Shetland
Islands Council

REPORT

To:	**Services Committee**	**18 October 2007**
	Shetland Islands Council	**31 October 2007**

From: **Head of Housing & Capital Programme Service**

Report No: **CPS-10-07-F**

Subject: **Anderson High School (AHS) – Progress Report**

1. Introduction

1.1. This report updates Members on the current status of the Anderson High School project and progress against the timetable set out in an earlier report to Services Committee on 21 June 2007 (Min Ref: 26/07).

1.2. This was followed by a further report regarding the appointment of a contractor for the Early Contractor Involvement (ECI) period (Min Ref: 132/07).

1.3. Bearing in mind that a large proportion of the current Council has not been involved in this project from the last Council, it is considered necessary to update Members on the latest developments and progress with this project.

1.4. At the last full Council Members requested greater detail to be presented to them informally on the history of decisions relating to this project. Members have had that information made available to them.

2. Links to Council Priorities

2.1. The Council on 19 May 2004 approved the construction of the new Anderson High School (Min Ref: 68/04).

2.2. The project is specifically listed in the Council's Corporate Plan.

3. Background

3.1. The report to Shetland Islands Council on 12 September 2007 (Min Ref: 132/07), detailed the steps to be undertaken for Early Contractor Involvement (ECI) for the Anderson High new build project. The appointed contractor is O'Hare & McGovern Ltd.

3.2. Further to the appointment of the Contractor, there follows a six to nine month period known as Early Contractor Involvement (ECI), which involves the Project Team (SIC and Contractor's Team) working through the detail of the design and cost information towards fixing the final design and target cost for the project.

3.3. The project team have been working with O'Hare & McGovern Ltd to identify potential cost saving ideas that do not adversely affect the educational requirements.

3.4. Members should note that any costs mentioned in this report are for indicative purposes only and may be subject to change as the detailed design progresses. This is because the specification, design and prevailing market may change between now and the end of the ECI period.

3.5. The final design and target cost will not be known with any certainty until the end of the ECI period.

3.6. However, in order to advance the detailed design and still have any chance of starting on site in 2008 as expected, it is necessary to have a firm concept upon which to base the detailed work.

4. Programme

4.1. If the project is to proceed on site at the earliest possible date, in April 2008, it is essential that fundamental key decisions regarding potential cost saving options be upheld at an early stage.

4.2. Since the appointment of the Contractor in September 2007 the project team have been discussing high level cost saving options. These discussions and proposals also take into account comments arising out of the consultation regarding the height of the building, its functionality and the perceived extravagance of the design.

4.3. Without compromising quality or educational requirements, the initial cost saving options are summarised below:

4.3.1. Omit the underground car parking and add back surface car parking, resulting in a reduction of one half storey to the height;

4.3.2. Omit the top floor by re-positioning classrooms, resulting in a further one storey reduction in height;

4.3.3. Reduce the height of the atrium and so the size of the glazed area;

4.3.4. Bring the library within the atrium to simplify construction;

4.3.5. Straighten the line of the atrium to simplify construction;

4.3.6. Rotate the main hall to create better use of internal space and further reduce the glazed area;

4.3.7. Simplification of roof plan;

4.3.8. SIC assisting with the provision of workers and site accommodation to reduce costs:

The costs associated with the proposals outlined above are currently being progressed by the design team and will not be available for the clearance of this report. However, it is expected that the costs can be tabled at the Services Committee.

4.4. In addition, the following approaches have been agreed by the design team as potential ways to reduce costs. However, the outputs cannot be calculated at this stage:

4.4.1. Maximise the use of local sub–contractors where practical, to reduce accommodation costs during the construction phase;

4.4.2. Prefabrication of components off site to minimise the number of site operatives:

4.5. All of these proposals have been fully discussed with the Head of the AHS and the School Service, who are of the opinion that, they can all be accommodated without compromising the concept or compromising the educational requirements.

4.6. The items identified in 4.3 and 4.4 may have the effect of reducing the capital cost but may also reduce the longer-term maintenance and running costs associated with the AHS.

4.7. There is still potential for further additional cost savings to be identified throughout the ECI process and the project team will continue to investigate all possibilities.

4.8. Commitment to the ECI phase does not commit the Council to the construction phase. A further decision of the Council will be required to enter into the construction phase when the Target cost has been set with greater certainty to inform any decision.

Should this process continue without interruption, the anticipated programme is as follows:

- ECI period - September 2007 - March 2008
- Council decision to proceed - April 2008

Naturally, should it prove necessary to extend the ECI period the subsequent dates will be extended.

5. Key Issues

5.1 Specification/ Size – The original budget was based on provision of a school with a floor area of 14,260 sq.m for 900 to 1100 pupils, based on a Glasgow PFI school in terms of area and facilities. The estimated cost of constructing a school of that size was £29.6m at 2004 prices. Using figures for inflation from the Finance Service, this would be the equivalent of £34.6m at 2007 prices. Since that time the concept design has progressed and the current proposed floor area is 18,472 sq.m. The main reasons for this are:

5.1.1 The general specification is based on a requirement for a school roll of 900 to 1100 pupils that in addition accounts for the specific requirements of the AHS in the Shetland environment. For example, the centralisation of house building and the associated long term pupil projections;

5.1.2 National policies to achieve a reduction in class sizes for S1 and S2;

5.1.3 Replication of current size;

5.1.4 Two value engineering exercises carried out to reduce accommodation schedule to current position;

5.1.5 The current estimate for the construction of the AHS is £48m. This process seeks to reduce the £48m construction cost.

5.2 Design – Since appointment of the Architect in 2005 five options were developed. The "living wall" emerged as the preferred option to be adopted as the "Stage C" proposal. This followed an extensive consultation process to consider all design concepts. This "Stage C" proposal is the concept that has been taken forward to the contractor for development of the detailed design during the ECI period.

5.3 Site Location – Naturally, as with any project there are site options. Options were considered within a feasibility report at the Services Committee in October 2003 and the Knab Site was selected as the preferred location (Min Ref: 48/03). In relation to the Knab site, this is a relatively clear flat site that allows integration with the existing Additional Support Needs (ASN) Unit. If another site was to be discussed further, the following would be critical factors for consideration:

5.3.1 The existing proposed design for the new AHS could be transferable but may need modification. This may result in abortive costs;

5.3.2 The substructure requirements (that is works that are underground) may be different and so represent a variation to the cost. This may be positive or negative;

5.3.3 If any alternative location is a Greenfield site, it is likely that additional infrastructure such as roads or drainage would be required;

5.3.4 If the ASN is to remain integrated into the mainstream AHS, a new ASN would have to be added to the design at additional cost, plus the abortive costs associated with the recent refurbishment of the existing ASN (£0.9m). However, the existing ASN may have other uses for the Council or other organisations;

5.3.5 If for procedural reasons, O'Hare & McGovern Ltd were unable to proceed with any alternative site, the likelihood of securing a suitable contractor into the future, taking into account one failed attempt and one year taken to reach the current position;

5.3.6 The educational impact of any delay;

5.3.7 Alternative use of the AHS site for other SIC aspirations such as housing, office or care home provision;

5.3.8 Greater efficiencies in service provision by co-location of schools and/ or other Council buildings;

5.3.9 Revenue savings arising from any efficiencies outlined in 5.3.8 above:

5.4 Maintenance of the Existing AHS – Unless and until a new AHS is built, there will be a requirement to continue investing in the maintenance of the existing AHS to keep it fit for purpose. Such investment may extend the life of the building. The Council's Building Services will shortly be carrying out a full condition survey of the existing AHS. The full extent of maintenance expenditure required will not be known until that survey is complete. Members should note that the funding for the identified works would have to come from the Capital Programme.

5.5 Traffic Management - The existing design recognised that traffic flow around the area was a key consideration. The existing proposal seeks to address this issue by reducing the amount of school traffic circulating around the existing one way system and in particular Lovers Loan. The design team have consulted with the Roads Service during the development of the design and a full traffic impact assessment will be carried out as part of the ECI process.

5.6 Elongation of Construction Phase – Early discussions with the contractor indicates that the preferred construction period for the AHS on the Knab site is in the region of 30 months. This is based on maximum efficiencies on site and the use, where practical, of pre-fabricated materials. This is deemed to be the most attractive in financial terms as it shortens construction activities.

5.6.1 As with any construction project there is always an option to elongate the construction period, therefore affecting the yearly financial spend. As a general rule, the longer the construction phase, the greater the total cost. This is due to the ongoing standing costs (labour, plant, site set up, transportation, accommodation, subsistence, etc).

5.6.2 The cost of the school can be reduced. However, the financial spend on the preferred 30 month construction period exceeds the £20M annual spend identified in Section 5.8.

5.6.3 It should be noted that to extend the construction programme has additional implications to form the basis of any discussions, simply:

5.6.3.1 Extended period of maintenance to the existing AHS to keep it fit for purpose until new school can be opened. Final cost to be determined by condition survey identified in 5.4 above;

5.6.3.2 Disruption to residential area for extended period;

5.6.3.3 Further discussions with the contractor and possible renegotiation of tender fee to reflect amended programme scenario;

5.6.3.4 Increase in abortive costs for construction in additional winter periods;

5.6.3.5 Potential for the construction market to change resulting in increased labour and material prices;

5.6.3.6 Risk that construction inflation exceeds the rate of return from investments:

5.7 Local Construction Market - It is generally considered that the Shetland construction market is operating at or close to full capacity. We do not know at this stage how much or how little of the new AHS may be sub contracted to local companies. The Council may seek to mitigate the effects of an under/ over heated construction economy by monitoring and controlling the amount of work that it releases at any one time.

5.8 Impact on Remaining Capital Programme - The Capital Programme is limited to spending £20m per annum. Any figure greater than £20m represents a policy change, which the Council will need to decide upon. Any change to that position would mean a potentially radical overhaul of Council financial policy, in which sustainability would have to be debated afresh. Further, it is recognised that the timing of an investment of this size will always have a dramatic impact on the Council's finances and the local community. At the same time we also know that there are many other Council projects and aspirations that will have to be met in the near future e.g. projects arising from the Social Work review and the transport strategy. The pressure from all of these projects is becoming unsupportable. Taking into account the aspirations and commitments known to us now, it remains likely that it will become harder to deliver expectations of the Capital Programme into the future, compared with any difficulties of today.

5.9 The comments within section 5 of this report outline the complexities surrounding this particular project. A summary of the key issues is attached as *Appendix A.*

6. Financial Implications

6.1 There are no direct financial implications arising from this report. However, this report should place in context the financial complexities of a project this size.

7. Policy and Delegated Authority

7.1 All matters relating to the education service stand referred to the Services Committee. The Services Committee has delegated authority to make decisions on matters within its remit for which the overall objectives have been approved.

7.2 Matters relating to the Council's Capital Programme are referred to Council for decisions (Min Ref: 122/03 and 145/03).

