improved outcomes with and for carers / young carers with health and social care needs

Decision Making

We aim to ensure consistency and transparency and timely decision making.

Expectation & Entitlements

Carers should not be worse off by caring and are clear about the support they are entitled to.

Recognition and Expertise

Unpaid carers are the largest group of providers of care in Scotland and should be recognised as equal partners in providing vital care and support.

Equity

Our framework creates a fair and transparent system for determining eligibility that is understood by carers

Diversity and Equality

Carers with different needs will be treated equally in accessing services and support.

Prevention
Assessments for support should prevent deterioration in the carer's health or the caring situation.
Ease
Carer's ACSP/YCS should not be burdensome. Questions about needs and outcomes will have a clear purpose for carers, not just the support system.

Explaining the Process
Through the Carers (Scotland) Act we have a duty to support carers who meet eligibility criteria framework. This can be broken down into four steps:
Step One
A carer who wishes to access support can request an ACSP/YCS. This will involve conversations with the carer to jointly assess their caring situation and needs and how they can best achieve their personal outcomes. Not all carers who are assessed will have an eligible need. However, many will still have access to universal and/or preventative services. Carers may also be signposted to information and advice centres, carer's organisations and projects in the city that provide carer services.
Step Two
Once the assessment is complete the carer's outcomes and actions will be identified in their ACSP/YCS. The framework for eligibility criteria will identify their level of support.
Step Three
Based on their eligibility, we will decide what level of support the carer is entitled to.
Step Four
Once the level of support has been agreed, the carer will then decide how they would prefer to arrange their support and choose from the four self-directed support options. Carers will be involved in each stage of the process and in all decision making. A review date will be set at this point.

Eligibility for Services is decided in terms of risk to an individual. There are five indicator categories:

No Impact	**Indicates that there are no quality of life issues resulting from the caring situation and at this moment no need for support or advice.**
Low Impact	**Indicates that there may be some quality of life issues but low risk to a carer's capacity for independence or health and wellbeing. There may be some need for universal and/or preventative support or advice.**
Moderate Impact	**Indicates that there is some risk to a carer's capacity for independent living and health and wellbeing. This may call for provision of some health and social care services.**
Substantial Impact	**Indicates that there is major risk to a carer's capacity for independent living and health and wellbeing. Likely to require urgent provision or health and social care services.**
Critical Impact	**Indicates that there are significant risks to a carer's capacity for independent living and health and wellbeing. Likely to require immediate provision or social care services.**

Indicators: Impact on and Risk to Carer Outcomes

Universal support moving to commissioned services and support (local authority More targeted 'power to support')	More targeted commissioned services and support (local authority 'duty to support')

	No impact	Low impact	Moderate Impact	Substantial Impact	Critical Impact
Health	Carer is in good physical and mental health with no identified medical needs	Carer's health beginning to be affected. But there are no health needs identified	Carer is able to manage some of the aspects of family/social roles and responsibilities and social contact, that pose some risk to gaining/ sustaining independence	Carer able to manage some aspects of the caring/family/domestic/ social roles. Carer's mental and physical health is affected.	Carer has significant physical/mental difficulties due to the impact of their role as a carer which may cause life threatening harm
Relationship / Emotional	Carer has positive emotional wellbeing. Carer has a positive relationships with the cared-for person, wider family and social networks and feels acknowledged by professionals.	Caring role beginning to have an impact on emotional wellbeing. Low Impact on relationship with cared for persons, wider family and social networks and feels acknowledged by professionals	There is some impact on the carer's wellbeing and on their relationship with the cared for persons wider family and social networks resulting in a strained relationship.	There is a major impact on a daily basis to the carer's wellbeing and this impacts on the cared for person. Carer is unable to sustain many aspects of their caring role.	There is a complete breakdown in the relationship between the person and the carer, and carer is unable to continue caring or has difficulty sustaining vital or most aspects of their caring role. Input is needed for the carers wellbeing and there are no positives in the relationship with the cared for person. Carer feels isolated and overwhelmed Carer never feels acknowledged and therefore feels excluded.

Finance	**The carer's financial position is secure and there is therefore no financial hardship. All relevant benefits are being accessed.**	**Caring is beginning to have an impact on the carer's finances but not causing hardship.**	**The caring role is impacting on the families' finances and their standard of living is being affected.**	**Caring is having a major impact on finances.**	**The carer's financial position is sever and there is financial hardship.**
Employment / Education / Training	**Carer continues to access employment, education and training or chooses to remain at home in unpaid work and has no difficulty in managing caring and employment and/or education.**	**Carer has some difficulty managing caring and employment, education and training.** **There is a small impact on sustaining employment and/or education in the long term.**	**Carer has some difficulty managing caring and employment, education and training.** **There is a risk to sustaining employment and/or education in the medium term.**	**The carer is missing employment/education and training and there is a risk of this ending in the near future.**	**Carer is at significant risk or has had to give up employment/education/training**
Living environment	**The living situation meets the needs of the carer and the cared for person.**	**Carer's living environment is mostly suitable but could have a small impact to the health and safety of the carer and the cared for person in the longer term.**	**The living environment is not suitable to the changing needs of the cared for person but there is no immediate risk.**	**Carer's living environment is unsuitable and there are safety risks which cannot be remedied in the short/medium term.**	**Carer's living environment is unsuitable and there are safety risks for the carer and the cared for person which cannot be remedied.**
Life Balance	**Carer has regular opportunities to achieve the balance they want in their life.**	**Carer has some opportunities to achieve the balance they want in their life.**	**Due to their caring role, the carer has limited opportunities to achieve the balance they want in their life.**	**Carer has few and irregular opportunities to achieve the balance they want in their life.**	**Carer has not opportunities to achieve the balance they want in their life.**

Young Carer Statements
Why?

- • To ensure that young carers do not take on inappropriate caring tasks or caring that is inconsistent with their age and maturity.
- • To identify and record each young carer's individual needs, personal outcomes and support to be provided by the responsible local authority to meet those needs.
- • To ensure that there is effective planning in place to further support transition arrangements from moving from a young carer statement to an adult carer support plan.

Preparation of young carer statement

- • The responsible authority is a health board for preschool age, and local authority for schools.
- • YCS should be offered to the young carer and the young carer can request one.
- • The YCS should link to the Child's Plan if there is one in place.
- • Consideration needs to be given to who is best placed to prepare the statement, e.g. the local authority, health professional or someone else who is suitably qualified to do so.

Identification of outcomes and needs for support

- • In identifying a young carer's personal outcomes and needs for support, the YCS must take into account any impact that having one or more protected characteristics has on the young carer.
- • Low level needs and the support to meet those needs will be considered as part of the young carer statement process. This process will be based on the identification of personal outcomes, needs and risks.