8. Recommendation

I recommend that Services Committee:

8.1 Note the contents of this report;

8.2 Endorse the potential cost saving measures identified in 4.3 & 4.4 of this report.

Our Ref: CM/RS/CPS-10-07-F Date: 18 October 2007

Enclosed: -
Appendix A – Summary of Key Issues

APPENDIX A

AHS Summary of Key Issues

1.0 Specification Size – Budget set for a school of 14,260 sq.m. The design process resulted in a school requiring 18,472 sq.m. This was due to the unique requirements of the AHS in the Shetland environment. Estimate of current proposals is £48m. Project team working to reduce cost through ECI process.

2.0 Design – Various options considered and consulted on. The current proposal considered being the most favourable. This concept was taken to RIBA, "Stage C". This concept design forms the basis of the work to develop a detailed design as part of the ECI process.

3.0 Site Location – There is a formal Council decision to use the Knab site and design is progressing on that basis. Many factors would have to be taken into account if looking at other sites for possible use.

4.0 Maintenance of the AHS – While design work continues, the existing AHS still needs to be maintained. Money from the capital programme will have to be spent on the existing AHS, in forthcoming years to keep the existing building fit for purpose.

5.0 Elongation of the Construction Phase – As with all construction projects the construction phase can be extended. However, associated cost implications would be incurred together with an increased period of disruption to local residents in the area. The existing AHS would have to be maintained during this additional period to keep it fit for purpose.

6.0 Local Construction Market – The local construction market will be affected by any new AHS. The SIC will have to monitor and control its spending to mitigate any damaging effects.

7.0 Impact on Capital Programme – The capital programme is limited to spending £20m per year unless there is a revised policy. There is growing pressure from all projects that will make programming into the future harder than today.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Head of Schools Service

JOINT MANAGEMENT:
FOULA AND ANOTHER SHETLAND SCHOOL

1. Introduction

1.1 The purpose of this report is to seek approval from Council Members to return a Head Teacher post for Foula Primary School following a two year pilot of joint management between Foula Primary School and another Shetland School (Bressay Primary School).

2. Link to Council Priorities

2.1 The Council will provide the best learning environment for all: a best value education service will continue to be Council policy (Achieving Potential).

2.2 Challenging target setting, frank and honest review of our performance and informed planning of how we deliver Best Value services are key Corporate Plan objectives (Organising Our Business - Priority D). This report addresses the provision of services with accountability for Best Value.

2.3 Regular reporting on the development of the Council's Performance Management Framework and its main components allows progress to be monitored and provides an opportunity for issues to be addressed.

3. Background to Joint Management of Schools in Shetland

3.1 Joint Management in schools was discussed as part of the Best Value Review of Education during the consultation period in June 2002. At some of the public meetings the concept of joint management was rejected by the audience and not seen as a way forward.

3.2 In 2003, parents approached Councillors and officials about the benefits of joint management from their perspective, as they saw it being a way of having the same teacher in the class teaching their children every day.

3.3 Following a successful pilot at Sandness Primary School, Skeld Primary School and Happyhansel Primary School, the Council approved a report (Min Ref: SIC 79/05 and SC 38/05) to establish this model, which is now running very successfully.

3.4 From January to July 2005 a temporary Principal Teacher was employed at Foula, and supported by a Head Teacher from another school, while the established Head Teacher from Foula took up a seconded post elsewhere.

3.5 A report was presented to Services Committee on 16 June 2005 (Min Ref: SC 47/05) to request the shared management of Foula Primary School and Papa Stour Primary School with another school. The Members asked the Education Service to consult with the parents and staff at Foula Primary School before making a decision (Min Ref: SIC 103/05). The situation then changed in that Papa Stour Primary School was mothballed.

3.6 The report on 20 October 2005 recommended to Council that a joint management be adopted for Foula Primary School and another primary school.

3.7 Joint Management of Foula Primary School and another Primary School became a pilot structure for two years. A two-year period was considered as a viable option, as this allowed for proper monitoring and evaluation processes to occur at this remote location. A two-year fixed term teaching post was considered to be more attractive in a remote location than an established post.

3.8 An opportunity for a Head Teacher in Shetland to manage Foula Primary School along with their current school was advertised locally. Consultation then took place with the relevant school boards. The Head Teacher from Bressay Primary School was then appointed.

3.9 The post of a Principal Teacher in Foula Primary School was advertised nationally as a two-year fixed term post.

4 Current Situation

4.1 There are currently 2 primary pupils on the school roll at Foula Primary School.

4.2 The Joint Management arrangement is due to end in April 2008. To allow enough time for recruitment of a post holder it was decided to carry out a consultation on how the pilot had worked for Foula Primary School in June 2007.

4.3 The consultation with staff, parents and members of the Foula community took place on 15 June 2007. Appendix A summarises the main points of the three meetings held on Foula.

4.4 The consultation with Mr Hibbert, the Head Teacher of Bressay Primary School took place on 27 June 2007.

5. Conculsion

5.1 It is recognised that for remote isles it is preferable to have a Head Teacher on the island. The difficulties with travel and communication has made this shared management model hard to implement.

6. Proposals

It is proposed that:

6.1 The Schools Service appoints a Head Teacher of Foula Primary School.

6.2 The current shared management arrangements cease on the appointment of a Head Teacher for Foula Primary School.

7. Financial Implications

7.1 A comparison of the cost of the shared management model and the Head Teacher model is attached as Appendix B. The Head Teacher model cost £8,897 more that the shared management model. This cost will be met from within existing resources – budget code GRE1251.

8. Policy and Delegated Authority

8.1 All education matters stand referred to the Services Committee. The Committee has delegated authority to make decisions on matters within its remit for which the overall objectives have been approved by the Council, in addition to appropriate budget provision, in accordance with Section 13 of the Council's Scheme of Delegation.

8.2 As the recommendation falls outwith delegated powers, a decision of the Council is required.

9. Recommendation

I recommend that Services Committee recommend to Shetland Islands Council to agree to:

9.1 the cessation of this shared management arrangement;

9.2 appoint a Head Teacher for Foula Primary School.

Summary of main points from consultation with staff, parents and members of the Foula community, held on 15 June 2007

- Temporary contracts make things difficult for teachers (getting mortgages, loans, etc).
- The school needs a Head Teacher.
- A visit from the Joint Head Teacher is weather dependent – to date Head Teacher only travelled to Foula 10 times during the pilot.
- There is only one day-return flight in winter – in at 10.30am and out before end of school day. Therefore it is not possible for anyone to be at the school for the whole school day.
- Feel Head Teacher should be here more due to logistics of it.
- There in no induction within the school that explains where the stopcock is etc for new employees.
- Principal Teacher responsible for ordering oil some times, this is not a normal duty of a Principal Teacher.
- Cleaner needs to have knowledge of how to light the coal heating system.
- It feels that Foula Primary School is last on list for getting things done. And again visits from technicians, etc are very weather dependant.
- Lack of access to information as Principal Teacher does not attend meetings, such as Head Teacher meetings where information is disseminated.
- Being a Principal Teacher in Foula Primary School is not a good move from a career development point of view for a teacher.
- It is very difficult to get supply teachers to work in Foula, this leads to a lack of training opportunities for the Principal Teacher.
- Principal Teacher has concerns about being on her own, particularly in winter.
- It would be good to get a teacher to come for a few days to have a PE / drama / art week.
- Head Teacher and Quality Improvement Officer visit and meet with parents, but Principal Teacher not involved, although the Principal Teacher is the teacher with daily contact with pupils.
- There were difficulties with ordering goods for the school, as school as no clerical support and Bressay Primary School clerical assistant had to do the ordering for Foula.
- The distance and logistics of getting in and out of Foula means that the children can't get same standard of provision as others on Shetland.
- There is a need for more staff travelling to Foula as it is not always possible to get the pupils out on particular days
- It seems that Foula Primary School is excluded due to its location.
- It is much better for the Principal Teacher, when there is a person in the post of Lunchtime Supervisor.
- The play equipment in the playground at Foula is now not useable by children.
- It would be better if the Shared Head was based in Foula. The Principal Teacher sometimes has difficulty getting in touch with the Head Teacher. It is very hard to get hold of people on Mainland.

- The children have missed out on a lot of the swimming lessons. It is important they learn to swim. This needs to be sorted out for another year.
- Shared headship had to be tried before you know if it works, however where practicable and possible a Head Teacher is better. This will lead to better level of service and a better environment for teacher. In reality the buck stops with the teacher who is at the school on a remote isle.
- The Shared Head should come out to school once a month, just to check and get a picture of what is happening in school.
- If a new teacher was to be appointed then someone would need to visit the school once a week.
- It was not good for the Principal Teacher when there was no clerical or other support staff to assist.
- The Principal Teacher plans things around the flight timetable, then it doesn't happen.
- There were problems getting the school requisition ordered and delivered to the school.
- It seems that it is not a 'fair' shared management. The Head Teacher pays more attention to his base school.
- Parents do not have an issue with the Head Teacher going off island for courses, etc. As long as work is left for the supply teacher who comes in.
- The Head Teacher should always have a record of work and plan ahead.
- Principal Teacher has to do a lot of Head Teacher and administration work although there are other duties the Principal Teacher cannot do because it is not her responsibility – eg closing school due to bad weather.
- Short term appointment: tend to restrict applicants.
- Lack of comprehension of Foula's unique circumstances leads to endless difficulties.
- Teacher needs to have confidence that joint head is committed equally to both schools and understands Foula's special situation,
- Lack of delegated authority to the Principal Teacher leads to an inefficient, unsafe and stressful situation in Foula.
- There are delays in everything; communication, stores/books etc, IT repairs.
- Support for the teacher and the school has to come from community – remote doesn't work.
- Principal Teacher is in very stressful situation, she should be teaching, but has to answer queries regarding head's job all the time. Often visitors and workmen all needing attention. The pupil's education therefore suffers.
- The Shetland Islands Council has a stated policy of regenerating peripheral areas – this must apply to Schools Service also. That means positive discrimination – we get opposite, which is disheartening and depressing.
- Ambience of the school has gone downhill during the Shared Management pilot.

Shetland
Islands Council

REPORT

To: **Services Committee** **18 October 2007**

From: **Head of Schools Service**

PUPIL AIR TRANSPORT

1. Introduction

1.1. The purpose of this report is to advise Members on issues relating to the transport of school pupils from Fair Isle to the Anderson High School, its significance in the context of the sustainability of the Fair Isle Community and seeks a decision on how the issue might be addressed.

2. Links to Council Priorities

2.1. This report meets the objectives of the Corporate Plan by contributing to the aim of sustainability and the provision of quality education to all pupils in Shetland's schools.

3. Background

3.1. Nine pupils from Fair Isle attending Anderson High School reside in the Halls of Residence and have every third weekend at home. They travel home on the scheduled flight departing Tingwall on Friday afternoon at 1500 and returning on the scheduled flight on the Monday morning departing Fair Isle at 0900.

3.2. During winter months the Friday afternoon timetable is restricted to daylight hours and departs Tingwall at 1340 in order that the later flight to Foula can also be provided in daylight hours.