- • Where there is a very young carer in the early years of primary school, caring for a family member, support provided should be directed towards removing them from that role through enhanced support for the person that they care for. There may be some scope for a young child to make a contribution to the care of their parents, but this has to be appropriate to their age and maturity amongst other factors.
- • The outcomes must cover the SHANARRI indicators of wellbeing. The SHANARRI indicators are: **S**afe, **H**ealth, **A**chieving, **N**urtured, **A**ctive, **R**espected, **R**esponsible and **I**ncluded.

Content of young carer statement

- • The YCS will include the nature and extent of care provided or to be provided as well as the impact of caring on the young carer’s wellbeing and day-to-day life.
- • The YCS must contain information about the extent to which the young carer is able and willing to provide care for the cared-for person. Consideration should also be given to ensure than any caring being undertaken should be age appropriate.
- • It is necessary to ensure that young carers are seen as children and young people first and foremost and are protected from undertaking inappropriate care tasks or caring that is inconsistent with their age and maturity.

Indicators: Impact on and Risk to Young Carer Outcomes

Universal; support moving to Commissioned Services and support (local authority 'power to support')	More targeted , commissioned services and support services (local authority 'duty to support')

	No impact	Low Impact	Moderate Impact	Substantial Impact	Critical Impact
Safe / Living environment	Young carer free from abuse, neglect or harm at home, at school and in the community.	Young carer's situation at home/within the community is currently stable and manageable.	Young carer's situation at home is not ideal and there is potential risk to Young Carer and Cared for person.	Young carer's situation at home is not ideal and there are safety risks which cannot be remedied in the short term.	Young carer's situation at home is unsuitable and there are safety risks for the young Carer and the Cared for person.
Health	Young carer is in good physical and mental health with no identified medical needs.	Young carer is able to manage some aspects of the caring /family/social roles and responsibilities and social contacts and there is a possibility of the young carer's health being affected.	Young carer is able to manage some of the aspects of caring/family/social roles and responsibilities and social contacts but the young carer's health is being affected.	Young Carer is having difficulty in managing aspects of the caring/family/domestic /social roles and the young carer's mental health is affected as a result.	Young carer has significant physical/mental difficulties due to the impact of their role as a carer that may cause life threatening harm
Achieving/ Education	Young carer continues to access education and training and has no difficulty in managing caring and education.	Young carer has some difficulty caring and education/training. There is a small risk to sustaining education in the long term.	Young carer has difficulty managing caring and education/training. There is a risk to sustaining education in the medium term.	The young carer is missing education/training and there is a risk of this ending in the near future.	The young carer is at significant risk of has had to give up education/training.
Nurtured/ Relationships	Young carer has positive emotional wellbeing. Has a nurturing place to live in and does not require additional help.	Young carer role beginning to have an impact on emotional wellbeing and may require additional help when needed.	There is some impact on the young carer's wellbeing and on their relationship with the cared for person resulting in a	There is a major impact on a daily basis to the young person's wellbeing and this impacts on the cared for person.	There is a complete breakdown in the relationship between the cared for person and the young carer and the young carer is unable to continue caring or has difficulty sustaining vital or most aspects of their caring role.

	Young carer has a positive relationship with the cared for person and feels acknowledged by professionals	**Risk of detrimental impact on relationship with cared for person.**	**strained relationship.** **Need additional help where possible, in a suitable care setting.**	**Young carer is unable to sustain many aspects of their caring role.**	**Input is needed for the young carer's wellbeing and there are no positives in the relationship with the cared for person.** **Carer never feels acknowledged and therefore feels excluded.**
Active/Life Balance	**The young carer has opportunities to take part in activities such as play, recreation and sport at home, in school and in the community.**	**The young carer has some opportunities to take part in activities such as play, recreation and sport at home, in school and in the community.**	**The young carer has limited opportunities to take part such as play, recreation and sport at home, in school and in the community.**	**The young carer has few and irregular opportunities to take part in activities such as play, Recreation and sport at home, in school and in the community and this may have a negative effect on healthy growth and development.**	**The young carer has no opportunities to take part in activities such as play, recreation and sport at home, in school and in the community and this has had a negative effect on healthy growth and development.**
Respect / Responsible	**The young carer has regular opportunities to be heard and involved in decisions and have an active and responsible role to be involved in decisions that affect them.**	**The young carer has some opportunities to be heard and involved in decisions and have an active and responsible role to be involved in decisions that affect them.**	**Due to their caring role, the young carer has limited opportunities to be heard and involved in decisions that affect them.**	**The young carer has few and irregular opportunities to be heard and involved in decisions that affect them.**	**The young carer has no opportunities to be heard and involved in decisions that affect them.**
Included/ Finance	**The young carer feels accepted as part of the community in which they live and learn. Has time to become part of community activities.** **Free from financial stress.**	**The young carer feels some acceptance as part of the community in which they live and learn but is unsure how to become part of the community activities.** **There is a small risk of financial stress.**	**Due to their caring role, the young carer has limited acceptance as part of the community in which they live and learn.** **There is a risk of financial pressure.**	**The young carer feels isolated and is not confident in the community in which they live.** **Needing financial support**	**The young carer does not feel accepted as part of the community in which they live.** **The young carer's financial position is severe and there is financial hardship.**

Implementation

Roles and Responsibilities

Those carrying out plans/assessments of an individual's needs must ensure that the appropriate carer eligibility criteria is satisfied before support is provided.

In all cases, those carrying out plans/assessments should ensure that carers are encouraged, and where necessary supported, to access mainstream public services, and local community services.

We give priority to carers who are assessed as being within the critical and substantial impact categories.

Carers who are assessed as being in moderate and low impact categories may be eligible for other services such as: advice and information; advocacy; carer support, counselling services and befriending and volunteer services.

Carers' eligibility should be recorded on client record systems as appropriate.

Related documents

Carers (Scotland) Act 2016

List all relevant statutory instruments by implementation date

Equalities and Impact Assessments

Needs done if not already completed

Strategic Environmental Assessment

This policy does not have any environmental implications.