3.3. These arrangements have been in place for over 30 years.

3.4. Earlier this year a request came from the Fair Isle Community through the Shetland South Members to the Transport Service to explore the possibility of providing a modified service to the island that could, as far as possible, transport the children to AHS so that they were able to attend for the full school day on the days that they travel to and from Fair Isle.

4. The Issues

4.1. Several discussions have taken place between representatives of the Fair Isle Community, Shetland South Members and Transport Service officers.

4.2. The principle issues surrounding this are: -

4.2.1. How the level of education able to be provided to Anderson High School pupils from Fair Isle is impacted upon by the reduction in attendance due to travel constraints.

4.2.2. The impact of having Monday morning and Friday afternoon flights (on the weekends that pupils are travelling) takes all available capacity on those days which impacts on the opportunity for others to travel.

4.2.3. The impact of this on the community is that it reduces the equality of opportunities and access to services that other areas of Shetland receive as a matter of course.

4.2.4. The Community is acknowledging that equality of opportunities and accessibility are becoming increasingly significant issues in terms of sustainable communities, both in terms of choices to remain in communities and in terms of people's choices of where to locate.

4.2.5. This previous point is acknowledged within many of the Scottish Government's strategies including the National Transport Strategy. These principles are also reflected within Shetland's Transport Strategy.

5. The Current Air Service

5.1. Shetland's inter-island air service is subject to a Public Service Obligation (PSO) in terms of EU regulations (EEC No 2408/92). The PSO sets out the service obligations on each internal route with regard to: -

- Minimum Frequencies
- Capacity
- Fares.

Services are provided to the islands of Fair Isle, Foula, Papa Stour and Out Skerries.

5.2. The current timetables operated to each of the four islands have been formulated in consultation with the island communities themselves and have been relatively unchanged over the years. The routine of life on each of the Islands and access to opportunities and services has largely developed around the air and ferry service provision.

5.3. The air services are provided using two Britten-Norman Islander aircraft with seating capacity for 8 passengers dependant on weight and weather conditions. However, at times when there are 9 passengers these can be accommodated providing weight restrictions are not exceeded.

5.4. The primary aircraft provides the scheduled services to four Islands and the stand-by aircraft is used to ensure continuity of service during periods of routine maintenance of the primary aircraft or if there is a breakdown.

5.5. The current contract is operated by Directflight Ltd and includes provision of sufficient personnel to administer the delivery of the air service and to crew and operate the aircraft in line with the requirements of the PSO and the Civil Aviation Authority. This includes cover for sickness and holiday relief. Within the available resources and through use of the stand-by aircraft, there is some additional capacity across the network. This resource is currently available outwith the PSO contract and could be accessed immediately by the Schools Service through charter arrangements.

5.6. Discussions with Directflight have established that, subject to certain risks (detailed in section 7 of this report), it would be possible to provide additional flights using the stand-by aircraft to get the school children from Fair Isle to and from Tingwall at times that would allow attendance for the full school day on the days that they travel from and to Fair Isle.

5.7. However, there is a period between 7 November 2007 and 28 January 2008 when constraints on daylight hours would prevent the flights departing early enough on Mondays and late enough on Fridays to allow attendance for the full school day.

6. The Proposal

6.1. Discussion on this matter has taken place between the Head of Schools and the Head of Transport and it has been determined that, if additional provision is appropriate, the lowest cost and lowest risk solution to this issue would be to provide additional charter flights using the stand-by aircraft and an additional pilot for each of the required days.

6.2. Adjusting the current timetable within the constraints on the use of the primary aircraft and the needs of other scheduled services is simply not possible without detriment to other islands.

6.3. During the school terms there are 29 occasions when Fair Isle pupils require transport to/from Tingwall. Taking into account constraints on daylight hours between 7 November 2007 and 28 January 2008, 6 of those occasions would be accommodated on the scheduled service. The additional requirement could therefore be met by 23 additional charter flights using the stand-by aircraft.

6.4. A price of £582.80 per flight has been quoted by Directflight giving a cost of £13,404.40 for 23 flights.

6.5. The cost of using the scheduled flights for this would be £2,318.40 giving a net additional cost of £11,086.00 over and above current cost to the Schools Service.

6.6. There will be additional servicing and maintenance costs to reflect the increased usage of the stand-by aircraft. These are estimated at £5,000 per annum.

6.7. There are also additional charges (staff costs, etc) if Tingwall Airport is opened earlier on the Mondays to allow the flight to go to Fair Isle to take the pupils out. Estimated annual cost £1,000.

6.8. The total additional cost therefore would be £17,086.

7. Risks and Constraints

7.1. In exploring means of providing additional capacity to accommodate the school travel needs of Fair Isle pupils, the Transport Service has established that the most cost effective means is by providing specific additional charter flights on the dates required using the Council's stand-by aircraft and additional pilot resource.

7.2. However, under the terms of the PSO, the Council's principal obligation is to provide the scheduled services and this places "first call" on pilots and aircraft.

7.3. This obligation introduces the following risks and constraints in relation to providing additional flights to Fair Isle.

7.3.1. If scheduled maintenance of the primary aircraft coincides with the additional flights then the secondary aircraft would be committed to the scheduled flights and may be prevented from providing the additional flights. Whilst scheduled maintenance can be planned in advance there is a risk that it may take longer than planned.

7.3.2. Leave periods or sickness may coincide with the specific dates. Again careful planning and scheduling can be used to minimise the risk but it is present nonetheless.

7.3.3. Disruption due to weather.

7.4. Should any of these risks arise then the alternative would be to use the scheduled service but if other travellers were booked on the scheduled service there may be a risk of pupils not getting on or off the island.

8. Financial Implications

8.1. As detailed above, the cost to the Council for providing 23 chartered flights over the course of the school year to meet the travel needs of the Fair Isle Anderson High School pupils would be £17,086.

8.2. There is no provision within budgets to accommodate this.

9. Conclusions

9.1. Members have been approached regarding the provision of dedicated flights for Fair Isle pupils attending Anderson High School.

9.2. Although the issue is about school transport, it potentially impacts more widely in terms of sustainability of remote communities.

9.3. Discussions with Directflight have established that it is possible to provide additional charter flights to Fair Isle subject to certain caveats detailed in section 7 of this report.

9.4. Should Members be minded to support additional air transport provision to allow the pupils from Fair Isle to attend the Anderson High School as is expected for all pupils for 5 full days per week, there is no legal impediment to prevent the Schools Service providing transport with immediate effect via charters.

9.5. There are no transport budgets available for additional provision, although discussion with the Head of Transport indicates there may be opportunities to contribute funding through appropriate funding streams aimed at addressing sustainability and economic development in remote and rural communities. This would, however, have to conform with the requirements of the legal PSO framework and at the time of writing this report the complexity of providing transport funding for these services through that means has yet to be explored.

10. Policy and Delegated Authority

10.1. All education matters stand referred to the Services Committee. The Committee has delegated authority to make decisions on matters within its remit for which the overall objectives have been approved by the Council, in addition to appropriate budget provision, in accordance with Section 13 of the Council's Scheme of Delegation.

10.2. As the recommendation falls outwith delegated powers, a decision of the Council is required.

11. Recommendations

I recommend that the Services Committee recommends to the Council that;

11.1. Services Committee consider the issue of the transport of Fair Isle Anderson High School pupils to and from Tingwall as described in sections 4, 5, 6 and 7 of this report and decide in principle whether the Committee supports additional air transport provision.

11.2. subject to 11.1, the Head of Schools work with the Head of Transport to identify funding from within appropriate approved Council budgets that could be used to provide additional flights and confirm that there are no legal impediments to allocating any funding to the provision of additional flights.

11.3. subject to the availability of funding and there being no legal impediments, the Head of Schools work with the Council's Transport Service to implement additional flights to transport Fair Isle Anderson High School pupils to and from Tingwall on the appropriate dates during the school year.

11.4. this additional provision be reviewed after the completion of the school year ending on 4 July 2008 with a further report to the Committee as soon as practicable after that date.

October 2007

HB/MC/SM ED-15-F

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Head of Schools

OLNAFIRTH PRIMARY SCHOOL

1. Introduction

1.1 On 10 September 1997 (Min Ref: SIC 146/97) the Council approved a method of establishing a Capital Plan, Programme and Budget. This required a report to the Council to seek approval to carry out a feasibility study into proposed projects.

1.2 On 26 September 2000 a report to Council gained approval to conduct a feasibility study on the provision of additional accommodation at Olnafirth Primary School (Min Ref: SC116/00). This feasibility study was undertaken in February 2001. This project featured in years 1 and 2 – 2001/2003 – of the Five Year Capital Programme. A Building Inspection Report was prepared in December 2004, and updated in February 2005.

1.3 However, work has not progressed on the project, mainly due to the Best Value consultations.

1.4 This report seeks approval to either, commence the maintenance and repair works needed to ensure that the school is made wind and water-tight, or to incorporate the repair and maintenance works with the construction of an extension to the school to provide additional accommodation.

2. Link to Council Priorities

2.1 The Council will provide the best learning environment for all: this report aims to ensure that all Shetland Schools are fit for purpose (Achieving Potential). Over the next few months Services Committee have undertaken to draw up a 'Blueprint for Education'.

3. Background

3.1 The accommodation in Olnafirth Primary School consists of two classrooms, a dining hall/small gym hall and extremely small staff room (approx 1.5m x 2.5m) in the main building and two hutted classrooms situated in the south playground area. There are currently 25 pupils on the school roll consisting of two composite classes.

3.2 Maintenance of the school has slipped due to the Best Value consultations and the school is now in need of considerable repair to ensure that it is made wind and water tight.

3.3 The present facilities do not fully meet the needs of the pupils and staff as detailed below:

- there is an extreme lack of storage facilities;
- the support for learning teacher has no base within the main building to provide either one-to-one or small group sessions;
- the staffroom cannot house all members of staff on days when peripatetic teachers are in school;
- because there is no office accommodation within the school, the small staffroom, in addition to its prime function, is used to provide:

    1. storage of teaching and learning equipment and professional reference material
    2. a base for support for learning
    3. a venue for interviewing parents
    4. accommodation for the school secretary

3.4 Furthermore the present facilities do not meet disability access regulations, particularly with regard to toilet provision.

3.5 A report from the Technical Support Manager, to the Capital Programme Review Team is attached as Appendix A.

4. Proposal

4.1 It is proposed that building works be done so that the school is made wind and water tight or that an extension is built to solve the acute accommodation and storage problems.

5. Financial Implications

5.1 The estimated cost of carrying out the work required will range between £200,000 and £600,000, depending on the decision of the Council.

6. Policy and Delegated Authority

6.1 All education matters stand referred to the Services Committee. The Committee has delegated authority to make decisions on matters within its remit for which the overall objectives have been approved by the Council, in addition to appropriate budget provision, in accordance with Section 13 of the Council's Scheme of Delegation.

6.2 As the recommendation falls outwith delegated powers, a decision of the Council is required.

7. Conclusions

71 Essential repair and maintenance work needs to be done at Olnafirth Primary School to ensure the building does not deteriorate further. However, it is recognised that the standard of the school building would be enhanced by building an extension to provide additional accommodation.

8. Recommendation

I recommend that the Services Committee recommends to the Council that

8.1 the Council agree to the immediate commencement of repair work to make the building wind and watertight, at an estimated cost of £200,000; or

8.2 the Council agree to construction work which will ensure the building is wind and water tight and will provide an extension to solve the accommodation and storage problems, at an estimated cost of £600,000.

October 2007

Our Ref: HB/SM Report No: ED-13-F

Appendix A

Shetland
Islands Council

REPORT

To: **Capital Programme Review Team** **30 April 2007**

From: **Technical Support Manager**

Funding for Capital Maintenance Projects
Addendum Report – Olnafirth Primary School

1. Introduction

1.1. This report sets out the case for additional funding to the Education Capital Maintenance programme. These additional funds are to cover the refurbishment of Olnafirth Primary School which is beyond the scope of the current budgets.

2. Link to Council Priorities

2.1. This report is consistent with the Corporate Plan 2004-2008. Section 1, Strengthening Rural Communities; Improving Health; Equal Opportunities; Community Safety; Achieving Potential; Our Unique Landscape; Our Natural Resources and the Management of Waste.

3. Background

3.1. Olnafirth School has been the subject of previous Schools Service reviews. A previous capital project was put in place but for a variety of factors it has a low priority on the list of prioritised Capital Projects.

3.2. The requirement for these works was previously communicated to CPRT on the 30 April 2007, but due to uncertainty regarding this property's future and suitability issues, costings were not included.

3.3. The last statutory indictor (SP8A) submission to the Scottish Executive and Audit Scotland listed this property as "category D", which is "life expired and/or serious risk of imminent failure".

3.4. Emergency remedial works have been carried out that have exhausted the limited revenue maintenance budget. However, elements of the fabric, structure and services installations are both economically and physically life expired, and the property received an unfavourable review during a recent inspection.

3.5. When assessing the current condition we have taken account of the following:

3.5.1. The Control of Asbestos Regulations 2006

3.5.2. Fire (Scotland) Act 2005
3.5.3. Fire Safety (Scotland) Regulations 2006
3.5.4. Workplace (Health, Safety and Welfare) Regulations 1992
3.5.5. Legionnaire's Disease: The Control of Legionella Bacteria in Water Systems.
3.5.6. The Electricity at Work Regulations 1989
3.5.7. Fixed Statutory Inspections and Reports
3.5.8. HMI Reports
3.5.9. Environmental Health Reports

4. Proposal

4.1. On behalf of the School Service we seek funding to carry out the works set out in the most recent condition survey. Andrew Lyall (CPS) will project manage implementation of this project. The longer term proposals for the school involve an extension and would not result in the current proposed spending being abortive.

4.2. This will bring the property up to standard, allow it to retain its function and value, and provide a safe and healthy place of work that continues to meet service delivery requirements.

5. Financial Implications

5.1. In broad terms the outline estimate for this project would be in the region of £250K. However, no detailed design has been carried out so this figure should be considered as indicative only at this stage.

6. Conclusion

6.1. It is questionable whether this school can continue to function without major investment in essential repairs and maintenance. If this property is to be retained in the long term a clear case for investment funding exists.

6.2. As previously accepted by CPRT, to effectively maintain the Council's corporate estate will require continued capital investment.

6.3. A lack of investment will have a negative impact upon both the long term viability of this property and its ability to deliver quality services in line with current requirements.

7. Recommendations

I recommend that the CPRT:

7.1. Consider the proposal in section 6.1 of this report and recommend to the Council that this project be appended to the existing Education Capital Maintenance Programme.

Shetland
Islands Council

REPORT

To: **Services Committee** **18 October 2007**

From: **Head of Housing and Capital Programme Services**

Appointments to Steering Groups and Working Groups - Housing

1. Introduction

1.1 A report to Services Committee on 21 June 2007, discussed the development of a four-year plan made suggestions to the appointment of Members to various strategic groups. Members chose to defer making those appointments until the Council had agreed on the future of forums and spokespersons.

1.2 This report now gives Members the opportunity to reconsider if they wish to allocate specific responsibility for Housing related activities and positions.

2. Links to Corporate Priorities

2.1 Developing effective working relationships and channels of communication between Members and staff will be a key aspiration of the developing Corporate Plan.

3. Background

3.1 There are three key groups, which Housing would like to invite Members to consider appointing to. The composition and remit of these groups is detailed in Appendices A, B and C. Involving Members directly in the work of the department is a key component of performance management and communication between our service users, the communities we serve and our front line staff and managers.

4. Proposal

4.1 It is proposed that 2 Members be nominated to attend the Housing Strategies Steering Group. The Housing Strategies Steering Group meets quarterly.

4.2 It is proposed that 5 Members be nominated to attend the Housing Allocation Policy Monitoring Group, which meets on an eight-weekly cycle.

4.3 It is proposed that a Member be appointed to chair the Fuel Poverty Working Group.

5. Financial Implications

5.1 Members are entitled to claim expenses in respect of any meetings attended or visits made in accordance with the Council's Scheme of Members Approved Duties. Any costs would be met from the approved budget for Members expenses.

6. Policy and Delegated Authority

6.1 In accordance with Section 13 of the Council's Scheme of Delegation, the Services Committee only has delegated authority to make decisions on matters within approved policy and for which there is a budget.

6.2 The nominations and appointments for positions of responsibility fall within the remit of the Services Committee.

7. Conclusion

7.1 Member involvement in the work of the Housing Service is actively sought and would be welcomed.

8. Recommendations

I recommend that the Services Committee agree that:

8.1 Two members are appointed to the Housing Strategies Steering Group;

8.2 Five members are appointed to the Housing Allocations Policy Monitoring Group;

8.3 One member is appointed to chair the Fuel Poverty Working Group.

Date: 03 October 2007
Our Ref: SP/AMJ/HS-05 Report No: HS-05-D1

APPENDIX A

Housing Strategies Steering Group – Terms of Reference

Purpose

To ensure a joint partnership approach to all Housing Strategies required by legislation, and Scottish Executive guidance, and to ensure proper information sharing, consultation and feedback on an appropriate multi-agency level.

Remit

- To establish a long-term vision for the partnership;
- To provide co-ordination between agencies and housing strategies;
- To agree on strategic priorities as required;
- To monitor action plans and timescales;
- To ensure community engagement through relevant channels;
- To scrutinise strategies and identify where changes are required, or actions not effective;
- To provide a high level of understanding of housing issues;
- To promote a partnership approach to resolving housing issues;
- To establish, where appropriate, sub-groups with specific remits.

Membership

The group will be made up of the following posts and agency representatives.

- Head of Housing – SIC Housing Service
- Service Manager, Housing Business Support – SIC Housing
- Service Manager – Housing and Property – SIC Housing
- Senior Housing Officer – Supported Accommodation – SIC Housing
- Senior Policy Officer – SIC Housing
- Supporting People Officer – SIC Housing
- Head of Community Care – SIC Community Care
- Service Manager, Adult Services – SIC Community Care
- Service Manager, Older People's Services – SIC Community Care
- Elected Member representatives (2)
- Environmental Health Manager – SIC Infrastructure
- Environmental Health Officer – SIC Infrastructure
- Planning Officer, Development Plans – SIC Planning
- Senior Planning and Information Officer – SIC Education & Social Care/NHS Shetland
- Youth Development Officer – SIC Children's Services
- Policy Development Co-ordinator – SIC Organisational Development
- Community Safety Officer - SIC
- Quality Improvement Officer – SIC Education

- Director of Public Health – SHB
- Community Mental Health Team Manager
- Hjaltland Housing Association
- Shetland Tenants Forum
- Shetland Alcohol and Drugs Service
- Advocacy Shetland
- Shetland Council of Social Services
- Citizen's Advice Bureau
- Shetland Enterprise
- Community Safety Officer- Northern Constabulary
- Communities Scotland

Meetings

Meetings will be held at least quarterly to fit in with reporting mechanisms such as the Housing Service Plan. Minutes and any other relevant information will be reviewed by the Community Planning Board and made available to the public under the terms of the Freedom of Information (Scotland) Act 2002.

Agenda items will include:

Policy and Strategy Updates
Resources
Management Issues
Client Satisfaction
Staff Satisfaction
Continuous Improvement
Market Image

APPENDIX B

Allocation Policy Monitoring Group

The effectiveness of the allocation policy is monitored by the allocation policy monitoring group.

The group consists of 5 Elected Members, staff from Housing Service and Shetland Tenants Forum Worker

The role of the Allocation Policy Monitoring Group is to ensure that there is an ongoing assessment of the effectiveness of the allocation policy and to annually review the allocation targets and letting profile areas

Part of the group's remit is also to consider ideas and issues for improving the policy where required, and to recommend changes to Services Committee, thereby ensuring the allocation policy remains relevant and up to date

Shetland
Islands Council

REPORT

To: **Services Committee** **Date: 15th June 2006**

From: **Head of Housing & Capital Projects**
Energy Manager – Infrastructure Services

Report No: HS-06-06

FUEL POVERTY STRATEGY
SET UP OF IMPLEMENTATION GROUP

1. Introduction

1.1 The Housing (Scotland) Act 2001 places a statutory duty on all Scottish Local Authorities to demonstrate how the authority will eradicate fuel poverty in its area by 2016.

1.2 This is provided in the form of a fuel poverty strategy, which was approved by Services Committee on 26th January 2006 (Min ref: 01/06).

1.3 In order to ensure that this strategy can progress its action plan and meet its objectives, this report seeks to set up a dedicated implementation group that will monitor progress and maintain commitment to tackle fuel poverty at the highest level.

1.4 This report also asks Committee to nominate a Councillor as Chair of the implementation group.

2. Background

2.1 The fuel poverty strategy covers the five-year period from 2005-2009.

2.2 A household is defined as being in fuel poverty if, in order to maintain an acceptable standard of heat, it is required to spend more than 10% of its income on household fuel costs.

2.3 The fuel poverty strategy aims to meet the Scottish Executive target of eradicating fuel poverty in all homes, whether private or rented, in Shetland by 2016.

2.4 The Housing Service and partners aim to set up a multi agency implementation group, who will work together to ensure we can achieve the aims set out in the strategy.

2.5 The appointment of a Councillor as Chair will also ensure that corporate commitment to improve energy efficiency and tackle fuel poverty is maintained at the highest level.

3. Remit

3.1 The purpose of the group is to:

- Gather information to establish the households in Shetland that are at risk of fuel poverty;
- Raise the awareness of fuel poverty amongst key agencies, partners and the general public;
- Develop a robust fuel poverty referral system to ensure help is available to all householders across all tenures;
- Encourage householders to access competitively priced household fuels;
- Monitor, evaluate and continue to develop the fuel poverty strategy.