Risk Assessment

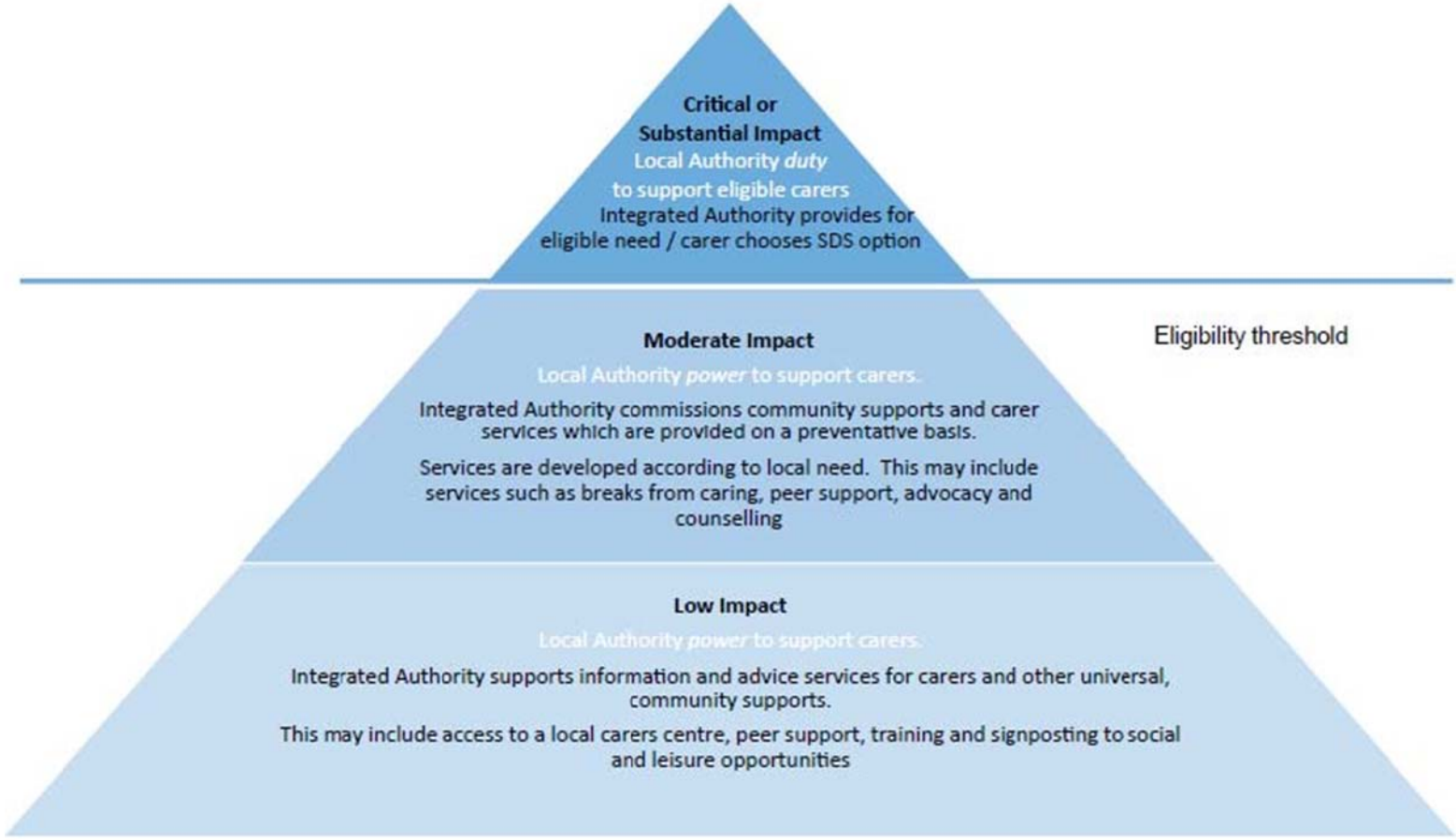
Decisions about who can receive ACSP/YCS are based on an assessment of need. Shetland Islands Health and social Care Partnership will give priority to carers who are at the greatest need. The carer's eligibility criteria is based on the Carers Act (Scotland) 2018. The eligibility criteria are is used to identify the degree of risk to an individual carer's capacity for independent living or health and wellbeing taking account of each carer's circumstance.

Review

The policy and associated procedures will be reviewed within 3 years subject to any further changes in legislation.

Monitoring procedures will be carried out 12 monthly to measure impact

Eligibility thresholds: where eligibility sits in relation to carer support as a whole



Appendix 2, Draft Amended Direction Carers Service

Direction from the Integration Joint Board

Carers Service

1.	**Reference Number**		
2.	**Date Direction issued by IJB**	13 July 2017	13 March 2019
3.	**Date from which Direction takes effect**	1 August 2017	13 March 2019
4.	**Direction to:**	Shetland Islands Council	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes
6.	**Functions covered by the Direction**	Implementation of the Carer's Strategy approved by the IJB in January 2017. Carers 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.	The functions will be: - Carers Lead Training - Waiving Charges - Carers Information and Advice - Continued implementation of the Carers Strategy to enable Carers to be: – 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	Deliver services as set out in this Direction including

		6 Inclusive) in partnership with third sector and carer's representatives.	the Improvement Plan
8.	**Budget allocated by IJB to carry out Direction.**	No specific budget allocation.	The budgets related to this Direction are; £26,224 – Carers Information Strategy, Training and Information Service. £95,747 – Waived Charges for Carers Total budget allocation of £121,971 There is a broad range of provision also available to Carers which has been approved under other Directions These services will include, but not be limited to: - Residential Respite - Care Centres (Respite and Day Care) - Non Residential Respite - Carers Attendance Scheme
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	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