4. Links To Corporate Priorities

4.1 The Fuel Poverty Strategy links through the Local Housing Strategy to the corporate themes of Benefiting People and Communities and Looking After Where We Live.

5. Financial Implications

4.1 There are no direct financial implications arising from this report. Subject to approval of the recommendations of this report, any costs associated with Members attendance would be met from the Council Members budget (cost centre SRX0160).

5. Policy And Delegated Authority

5.1 All matters relating to Housing stand referred to the Services Committee (Min Ref: SIC70/03). As the recommendations in this report fall outwith delegated authority, a decision of the Council is required.

6. Recommendations

I recommend that the Services Committee recommend that the Council:

6.1 Approves the creation of a dedicated implementation group to meet the aims of Shetland's fuel poverty strategy;

6.2 Agrees to award the group approved duty status;

6.2 Agrees to the implementation group being Chaired by a Councillor, and nominates an appropriate Member to that position.

Date: 2 June 2006
Our Ref:AMJ/SA Report No: HS-06-06

Shetland
Islands Council

REPORT

To: **Services Committee** **18 October 2007**

From: **Head of Community Care**

Report No SC09-07F
Shetland Mental Health Strategy

1. Introduction

This report presents Shetland's Mental Health Strategy for approval by the Council's Services Committee. The Strategy was approved by Shetland NHS Board on 4 September 2007.

2. Links to Corporate Plan

2.1 The strategy links into the corporate plan by 'benefiting people and communities' through improving health; equal opportunities; social justice; and keeping people safe.

2.2 It contributes to the planning and prioritising of our services; assists in monitoring and achieving targets; and helps maintain good communication between agencies.

3. Background

3.1 The draft Mental Health Strategy has been developed by the Shetland Mental Health Partnership over the last 18 months. This multi-agency group has representation from the statutory sector and key voluntary agencies which are involved in developing and delivering mental heath services in Shetland, as well as user and carer membership. The Partnership is supported by a Mental Health Forum, which is a wider group of people with an interest in improving mental health, preventing mental ill health or who currently have or have had experience of mental health problems.

3.2 It was agreed at an early stage that the development of the strategy should be participative and should involve as many people as possible with an interest in mental health in Shetland. The process

has included a questionnaire, gathering information from service providers and their clients; a workshop and wide consultation on the draft strategy. Further details of the process are included in the strategy document.

4. Proposals

4.1 The strategy is structured on the service framework described in national policy, as set out in the National Framework on Mental Health. There is a tiered approach to the varying levels of mental health services and the strategy has sections on:-

- improving patient and carer experience,
- tackling stigma and awareness raising,
- training and skills development, and
- information sharing.

4.2 The strategy describes our vision for mental health in Shetland, reflecting national policy but applying that to the local context. It covers the range of needs and service provision from a community approach to mental health and well-being, to the very specialised treatment and care services provided nationally in Scotland. The aim is to achieve a single plan for local comprehensive mental health services; and to use the resources employed in the delivery of existing mental health services in the most effective way.

4.3 Each section of the strategy sets out the policy context; targets and commitments; local service provision; strengths and gaps as identified locally; and plans for action to meet local needs. These are summarised in the Action Plan, which highlights those actions that are needed for further work in terms of service redesign or practice development.

5. Financial Implications

There are no financial implications arising directly from this report.

6. Policy and Delegated Authority

All Social Care matters stand referred to the Services Committee. The Committee has delegated authority to make decisions on matters within its remit and for which the overall objectives have been approved by the Council, in addition to appropriate budget in accordance with Section 13 of the Council's Scheme of Delegations.

7. Conclusions

Shetland's Mental Health Strategy sets out its vision, aims, priorities and a framework for core service elements, which reflect national policy and is set within the local context. The action plan summarises the local improvements required and sets out a multi-agency strategy to address the identified problems.

8. Recommendations

I recommend that Services Committee approve the Shetland Mental Heath Strategy.

Date: 18 October 2007
Ref: CF'AN'SC09-07 Report No: SC09-07D1

NHS Shetland

SHETLAND MENTAL HEALTH PARTNERSHIP

MENTAL HEALTH STRATEGY

Contents

a) Introduction

The Burden of Mental Ill Health:

The World Health Organisation defines mental health as *"a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community."* [1]

By 2020, it is expected that depression will be the highest ranking cause of disease in the developed world.[2]

One in five adults in Scotland is affected by mental ill health each year. In Scotland between 25% and 30% of all General Practitioner (GP) consultations involve depression, stress or anxiety. Evidence shows that people with a mental illness are the highest 'at risk' group for suicide, with a rate of suicide 10 times that of the general population. In addition there are growing numbers of people suffering from dementia.

Mentally unwell people can often be rejected by friends, relatives, neighbours and employers leading to aggravated feelings of rejection, loneliness and depression;

- they are often denied equal participation in family life, normal social networks, and productive employment;
- stigma has a detrimental effect on a mentally ill person's recovery, ability to find access to services, the type of treatment and level of support received and acceptance in the community;
- rejection of people with mental illness also affects the family and caretakers of the mentally ill person and leads to isolation and humiliation.

There is therefore a strong link between poor mental health and social deprivation and exclusion. Shetland does not fall into traditional categories of deprivation but we do have individuals and groups of people who are socially isolated.

Mental illnesses affect the functioning and thinking processes of the individual, which may greatly diminish his or her social role and productivity in the community. In addition, because mental illnesses are disabling and may last for many years, they can take a tremendous toll on the emotional and socio-economic capabilities of relatives who have a caring role, especially if the health system is unable to offer treatment and support at an early stage. Some of the specific economic and social costs include:

- lost production from premature deaths caused by suicide (generally equivalent to, and in some countries greater than deaths from road traffic accidents);
- lost production from people with mental illness who are unable to work, in the short, medium or long term;
- lost productivity from family members caring for the mentally-ill person;
- reduced productivity from people being ill while at work;
- supporting dependents of the mentally ill person;
- direct and indirect financial costs for families caring for the mentally-ill person;
- unemployment, alienation, and crime in young people whose childhood problems, e.g., depression, behaviour disorder, were not sufficiently well addressed for them to benefit fully from the education available;

- there can be poor cognitive development, attachment and relationship difficulties, anxiety and depression and more likelihood of substance misuse in the children of mentally ill parents, and
- the emotional burden and diminished quality of life for family members. [3]

It is generally accepted that good mental health underpins all other aspects of health. Those who suffer from mental illness have greater risk of, and higher rates of, heart disease, diabetes, respiratory disease and infections. They also have higher rates of smoking, alcohol consumption and drug misuse. They die younger and have a poorer quality of life.

Those who can take control of their own life positively, and use their experiences to learn to cope with behaviour, thinking and feeling, can understand their difficulties and move forward in a positive way.

Within this strategy we set out our vision for treating and preventing mental illness while continuing to promote mental health and well-being. We include within the strategy severe and enduring mental illnesses such as schizophrenia, bi-polar disorder and dementia as well as the wider range of disorders and illnesses including depression and anxiety, and the psychological and social approaches to mental distress.

b) Vision

This section describes our vision for mental health and mental health services in Shetland. It reflects the vision within national policy in Scotland, but applies that to our own situation locally.

Services will be underpinned by values based on a culture of respect and the recognition of issues of equality, social inclusion, recovery and rights.

Services offered will be evidence-based, effective, efficient and delivered to the highest possible standards within sustainable systems.

The journey of care will be smooth and quick, providing patients with the treatment they need, at the level they need it, where they need and when they need it.

There will be more user and carer involvement in the design and delivery of services, and more emphasis on self-care, promoting choice and autonomy.

We will protect and promote the mental well-being of the whole population.
We will work to prevent mental illness by reducing risk factors and increasing protective factors.
We will improve the quality of life of those people experiencing mental health problems, and promote and support recovery.
We will strengthen individuals and our communities, and reduce the structural barriers to mental health.
We will raise awareness, and eliminate stigma and discrimination around mental ill health.
We will prevent suicideand support people bereaved by suicide.

This strategy will consider the range of care and treatment options available including on island, off island, 24 hour supported accommodation, hospital based and community based, with a view to best using the available resources and expertise to provide as much range and choice of effective service as possible.

We will ensure that:
service users and carers are treated equitably and with respect (in terms of gender, age, race, sexuality etc);
service users and carers are given enough information to be able to make decisions about their care and supported in making decisions;
local services are able to meet the needs of all clients and age groups including those with specific needs.

Recovery

There are many different routes to recovery, but certain themes:

- the importance of identity and how individuals understand themselves;
- the need for autonomy in setting goals, making decisions;
- the importance of hope;
- the need for supportive relationships, both professional and personal; and
- attention to enhanced rold functioning

The theory of self determination has come up with three fundamental human needs – autonomy, confidence and relatedness (feeling connected to other people). Satisfying these needs promotes well being and feelings of security.

There is evidence to show that outcomes improve when care and treatment is delivered in this way. Consequently recovery oriented practiced are intended to enhance feelings of autonomy, confidence and relatedness.

We recognise that in order to achieve our vision, we need to

- Reduce deprivation and exclusion which lead to inequalities in health
- Address the stigma attached to mental illness
- Ensure that patients, their carers and all who work with them are treated with dignity and respect.
- Evaluate and review existing services.

In this document we use a range of terms that can be differently interpreted or misinterpreted. For instance we use the term ‘needs’ to mean a person’s problem for which a service can provide an effective care / treatment / intervention; and the term ‘gaps’ to mean services not available locally or needs that are unmet. For clarity we have defined some of our key terms in Appendix 1.

c) Aims

In developing a strategy, we aim to achieve a single plan for local comprehensive mental health services; and to use the resources employed in the delivery of existing mental health services in the most effective way, avoiding gaps and overlap. This will involve health, social care, housing, education, employment, voluntary and other agencies in working jointly with the local community in the provision of complementary services for people with mental health problems.

In delivering this aim, we commit to the following principles:

- Wherever practicable and possible, the local service will be provided as a home-based service or in small facilities as close as possible to an individual's home. Points of access to specialist secondary health services should be reviewed, simplified, and widely publicised.

- Service users are central to their own care, treatment and recovery. Patients and carers should therefore be partners in designing and delivering services.

- We should provide systematic support for people with long-term conditions

- We should actively manage admissions to and discharges from hospital in order to minimize the incidence of delayed discharge and inappropriate readmission and to ensure that patients are provided with appropriate support.

- We need to address the stigma attached to mental illness, and treat all people with dignity and respect.

- We need to recognise that all human beings have emotional issues, the important factor is the effect they have on people’s quality of life.

- We should use the evidence on what works in organizing and delivering services to improve outcomes.

- Rather than being prescriptive about the structure of services, we should be clear about purpose and the target populations of services, and what outcomes we expect to see from them.