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

Shetland Islands Health and Social Care Partnership

Direction for Carers Services

Service Model
Outcomes Framework
Improvement Plans

February 2019

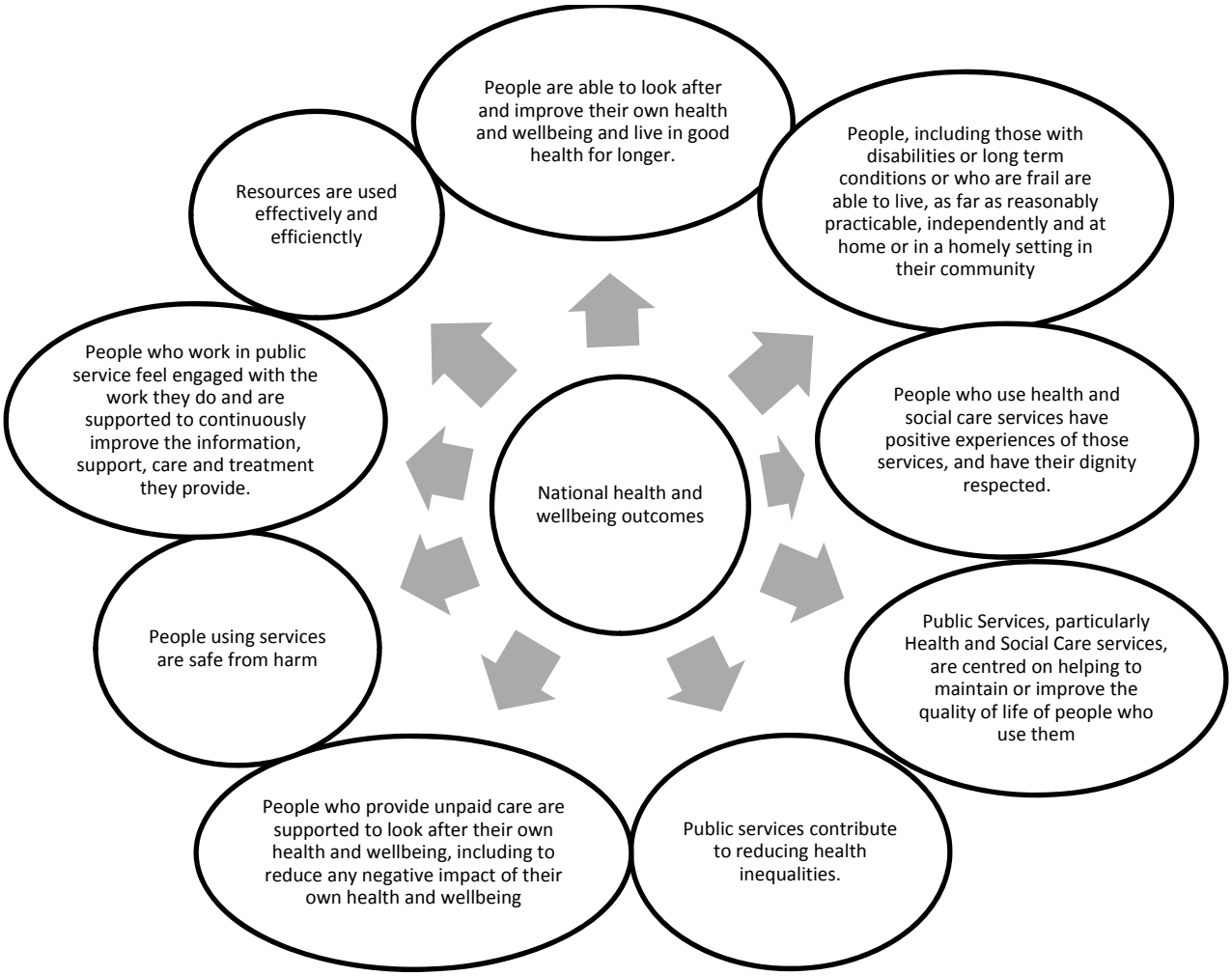
Service Model

The service model and indicative activity levels are shown below. This is the service model that the IJB is commissioning directly from NHS Shetland and Shetland Islands Council and through them from the voluntary sector.

Services in Support of Carers	Numbers of Service Users
Number of Carers with support plans	Adults Current Assessments 59
	Adults Potential Assessments 400 – 1,600 / 2,000
Number of Young Carers identified	Young Carers People Currently Known 4
	Potential Young Carer Statements 4-300
Carers Groups	2 groups individual numbers included in VAS info & Advice below (17/18)
New Craigielea	30 allocations & 8 day services (17/18)
Care Centres (Respite)	197 (17/18)
Non Residential Respite	15 (17/18)
Carers Attendance Scheme	53 (17/18)
Information and Advice	CAB: 152 (17/18) VAS: 260 (17/18)

Outcomes Framework

The IJB Commissions Services for Carers in line with the general Health and Wellbeing Outcomes.



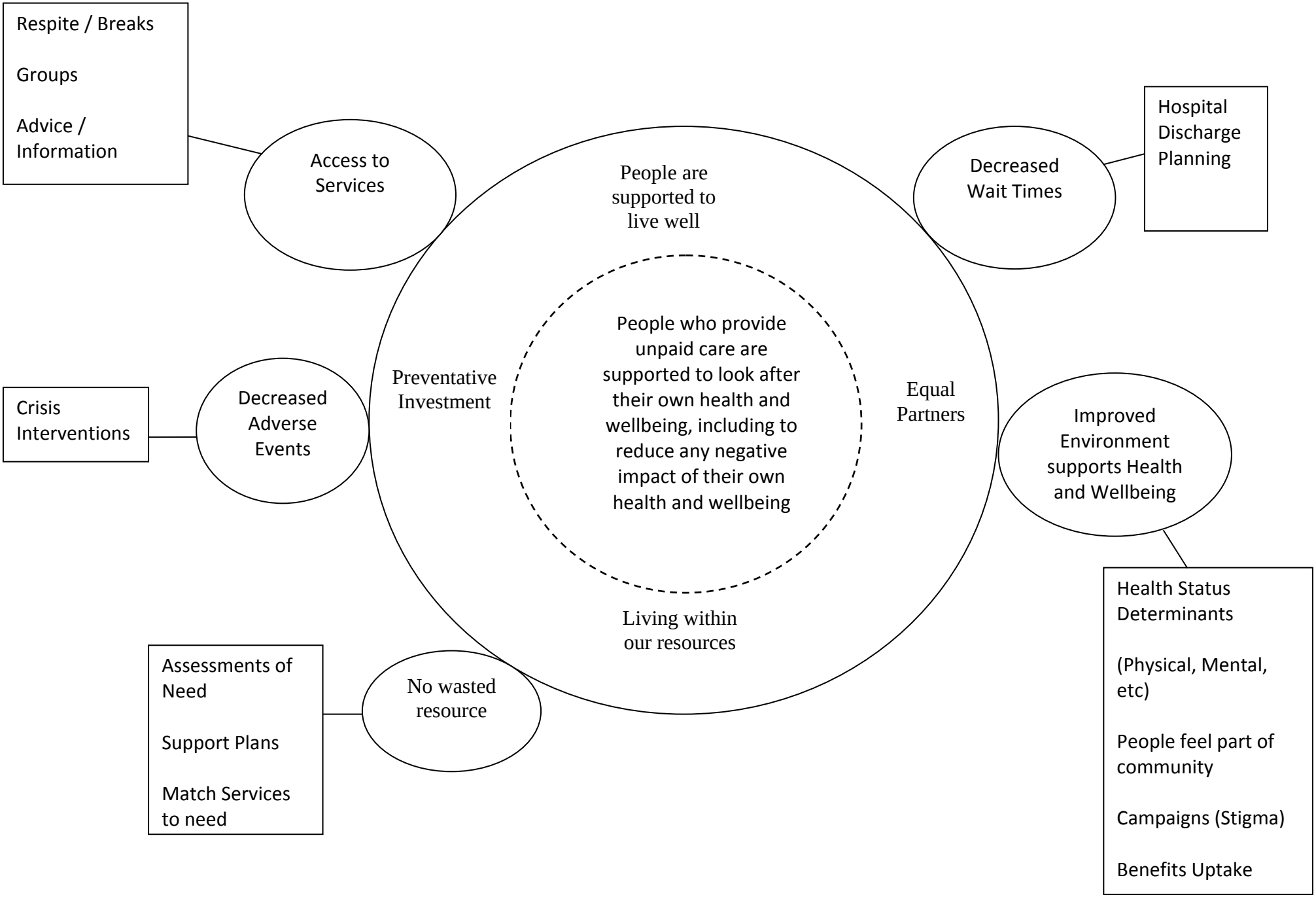
There is one specific outcome in place for Carers:

- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their own health and wellbeing

In the latest available data (2017-18), Shetland recorded 41%, compared to a Scottish average of 37%.

Indicator	Shetland	*Scotland*
8. Percentage of carers who feel supported to continue in their caring role. (2017-18)	41%	*37%*

Others Indicators will be developed as part of the Improvement Plan.
The concept diagram for outcomes has been developed in line with the Canterbury, New Zealand Health System Outcomes Framework (http://ccn.health.nz/Resources/OutcomesFramework.aspx) shown below, with examples of indicators.


Respite / Breaks
Groups
Advice / Information
Access to Services
People are supported to live well
Decreased Wait Times
Hospital Discharge Planning
Crisis Interventions
Decreased Adverse Events
Preventative Investment
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their own health and wellbeing
Equal Partners
Improved Environment supports Health and Wellbeing
Health Status Determinants
(Physical, Mental, etc)
People feel part of community
Campaigns (Stigma)
Benefits Uptake
Living within our resources
Assessments of Need
Support Plans
Match Services to need
No wasted resource

Improvement Plans

By 2018 the Shetland Carers Strategy Group would like to see the following for Carers in Shetland.

- Carers truly seen as equal partners
- Support plans put in place for all carers
- Quality implementation and review processes for carer support plans
- Measurable impacts on carer support plans
- Preventative investment in services for carers
- Help for carers when they need it
- Fast, responsive & flexible support
- The same support regardless of where you live

EPiC- Equal Partners in Care

The Shetland Carers Strategy Group adopted the EPIC model for our strategy. Equal Partners in Care (EPiC)1 - NHS Education for Scotland & Scottish Social Services Council. Alongside each aim, are the key outcomes that carers and partners wish to achieve.

Carers Strategy Implementation Plan

This Carers Strategy Implementation Plan looks at the outcomes for Carers in the Carer Support Plan, and links these with the Carers Strategy proposals, to outline a programme of action. This plan will be monitored by the Shetland Carers Strategy Group.

Carers Strategy Implementation Plan

PUTTING THE CARER'S STRATEGY INTO PRACTICE

This Carers Strategy Implementation Plan looks at the outcomes for Carers in the Carer Support Plan, and links these with the Carers Strategy proposals, to outline a programme of action. This plan will be monitored by the Shetland Carers Strategy Group.

Action	Lead	Date	Progress
EPIC Principle 1: Identify Carers			
Continue to celebrate Carers Week and use to help identify carers at an earlier opportunity.	VAS	Annual event	
Raise awareness by attending events for example flu flairs with leaflets and information for carers.	VAS	Continuous	
Offer carer awareness training to all organisations with representatives on the Carers Strategy Group.	VAS	September 2017	
Reissue the information pack for young carers, to all schools and present at a Head Teachers meeting.	VAS & Young Carer Lead	June 2017	
Embed the protocol for GP surgeries to encourage staff to take a proactive role identifying carers.	VAS & NHS Primary Care Developm ent Officer	June 2017	
Ensure process for hospitals to encourage staff to take a proactive role identifying carers is included in Admissions and Discharge protocol.	Executive Manager Adult Social Work	June 2017	
Ensure there are regular displays and poster campaigns in a variety of establishments including local shops, ferries, halls, ARI, GBH, Forrester Hill and all hospitals that Shetland residents use.	VAS	Quarterly from 2017	
Deliver carer awareness training to Community Health and Social Care Directorate Team Meeting for dissemination to all staff.	VAS, Executive Manager Adult Social Work	September 2017	
EPiC Principle2: To be supported and empowered to manage my caring role			
Training for staff to carry out carer support plans (including Young Carer statements) including menu of info so all carers are aware of support available.	VAS & Self-directed Support Officer	April 2018	

Action	Lead	Date	Progress
Ensure that information about carer support plans are cascaded to their respective organisations.	Carers Strategy Group	April 2018	
Promote the use of emergency cards for carers to carers	Carers Strategy Group	Continuous	
Promote income maximisation through referral to CAB for benefits checks at every opportunity.	Carers Strategy Group	Continuous	
EPiC Principle 3 – To be enabled to have a life outside caring			
Third sector to continue applying for external funding for example the Shortbreaks Fund.	Third Sector	Continuous	
Ensure carers are aware of the range of support services such as day care, respite Alzheimer Scotland activities, befriending and Shetland Care Attendant Scheme.	Strategy Group	Continuous	
Through support planning ensure carers who wish to access learning, volunteer and employment opportunities can do so by promoting in newsletter, and through website.	Assessors / Care Managers	Continuous	
EPiC Principle 4: To be fully engaged in the planning and shaping of local services.			
Seek views of carers and cared for people at their review and use this information in service planning.	Care Manager	Continuous	
Increase carer representation on the Strategy Group.	Strategy Group	Continuous	
Ensure consultation of carers for any change in services which affect them.	All services	Continuous	
EPiC Principle 5: To be free from disadvantage or discrimination related to their caring role			
This Strategy and good carer support planning will assist in carers being free from disadvantage or discrimination.	N/A	N/A	
EPiC Principle 6: To be recognised and valued as equal partners in care			
Explore the use of the principles of the “Triangle of Care” for all carers.	Strategy Group	Continuous	
Publicise and promote Carers Advocacy service to carers and professionals/other services.	Strategy Group	Continuous	

Appendix 3, Forecasting and Scenario Planning of Need and Demand for Carers Services

Background

The Carers (Scotland) Act 2016 came into force on 1st April 2018.

The Act has a number of duties for both the local Authorities and the NHS:

1) Duty to prepare Adult Carer Support Plans and Young Carer Statements,
2) Duty to set a local eligibility criteria for carers support,
3) Duty to provide support to those eligible under Self-directed Support,
4) Duty to involve carers in carer services,
5) Duty to include carers in hospital discharge,
6) Duty to prepare a local carer strategy,
7) Duty to provide information and advice services for carers.