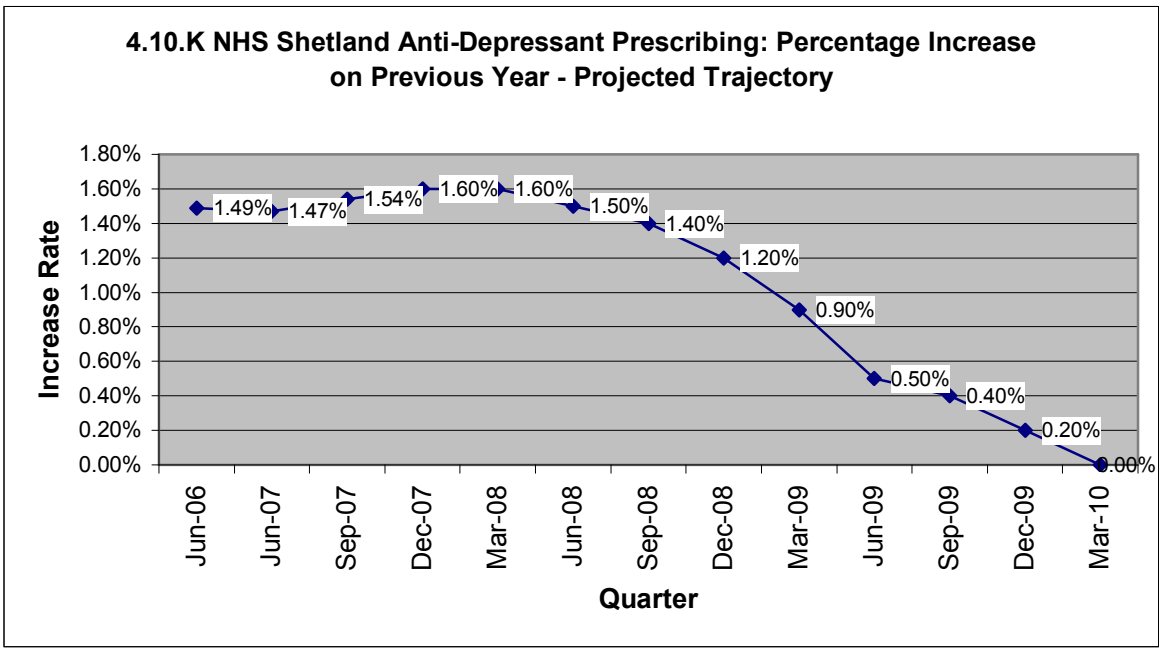
- The strategy should be consistent with local community care and housing plans to allow it to take account of the social care, housing, education, employment and leisure issues involved in providing effective mental health services.

d) Targets

The Scottish Executive gives us a range of specific targets to reach, and commitments and actions to deliver from the national policies in place:

Target	Timescale
Target 1: Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10.	2009/10
Target 2: Reduce Suicides in Scotland by 20% by 2013 (existing target).	2013
Target 3: We will reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% by the end of December 2009	Dec 2009

Target 1 Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10.



This graph shows that the amount of antidepressants prescribed in Shetland has been rising by about 1.5% year on year (in line with national figures), and the local service has a target of reducing the rise, so that prescribing is no longer increasing by the year 2010.

Local implications of meeting the target

Work done over the last few years would indicate that in Shetland, though anti-depressant prescribing has risen (as in other parts of the UK), there may still be unmet need: there are people who may still require treatment for depression, whether that is medication or psychological supports. Because of the nature of mental and emotional distress or mental illness, particularly in small communities patients do not always present themselves for diagnosis and treatment or support. The indicator takes no account of unmet need, and

does not consider baseline prescribing information. Shetland has the lowest number of defined daily doses (DDD)s of antidepressants per capita in Scotland, and has the highest rate of increase in prescriptions.

In order to meet the target, we need to understand and identify unmet need, while at the same time reviewing any inappropriate prescribing. This needs to be done over the next 12 -18 months.

Risks associated with achieving delivery
The most significant risk is the risk to patients; an over emphasis on the target could lead to patients not receiving the treatment that is needed. In order to eliminate this risk more emphasis will be put on identifying need over the next 12 months. In turn, the risk is that the delivery will not be achieved in the prescribed timeframe.

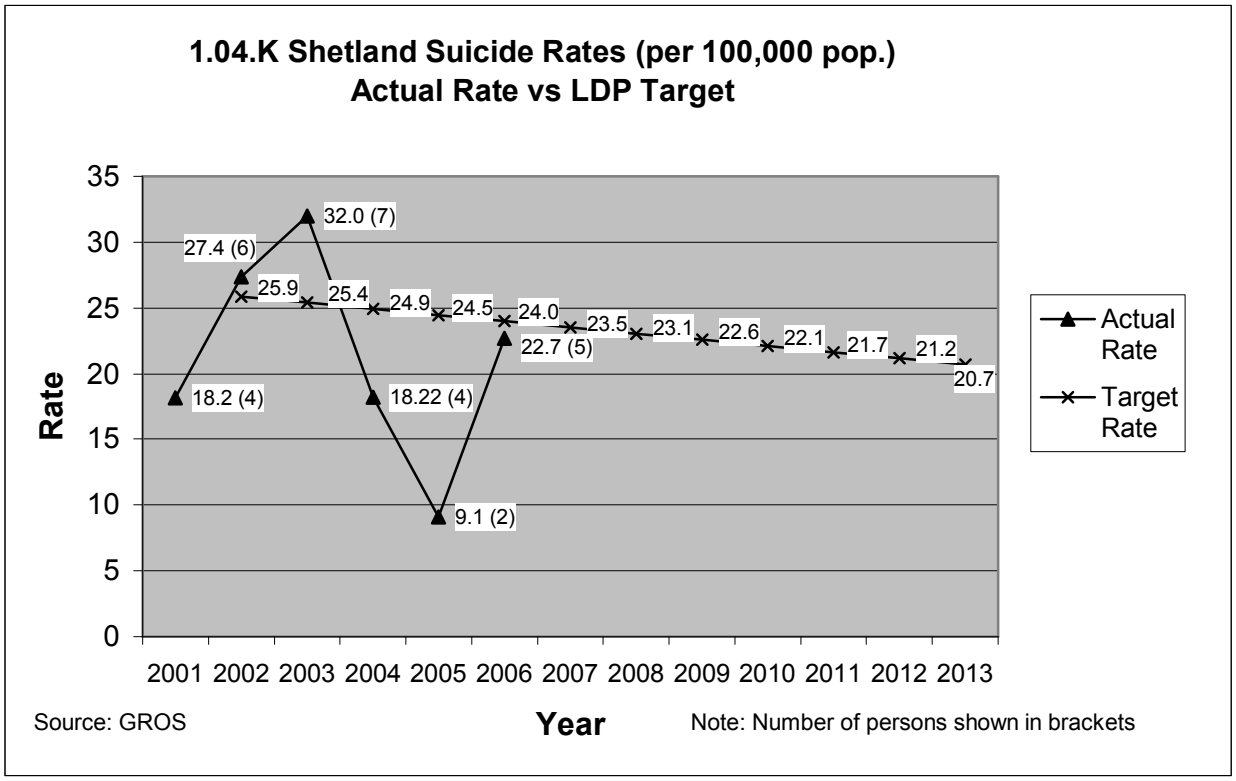
Local Actions
The Mental Health Partnership is taking this forward locally, within the action plan to this strategy which includes identifying any significant unmet need. At the same time an audit has been commissioned to look at the prescribing of antidepressants. This audit will be targeted initially in practices identified as higher prescribers who will be supported to develop practice action plans to deal with the results of the audit.

There are a range of support services in place locally to support and complement anti-depressant prescribing, with an extensive GP counselling service, and access to well-being and mental health promotion resources via GP practices, the Community Mental Health Team, Healthy Working Lives, and other health promotion outlets. There are strong links to other agencies including voluntary sector support organisations working in supported employment, Citizen's Advice Bureau for economic welfare, etc. The strategy addresses strengthening these links as well as additional possible resource development or redesign on supported self care, the pathways between primary care and direct access, and the specialist services such as the Community Mental Health Team. Specific work within the Framework on Child & Adolescent Mental Health[4] includes the development of self help and family resources, as well as working with partners such as education to provide resources and up-skilling of generic workers and related professionals.

Target 2 **Reduce Suicides in Scotland by 20% by 2013**

This graph shows the number and rate of suicides in Shetland from 2001 to 2006, against the target set by the Scottish Executive to reduce the rate of suicides by the year 2013. Numbers in Shetland are very small, varying from 2 to 7 per year, so we see what appear to be large variations from the addition or reduction of one or two individual events. The trend set towards the target is also shown as a gradual reduciton in rate which does not fit with actual numbers, again because of the small scale of the local population.

Targets



There is a local Suicide Prevention programme in place built on the Choose Life[5] initiative, which links into the Mental Health Promotion and Well-being Strategy that was developed two years ago. The first phase of health needs assessment undertaken in collaboration with local service providers from the statutory and voluntary sectors, and with users and carers, has informed the development of this strategy, and the action plan for redesign and development includes the priorities for, and future of suicide prevention in Shetland.

The current programme includes an extensive investment in ASIST (Applied Suicide Intervention Skills Training) and Mental Health First Aid training, and specific initiatives aimed at vulnerable groups such as survivors of sexual abuse, bereavement support, and those suffering from severe and long term mental illness in rehabilitation.

There is close working and cross-membership between the Mental Health Partnership and the Shetland Alcohol and Drug Action Team (SADAT), as well as between local services such as the local drug and alcohol support services and the Community Mental Health Team, and the dual diagnosis service and specialist Alcohol Nurse operate from within the Community Mental Health Team. The action plan considers the development of formal dual diagnosis provision for people with drug dependency and mental health problems.

The recent research undertaken in Shetland on inequalities has provided helpful information about the characteristics of deprivation and social exclusion locally, which included specific experience of people with mental illness and distress describing the additional problems in access to services and social isolation. This is now being used to help service providers consider how to reach the 'hardest to reach' individuals and households in Shetland, and there have already been some specific service responses, for instance the delivery of ASIST training to remote island communities within Shetland, and

Targets

Mental Health First Aid training as part of the development of local community resilience. More generic service responses will also have an impact on people with mental illness living in circumstances of deprivation or social exclusion, such as community transport, and befriending and advocacy.

There are risks in achieving this target because of the small numbers in Shetland, and the difficulties of measuring the significance of trends. Because the baseline rate in Shetland is low, improvement is more difficult to demonstrate, particularly when we are looking at one or two events per year. A system of local audit of individual suicides is in place to learn lessons from each event that can be translated into service change where appropriate. In addition, with the commitments and priorities posed in Delivering for Mental Health[6], there are some local challenges for redesign and service development that are prioritised within the Strategy. There are some specific issues around workforce and sustainability given the remote and rural nature of the service in Shetland, and the distance from more specialist mainland services, that are also taken into account.

Target 3 **We will reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% by the end of December 2009**

In Shetland we have a very small number of patients with severe and enduring mental illness who relapse and require readmission. We have no local inpatient mental health beds in Shetland, so all our inpatient admissions are through Royal Cornhill Hospital in NHS Grampian. During the year 1st April 2005 to 31st March 2006, we had 22 admissions to Cornhill, out of which 6 (25%) were re-admissions.