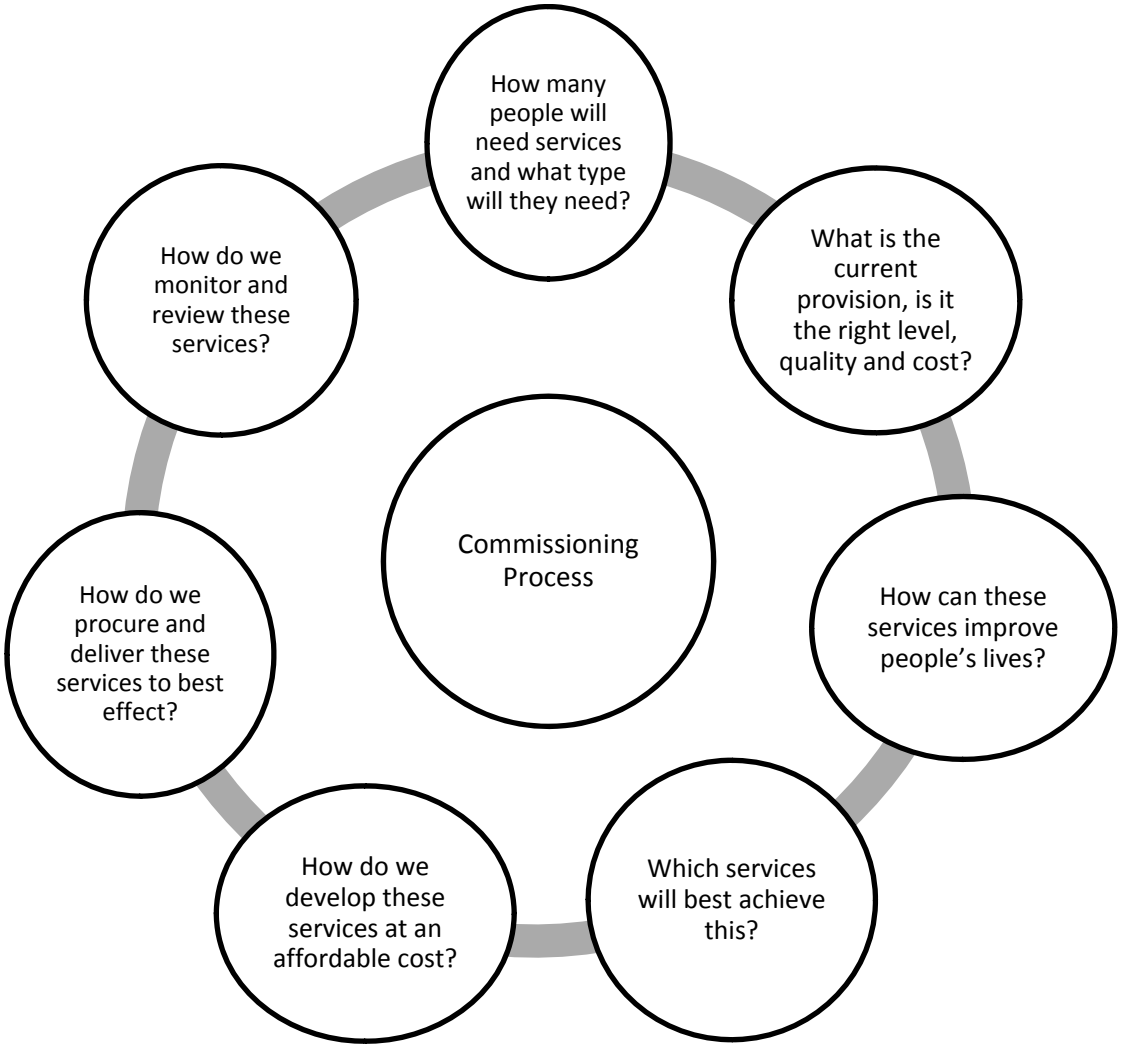
Commissioning Process

The process of commission is to make sure that all resources (staff, assets, information, treatments, etc.) are applied to best meet people's outcomes. In IJB terms it is called the 'commissioning process'.

The 'Commissioning Process' has 5 key stages:

- assessing and forecasting needs
- linking investment to agreed outcomes
- considering options
- planning the nature, range and quality of future services
- working in partnership to put these in place

as shown in the diagram below.



The start of the process is to determine how many people will need services and what type will they need. At this point in time, data to help to answer that question is not complete.

This paper sets outs some national data, to provide an indication of possible overall numbers of carers in Shetland. It then goes on to set out three scenarios for growth.

These new duties will have a local cost implication which the Scottish Government has recognised in additional funding provision to local partnerships.

New duties under the Carers (Scotland) Act 2016 require the Local Authority to produce data around Carers. This will require some work to record what has not previously been captured. These new ways of recording will mean a better understanding of the future eligible needs for Carers support and Self Directed Support costs associated with that need.

Data capturing costs associated with Carer support has not previously been separated from the overall costs of Self Directed Support options one and two. This will now be done in order for us to understand the costs associated with supporting Carers eligible needs.

National Position

Demand for support is increasing as the demography of Scotland changes. Projections suggest that the number of people (including carers) aged 75 and over is projected to increase by around 28 per cent from 0.42 million in 2012 to 0.53 million in 2022. The numbers in the same age category will continue rising, reaching 0.78 million in 2037, an increase of 86 per cent over the 25 year period. The number of people aged 80 and above is projected to more than double by 2037 (an increase of about 105 per cent) and the number of centenarians is projected to rise from 800 to 7,800 by 2037, more than an eightfold increase.

There are currently around 745,000 identified adult carers and 44,000 identified young carers in Scotland. This equates to around 17 per cent of Scotland‘s population who are in an adult caring role and around 5 per cent of children and young people aged four to seventeen who are in a caring role as a young carer. The number of young carers is likely to be an underestimate as young carers in particular may not identify themselves as such in a survey.

Whilst the number of carers in Scotland has remained relatively steady over the last 10 years, the trend in the same period is for more intensive caring by hours of caring. The proportion of carers caring for 20 or more hours each week has increased from 37 per cent (in 2001) to 45 per cent (in 2011). The number of carers (including young carers) might grow to an estimated 900,000 by 2037 with three out of five people becoming carers at some point in their lives. This will be due primarily to the rapidly growing older population suggesting that the demand for carers will increase in the coming years. However, the number of carers required might fall short of the number of carers available.

Around one-third (32 per cent) of Carers across Scotland who responded to the recent Scottish Health and Care Experience Survey reported that caring had a negative impact on their own health and wellbeing.

The Scottish Health and Care Experience Survey also found that, in general, those who provided more hours of care were more negative about the balance of caring in their lives, being able to spend time with others and the impact of caring on their wellbeing compared to those providing fewer hours.

The intensity, duration and complexity of the caring situation influences carers‘ health and wellbeing. The Scottish Health and Care Experience Survey also found that those in the middle groups by hours of caring – providing between five and 49 hours – were slightly more negative around the co-ordination of services and support to continue caring compared to those in the bottom (up to four hours) and top groups (over 50 hours). This may be due to the middle group of carers juggling both employment and caring responsibilities who may receive less support from services or others to continue caring.

The Scottish Government is not starting from the premise of supporting **all** existing carers (and indeed young carers) in order to achieve the outcome of all carers feeling supported to continue caring and being able to achieve a good balance between caring and other things in their lives. This is because, according to the Scottish Health and Care Experience Survey, some of the cohort (44 per cent) either strongly agree or agree that they feel supported to continue caring, 38 per cent were neutral and 18 per cent indicated that they were not supported to continue caring. Some (42 per cent) did not experience a negative

impact on their health and wellbeing as a result of caring, 25 per cent were neutral and 32 per cent indicated that caring had a negative impact.

Assessing Need

There are a number of areas for new associated costs with the Act's duties. These relate mainly to the new Adult Carer Support Plans (ACSP) and Young Carer Statements (YCS); in order to embed a new-style, outcomes-focused and co-produced assessment and support plan for all carers.

Personalised assessment and support planning is a systematic process based around 'better conversations' between the person and their social care practitioners. The overall aim is to identify what is most important to each person for them to achieve a good life and ensure that the support they receive is designed and coordinated around their desired outcomes.

The importance of good assessment and support planning cannot be underestimated in relation to determining eligibility, the success of Carers meeting outcomes and also the appropriate and effective use of budgets allocated to them.

The duty to offer support to adult and young carers must continue. However, estimated costs for meeting the duty to provide support to carers is less clear. Previously these costs have been included in overall Self Directed Support budgets and not identified specifically against meeting Carers needs/outcomes. Changes in the way associated support costs for Carers are recorded must now be implemented.

The total estimated costs for all local authorities across Shetland for conducting ACSP and YCS is a minimum of £11.303 million in 2017-18 rising to a minimum of £71.791 million in 2021-22. The maximum costs in the same years are £12.463 million rising to £83.501 million. The difference in the minimum and maximum estimated costs is due to minimum and maximum unit costs used for the adult carer support plan and young carer statement.

In terms of the potential for avoided costs, there is evidence of savings in health and social care when both cared-for persons and carers are not admitted to hospital. Three separate research studies suggest that poor carer health can result in greater use of health and care services by the cared-for person, particularly older people, for example, through: admission and readmission to hospital; delayed discharge; referral to a day hospital or geriatric unit; and admission to institutional care. Therefore supporting carers at the earliest opportunity can prevent unwanted admissions to hospital.

At a national level, over half (56 per cent) of carers are in employment, compared to 58 per cent of non-carers. At this high level, the employment status of carers and non-carers is not that different. However, with regard to the different levels of caring, 69 per cent of those caring for between one and 19 hours a week are in employment, 56 per cent of those caring for between 20 and 34 hours a week are in employment and 35 per cent of those caring for 35 or more hours a week are in employment. There are potential cost savings by carers being in employment. Therefore supporting Carers to have a balance between their caring role and life outside caring has potential cost savings.

Hidden public expenditure costs of caring include, for example, costs to the NHS incurred by carers; costs to the Department for Work and Pensions (DWP) arising from increased benefits and pensions paid to carers; and lost income to HM Treasury arising from the

lower employment rates of carers. Hidden individual costs of caring include the opportunity costs of caring i.e. the alternatives forgone by the carer as a result of taking on a caring role, such as employment opportunities and leisure.

In the Financial Memorandum that accompanied the CARERS (SCOTLAND) BILL, it is estimated that for every £1 spent on supporting Carers, between £4 and £10 is saved by the Local Authority.

Shetland Forecasts and Scenarios

Extrapolating the national position to Shetland would equate to approximately 2,000 adult carers and 300 young carers.

Current recorded figures would indicate a significant shortfall of identified carers in Shetland, with 400 adult carers and 4 young carers with recorded 'carer' status on local systems.

Information - Adults	Numbers	NOTES
1 in 8 of the Shetland population estimated to be Adult Carers	2,000	In line with 1 in 8 average of the Shetland population
Adult Carers known to Social Care and Carers Centre services	400	Identified across SIC Social Care and VAS Carers Centre
Adult Carers known to GP Practices	98	Identified through EMIS - Unclear how many of these are also know by SIC and VAS
Estimated Carers unknown	1,600	Duty for Social Care

Information – Children & young People	Numbers	NOTES
Young carers estimate 7% of young people are carers	296	Based on the total number of young people under 16 in Shetland of 15,000
Young carers known to services	4	Identified on SEEMIS (School system)
Estimated Young Carers unknown	292	Duty for Children's Services and Education

The table below shows the adult Carers data from first census return to the Scottish Government in 2018.

Carers Assessments	Aged 18 -64			Aged 65+			All		
	Male	Female	All	Male	Female	All	Male	Female	All
Adult carers assessments completed in 2017/18	7	21	28	6	15	21	17	42	59

Various scenarios have been developed and costed, as follows:

- Growth at current prevalence of uptake;
- Growth at an increase of activity by 100%; and
- Growth to meet the estimate of all carers needs.
-

Scenario	No of Additional Plans per annum		Estimated Additional Cost per Annum per Scenario					
	Adults	Young People	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Current Rate	60	0	10	10	10	11	11	53
Mid-Point	120	26	26	26	26	26	26	132
All Support Plans	320	58	66	66	66	66	66	333

The Scenarios identify a potential increase in demand for services at a cost of between £10,000 and £66,000 per annum.

Shetland Islands Health and Social Care Partnership

Agenda Item

7

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	13th March 2019
Report Title:	IJB Business Programme 2019 and IJB Action Tracker	
Reference Number:	CC-17-19-F	
Author / Job Title:	Simon Bokor-Ingram, IJB Chief Officer	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board RESOLVES to consider and approve its business planned for the financial year to 31 March 2020 (Appendix 1).

1.2 To REVIEW the IJB Action Tracker (Appendix 2).

2.0 High Level Summary:

2.1 The purpose of this report is to allow the IJB to consider the planned business to be presented to the Board during the financial year to 31 March 2020, and discuss with Officers any changes or additions required to that programme.

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 In order to fulfil the statutory duties with regard to the functions delegated to the IJB by the Shetland Islands Council (the Council) and Shetland NHS Board (the Health Board), and in order to meet public governance principles, the IJB must make sure its Business Programme supports its role in the planning and direction of services to meet the needs of some of the most vulnerable people in our community, and to set its business in accordance with local and national reporting frameworks.

4.0 Key Issues:

4.1 The IJB's governance documents contain the legislative requirements and matters of best practice and standards, and the Business Programme enhances these by publicising the plans for decision making and other public reporting requirements, in keeping with the principles of good governance.