A number of areas for development are identified within the strategy which will assist in achieving the target:

- Development of Integrated Care Pathways (ICPs) - Joint work in process mapping has commenced between NHS Shetland and Shetland Islands Council (SIC) in preparation for Preliminary Mapping ICPs later this year. This is being done with help from the NHS Quality Improvement Scotland Integrated Care Pathway national co-ordinator.
- Services for patients in crisis and alternatives to admission to Cornhill Hospital.
- Further exploration of local out of hours availability of the Community Mental Health Team. We are aware of the National Standards for Crisis Services[7] which have been considered during the production of the Mental Health Strategy, and redesign of local crisis support services will take these into account.

Risks associated with achieving delivery

If this patient group remains static and begins to become more stable then the target is achievable. However it is likely that in keeping with national trends, we will see an increase over time of severe and enduring cases rather than a decreased number of such patients, unless long term investment in prevention and care can reverse this trend.

Within the strategy, we are looking at resources available for mental health services across Shetland, as well as specific service improvements on crisis support and better admissions / discharge arrangements.

The Scottish Executive, via it's national policy on mental health services, also gives us a set of commitments to be adopted by local services:

Delivering for Mental Health[8] – National Commitments

Commitment 1: We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010

Commitment 2: We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas, later that year

Commitment 3: We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes, who are identified under the new Quality Outcomes Framework (QOF) arrangements.

Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.

Commitment 5: We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months.

Commitment 6: NHS Quality Iimprovement Service (QIS) will develop the standards for ICPs for schizophrenia, bi-polar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.

Commitment 7: Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes. 50% of target staff will be trained by 2010

Commitment 8: Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009

Commitment 9: We will establish acute inpatient forums across all Board areas comprising service providers, service users and carers as well as other stakeholders such as Local Authority colleagues

Commitment 10: We will improve mental health services being offered to children and young people by ensuring that by 2008:

- a named mental health link person is available to every school, fulfilling the functions outlined in the Framework.
- basic mental health training should be offered to all those working with, or caring for, looked after and accommodated children and young people

Targets

Commitment 11: We will reduce the number of admissions of children and young people to adult beds by 50% by 2009

Commitment 12: We will implement the new Care Programme Approach for all restricted patients by 2008

Commitment 13: We will translate the principles of Mind the Gaps[9] and a Fuller Life[10] into practical measures and advice on what action needs to be taken to move the joint agenda forward and support joined-up local delivery by the end of 2007.

Commitment 14: We will work with the Dementia Services Development Centre at Stirling University and NHS Forth Valley to undertake a pilot programme in improving dementia services. The Pilot will be evaluated in 2008.

Delivering for Health[11] – National Actions

Action	Date	Commentary
Start implementation of the local elements of the Child and Adolescent Mental Health Services (CAMHS) Framework.	December 2006	Implementation started with drafting of local Integrated Care Pathways and further planning in progress – development of local CAMHS strategy by end March alongside local Mental Health Strategy.
Develop local action plans based on National Mental Health Delivery Plan.	December 2007	Work in progress via local Mental Health Partnership developing local Mental Health Strategy due end March 07. Will include action plans to ensure local delivery of national plan.
Develop local integrated care pathways to meet national standards (available December 2007)	December 2008	National guidance now being used within development of MH Strategy, ICP development will be included in implementation action plan.

Rights, Relationships and Recovery[12] - Summary of Key Actions

- Training programmes that are values-based practice and recovery-based practice will be implemented
- Recovery based approach to practice will be implemented
- New whole-systems ways of working should be developed and implemented to enable contuinuity of nursing care across service boundaries with planned rotation of staff across different service elements
- Competency-based frameworks will be implemented for mental health nursing in acute and crisis care and older people's mental health nursing
- Mental health nursing's contribution to nurse prescribing should be developed
- The leadership capacity and capability of the mental health nursing profession must be strengthened and enhanced

See Appendix 2 for full action plan.

e) Mental Health Policy Summary

This strategy is shaped by a number of policy documents. The key ones are summarised below, with the remainder being detailed in Appendix 3.

Delivering for Mental Health[13] (2006)
http://www.scotland.gov.uk/Publications/2006/11/30164829/0

This is a Scottish Executive Health Department policy document on the development of Mental Health services and the improvement of mental health in Scotland as set out in Delivering for Health 2005. It contains chapters on improving patient & carer experience; responding better to depression, anxiety and stress; improving the physical health of people with mental illness; better management of long-term mental health conditions; early detection and intervention in self-harm and suicide prevention; manage better admission to, and discharge from hospital; child & adolescent mental health services; enhancing specialist services (forensic, perinatal, and eating disorder services); areas for further work that include mental health & substance misuse, services for older people with mental health problems, mental health & employment, and implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003; and support for change.

Delivering for Health (2005)
In response to the report produced by the Kerr Committee *Building a Health Service fit for the future*,[14] the Scottish Executive published *Delivering for Health*[15]. The headline messages from *Delivering for Health* are as relevant for mental health as they are for all other care.

Delivering for Health sets clear objectives including an aim to improve the health (and mental health) of Scotland with a greater and wider effort on improving health and well being through preventative measures, support for self care and a targeting of resources on those at greater risk. That ambition reflects much of what already drives mental health policy and delivery agendas in Scotland. The mental health priority is recognised throughout *Delivering for Health* and in particular in sections 3.5, 3.6, (for the child and adolescent aspects) and 3.7. Undertakings are made for mental health that involve:

- Partnership working on a national mental health delivery plan (by an expert group; see below);
- An evidence based practice guide to depression;
- continued investment on crisis prevention, response and recovery;
- national standards for Integrated Care Pathways; and
- an analysis of specialist service needs.

Relevant and current information will have a part to play in the work on all these proposals.

The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)[16]
http://www.scotland.gov.uk/Publications/2005/10/2191333/13337
This is a Scottish Executive framework developed to assist all agencies with planning and delivering integrated approaches to children and young people's mental health.

National Programme to Improve the Mental Health and Well Being of the Scottish Population[17]

http://www.wellscotland.info

The National Programme for Improving Mental Health and Well-being was launched in October 2001. Their aim is to improve the mental health and well-being of everyone living in Scotland and to improve the quality of life and social inclusion of people who experience mental health problems. They take the lead on positive mental health and well-being improvement. They have four key aims (raising awareness and promoting mental health and well-being, eliminating stigma and discrimination, preventing suicide, and promoting and supporting recovery) and six priority areas (improving infant mental health (early years), children and young people, employment and working life, improving mental health and well-being in later life, improving community mental health and well-being, and improving local services).

They also help shape, fund and support a series of key initiatives and support partnerships that are focused on different aspects of improving Scotland's Mental Health.

Framework for Mental Health (1997)[18]

http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm

The framework sets outs in a tiered service system, the essential features of a local mental health strategy for people with severe and/ or enduring mental health problems, including those with dementia. The Framework does not address the needs of those with learning disabilities, or alcohol and/ or substance misuse, unless there are concomitant mental health problems.

Mental Health (Care and Treatment) (Scotland) Act 2003[19]

www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm

The Act was introduced to the Scottish Parliament in September 2002 and given royal assent in April 2003. The Act contains sections concerning: compulsory care and treatment of people with mental disorders; creation of a Mental Health Tribunal; powers and duties of Mental Welfare Commission; arrangements for mentally disordered offenders; patient representation; medical treatment safeguards; a duty to provide age-appropriate in-patient facilities for children and adolescents; a duty to provide mother and baby unit places for women with post-natal depression who require to be admitted to hospital; and a duty to offer psychological assessment and therapy from a qualified Clinical Psychologist for people referred under the terms of the act.

Choose Life : A National Strategy and Action Plan to Prevent Suicide in Scotland (2002)[20]

www.chooselife.net

The Scottish Executive's Choose Life strategy was launched in December 2002 and forms a key part of the National Programme for Improving Mental Health and Well-Being Action Plan in Scotland. Choose Life is a 10 year plan aimed at reducing suicides in Scotland by 20% by 2013. The strategy and action plan aims to ensure we take action nationally and locally to build skills, improve knowledge and awareness of 'what works' to prevent suicide, improve opportunities to prevent premature loss of life and provide hope and optimism for the future.

Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland (2006)http://www.scotland.gov.uk/Publications/2006/04/18164814/0

This, the first national review of mental health nursing in Scotland, was launched in April 2006. Mental health nurses are the largest professional workforce group in mental health care and make a significant contribution to the work of NHS Scotland. This report sets out the central importance of:

- a rights based approach to practice
- developing positive relationships as a starting point for all interventions with sevice users, carers and families in Mental Health nursing practice
- recovery as the underpinning priciple of therapeutic interventions.

f) Facts and figures

Research indicates that mental health can be considered to consist of two dimensions: mental illness (mental health problems) e.g. schizophrenia, depression and anxiety, and positive mental health (mental well-being) which includes life satisfaction, positive relationships with others, and purpose in life. Good mental health is therefore more than the absence of mental illness. Historically, however, assessment of population mental health has largely focused on levels of psychiatric morbidity using surveys and scales to determine prevalence of mental illness. The growing recognition of the importance of positive mental health has generated interest in developing indicators to measure positive mental health to accompany indicators of psychiatric morbidity, but these are not yet well enough developed or collected to use.

In terms of diagnosis and risk, (the medical model perspective of describing facts and figures to do with mental ill-health), the groups most at risk of suicide are those with a diagnosis of severe and/or enduring clinical depression, followed by bipolar affective disorder, schizophrenia and other psychoses.

In addition to the number of elderly people who develop dementia increasing over time, the number of people with anxiety and depression is also increasing. The growing numbers of people suffering from dementia (assessed as around 65,000 in Scotland now, but likely to grow to 192,000 by 2040).

Research conducted in 1990 by Regier et al[21] demonstrated the degree of overlap between mental health and alcohol problems. Among people with an alcohol disorder the incidence of concurrent mental health problems was as follows:

19% had an anxiety disorder
14% suffered from antisocial personality disorder
13% had affective disorders
4% had schizophrenia.

The same research found the following patterns:

Mental health problem	**% with alcohol problem**
anti-social personality	74%
schizophrenia	34%
affective disorders	22%
anxiety disorders	18%

Of people referred to the Shetland Specialist Alcohol Nurse in 2005, 97 / 154 (63%) have a history of mental health problems.

The local Mental Health needs assessment of 2002, which looked at the profile of people accessing the services of the Community Mental Health Team (CMHT), showed that more women than men were referred in all age groups (a ratio of 2:1) except ages 40-49 where numbers were equal. Younger men age 18-29 were underrepresented. These figures are similar to national findings.

Facts and figures

Depression

The World Health Organisation estimates that by 2020 depression will be the world's second most disabling condition after cardiovascular disease.

An estimated 20% of the population between 16 and 65 will experience depression at some time in their lives.
It is estimated that the needs of 95% of people with clinical depression who come for treatment are looked after in primary care.
More women than men – about 2:1 are diagnosed and treated for depression.