4.2 There is a strong link between strategic planning and financial planning, to provide

the best possible environment to ensure that the strategic direction, service models and resources to deliver services are aligned.	
5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The Business Programme provides the community and other stakeholders with important information, along with the Strategic Commission Plans, as to the planned business for the coming year.
6.2 Human Resources and Organisational Development:	There are no direct impacts on staffing or organisational development matters with regard to approval of the Business Programme. However approval of the Business Programme will give direction and assurances to staff with regard to the timing and requirements for decisions and public reporting that the IJB has agreed. Changes that have the potential to impact on the workforce will be reported to the Joint Staff Forum for consultation with staff representatives.
6.3 Equality, Diversity and Human Rights:	There are no direct impacts on equality, diversity or human rights with regard to approval of the Business Programme, although individual items will have to have regard to those in terms of any outcomes and associated risks. The recommendation in this report does not require an Equalities Impact Assessment.
6.4 Legal:	The IJB is advised to establish a Business Programme, but there are no legal requirements to do so. There are no direct legal impacts with regard to approval of the Business Programme, although individual reports will have to have regard to current and impending legislation and the impact on the IJB, and the services which the NHS and SIC deliver, in terms of outcomes and legal risks.
6.5 Finance:	The there are no direct financial implications by approving the Business Programme, but indirect costs may be avoided by optimising time spent by officers and members of the IJB at scheduled meetings. Regular financial and performance reporting will ensure that the IJB fulfils the terms of the Integration Scheme.

	Any costs associated with the development and maintenance of the IJB Business Programme will be met from within existing budgets of the Council and the Health Board.
6.6 Assets and Property:	There are no implications for major assets and property. It is proposed that all meetings of the IJB will be held in either the premises of the Council or the Health Board and that the costs will be covered accordingly by the Council and the Health Board.
6.7 ICT and new technologies:	There are no ICT and new technology issues arising from this report.
6.8 Environmental:	There are no environmental issues arising from this report.
6.9 Risk Management:	The risks associated with setting the Business Programme are around the challenges for officers meeting the timescales required, and any part of the Business Programme slipping and causing reputational damage to the IJB, the Council or the NHS. Equally, not applying the Business Programme would result in decision making being unplanned and haphazard and aligning the IJB's Business Programme with the objectives and actions contained in its Strategic Plans could mitigate against those risks.
6.10 Policy and Delegated Authority:	As a separate legal entity the IJB has full autonomy and capacity to act on its own behalf. Having in place a structured approach to considering key planning, policy and performance documents at the right time is a key element of good governance. Regular Business Planning reports are already prepared for each IJB meeting.
6.11 Previously considered by:	NA

Contact Details:
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IJB Chief Officer
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Appendices:
Appendix 1 Business Programme 2019-20
Appendix 2 IJB Action Tracker

Shetland NHS Board | Shetland Islands Council

Shetland Health and Social Care Partnership

Integration Joint Board
Meeting Dates and Business Programme 2018/19

as at Friday, 08 March 2019

Integration Joint Board 2018/19		
Quarter 4 1 January 2019 to 31 March 2019	Wednesday 23 January 2019 at 2 p.m.	• Financial Monitoring Report to 30 September 2018 • Shetland Islands Health and Social Care Partnership Quarterly Performance Overview : Quarter 2 – July –September 2018 • Mental Health Service Review: Findings and Directions • Domestic Abuse and Sexual Violence Strategy 2018-23 • IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker
	Wednesday 13 March 2019 at 2 p.m.	• Carers Eligibility • Financial Monitoring Report to 31 December 2018 • IJB Budget 2019/20 • Shetland Islands Health and Social Care Partnership Quarterly Performance Overview : Quarter 3 - October-December 2018 • Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan, Refresh 2018-2021 • IJB MTFP Report • IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker

Integration Joint Board 2019/20		
	Date of Meeting	**Business**
Quarter 1 - 1 April 2019 to 30 June 2019	Tuesday 14 May 2019 11 a.m.	• IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker
	Thursday 27 June 2019 *Special Meeting A/Cs only* 3 p.m.	• Draft 2018/19 Accounts • IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker
Quarter 2 – 1 July 2019 to 30 September 2019	Thursday 29 August 2019 3 p.m.	• IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker
	Thursday 26 September 2019 *Special Meeting A/Cs only* 3 p.m.	• Final 2018/19 Accounts • IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker

Shetland NHS Board | Shetland Islands Council

Shetland Health and Social Care Partnership

Integration Joint Board

Meeting Dates and Business Programme 2018/19

as at Friday, 08 March 2019

Quarter 3 - 1 October 2019 to 31 December 2019	Thursday 28 November 2019 3 p.m.	• IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker
Quarter 4 - 1 January 2020 to 31 March 2020	Tuesday 25 February 2020 11 a.m.	• IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker

Planned business still to be scheduled - as at Friday, 08 March 2019

- Code of Corporate Governance
- Right to Advocacy
- Joint Organisation and Workforce Development Protocol

END OF BUSINESS PROGRAMME as at Friday, 08 March 2019

	ACTIONS - IJB						
No	**Agenda Item**	**Responsible Post Holder**	**IJB Meeting Date**	**Target Date**	**Action**	**Update**	**R/A/G Status C (Completed)**
1	Intermediate Care Team Update	Chief Nurse (Community)	11.11.18		Once resolved provide briefing by email about car insurance issue around the use of the NHS owned vehicle for SIC use/delivery Intermediate care team updates to be provided in quarterly performance reporting.	Ongoing issue which has been raised at a national level. Exception reporting only.	A
2	Carers Information Strategy Update	Self-directed Support Officer / Carers Lead	11.11.18		Future report to include census data and information on types of care, age and demographic.		A
3	Primary Care Improvement Plan Update	Service Manager Primary Care/Chief Social Work Officer	11.11.18		Training Budget issues for GPs and other professionals to be raised as an issue for future budgeting Briefing to be provided on general practice nursing	Future reporting through performance reporting.	G

					More detail on how far along towards completion of actions to be included in Appendix 2		
4	Shetland Islands Health and Social Care Partnership Quarterly Performance Overview, Quarter 2: July - September 2018	Director of Community Health and Social Care/ IJB Chief Officer and Head of Planning and Modernisation	23.01.19		For future reporting on the Risk Register more clarity in the wording used to be considered. Indicator E15 data to be provide differently on ongoing basis. Appendix 1A will be refreshed and updated for 2019/20 following the approval of the Joint Strategic Commissioning Plan.		
5	Mental Health Service Review: Findings and Directions	Director of Community Health and Social Care/K Smith, Mental Health Service	23.01.19		Provide an email to IJB members an update on progress in regard to multipurpose accommodation for use by the Mental Health Team.		