Lanarkshire showed annual contact rates for depression in 25-34 yr old women at 345/1,000 and 142 for men. Admissions to hospital in Lanarkshire in 2003 were 483 women and 302 men.[22]

In Shetland, GP practice information for 2006-07 showed 112 people presenting to their GP with a new diagnosis of depression (adults excluding presentations of post-natal depression), though this is a new way of collecting data in general practice and may be an underestimate of the numbers presenting.

Male depression is known to be under-reported as many men do not acknowledge emotional distress, use other coping mechanisms and do not attend services for help.

The Mental Health Foundation estimates that 70% of recorded suicides are by people experiencing depression.

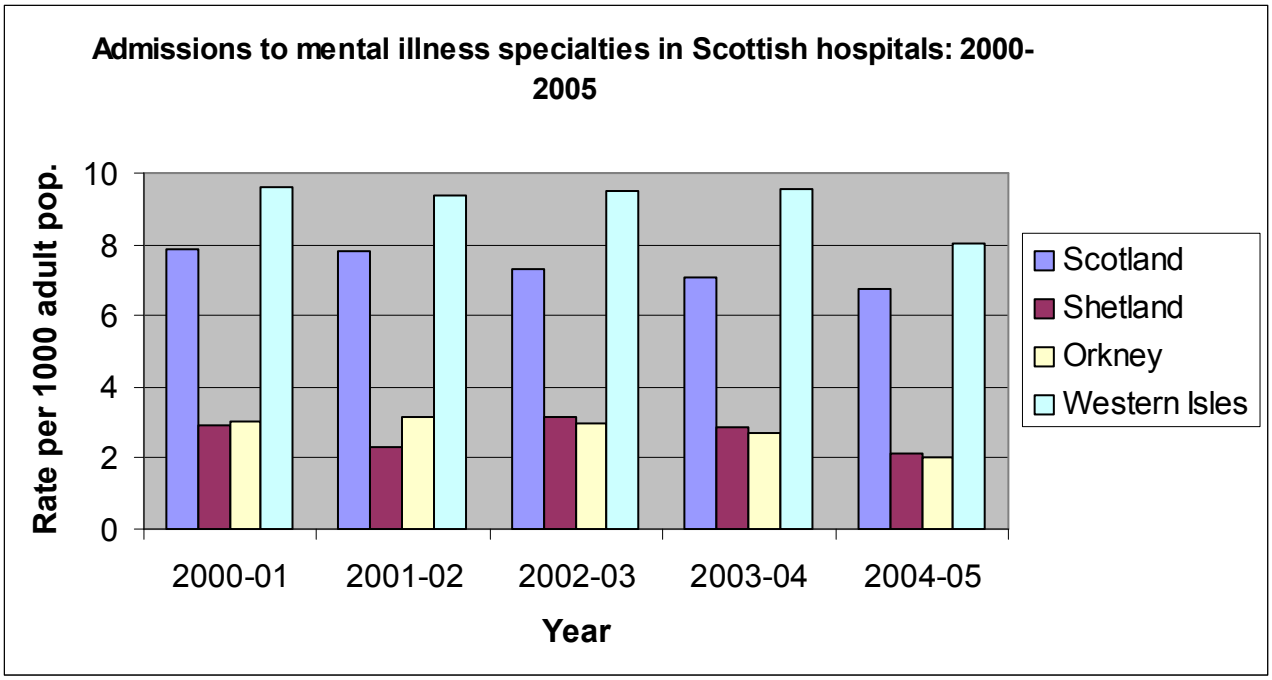
Vulnerable groups: social and economic deprivation have been highlighted as factors contributing to depression and psychological distress. Studies from USA suggest that gay and lesbian individuals are more vulnerable to anxiety, depression, deliberate self-harm, suicide and substance misuse than heterosexuals.

There have been changes in presentation and treatment over the last 2 decades: the proportions of people receiving treatment has increased largely with medication.
There has been an increase in prescribed anti-depressants in Scotland from 1.16 million in 92-93 to 3.48 million in 04-05, daily dose per 1,000 population of anti-depressant medication in Scotland 23,945.

The proportion of people receiving psychological treatments has not changed significantly over that period.

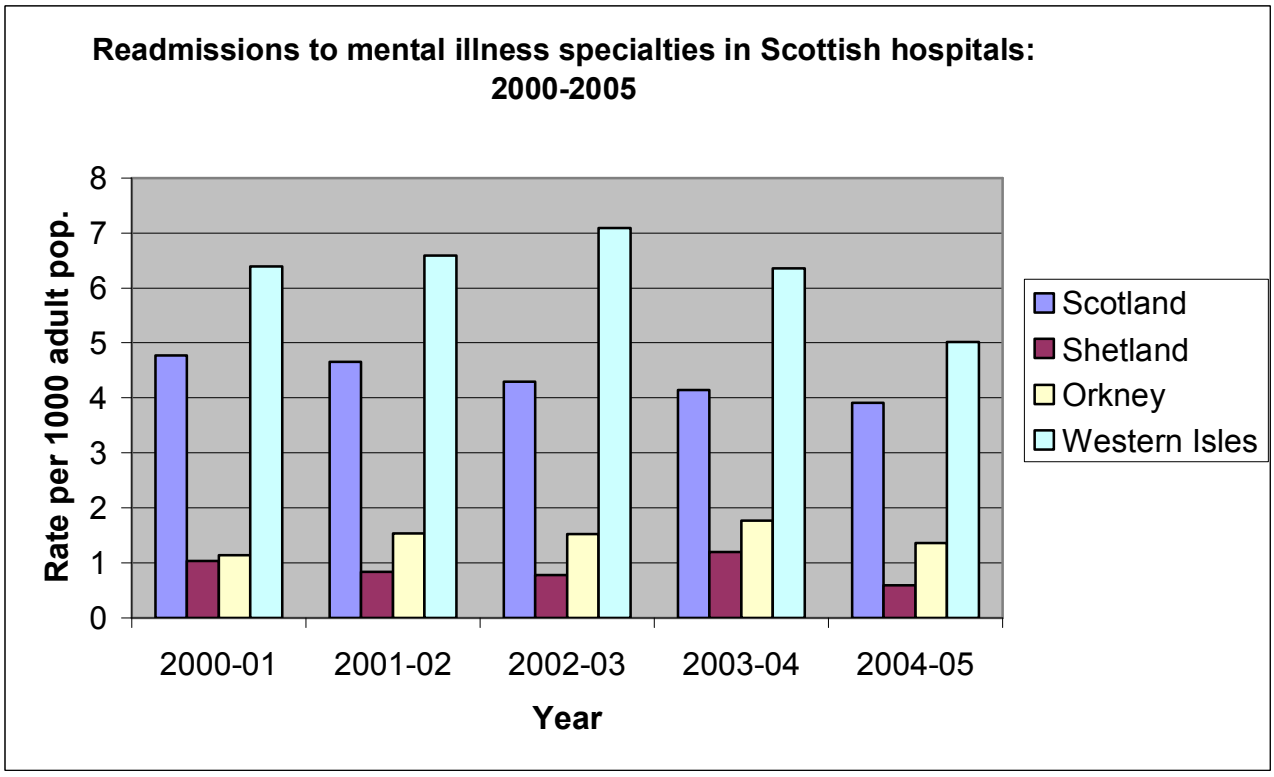
Admissions to hospital

Shetland shows a rate of admissions to psychiatric hospital lower than the Scottish average, on a par with Orkney, and fairly stable over time. We assume that the lower rate is due to the geographical distance to Aberdeen where in-patient facilities are available, and a local emphasis on local treatment within the community wherever possible.



Source: ISD Scotland SMR04

Readmissions ot hospital is one of the national policy targets – to reduce readmissions over time as a proxy for good quality community based care. This graph shows that Shetland has a lower rate of readmissions than the Scottish average, and lower than the other island Boards.



Source: ISD Scotland SMR04

In terms of length of stay in psychiatric hospital, the majority of patients stay less than 4 weeks, though in Scotland as a whole over a third of hospital residents stay over 2 years. This figure is weighted by those who are resident long-term in a psychiatric hospital,

though in Shetland that applies to only one or at most two people at any one time, who have very complex needs and are in placements in mainland hospitals. In children and young people nationally, maximum lengths of stay are under 2 years, with the majority staying less than 6 months.

About 17% of men admitted to psychiatric hospitals are admitted formally under the terms of the mental health Act, that is, and 13% of women (nationally).

Primary care data

Primary care data on referrals to the Primary Care Counselling Service shows that people are referred with the following presenting problems:

Addictions
Anxiety/Stress
Bereavement/Loss
Depression
Eating Disorder
Interpersonal/Relationship
Living/Welfare
Other
Personality Problems
Physical Problems
Self Esteem
Trauma/Abuse
Work/Academic

The national GP contract now also encourages practices to collect data for the Quality and Outcomes Framework (QOF) which includes a mental health domain on disease registers for people with severe long term mental health problems (people with schizophrenia, bipolar affective disorder and other psychosis) who require and have agreed to regular follow up.This is designed to capture information on their physical health, and will also allow us, over time, to build up a picture of the numbers of people in this category. In the first year of this data collection, practices in Shetland recorded 107 people with these major mental illnesses. Domains on dementia and depression have also recently been introduced (during 2006) and again should build on the limited information currently available.

g) Process of Developing the Strategy

The Shetland Mental Health Partnership was established in June 2006 to oversee mental health services and to develop a mental health strategy for Shetland. The Mental Health Partnership has representation from the statutory sector and key voluntary agencies which are involved in developing and delivering mental health services in Shetland, as well as user and carer membership. The Partnership is supported by a Mental Health Forum. This is a wider group of people with an interest in improving mental health, preventing mental ill health or who currently have or have had experience of mental health problems.

It was agreed at an early stage that the development of the strategy should be participative and should involve as many people as possible with an interest in mental health in Shetland. Questionnaires were sent to all agencies currently involved in delivery of mental health services in Shetland to identify the services they deliver, their client groups, any funding issues they have and to assess their unmet needs and the unmet needs of their clients. The response rate was 95%.

An 'away day' was held in January 2007. Participants included members of both the Partnership and the Forum and other interested individuals. The aims of the day were to give participants a good understanding of the national and local policy context within which the strategy was being developed and to provide epidemiological information, for example, what we know already about the number of people suffering mental ill health, or national figures compared to local figures. A summary of what we knew already from the needs assessment was presented. Participants then broke in to groups to work on these initial findings; to identify any additional needs and to help develop potential solutions.

The policy information, the epidemiological information and the identified needs and plans for action have now been pulled into this strategy document, and have been reviewed and commented on by the Mental Health Partnership and Mental Health Forum.

The draft strategy also went out for wider consultation during June and July 2007.

Further details are available in Appendix 4: Remit of Shetland Mental Health Partnership, Remit of Shetland Mental Health Forum and Remit of Joint Mental Health Management Team; and Appendix 5: Proposal for Undertaking Mental Health Needs Assessment in Shetland.

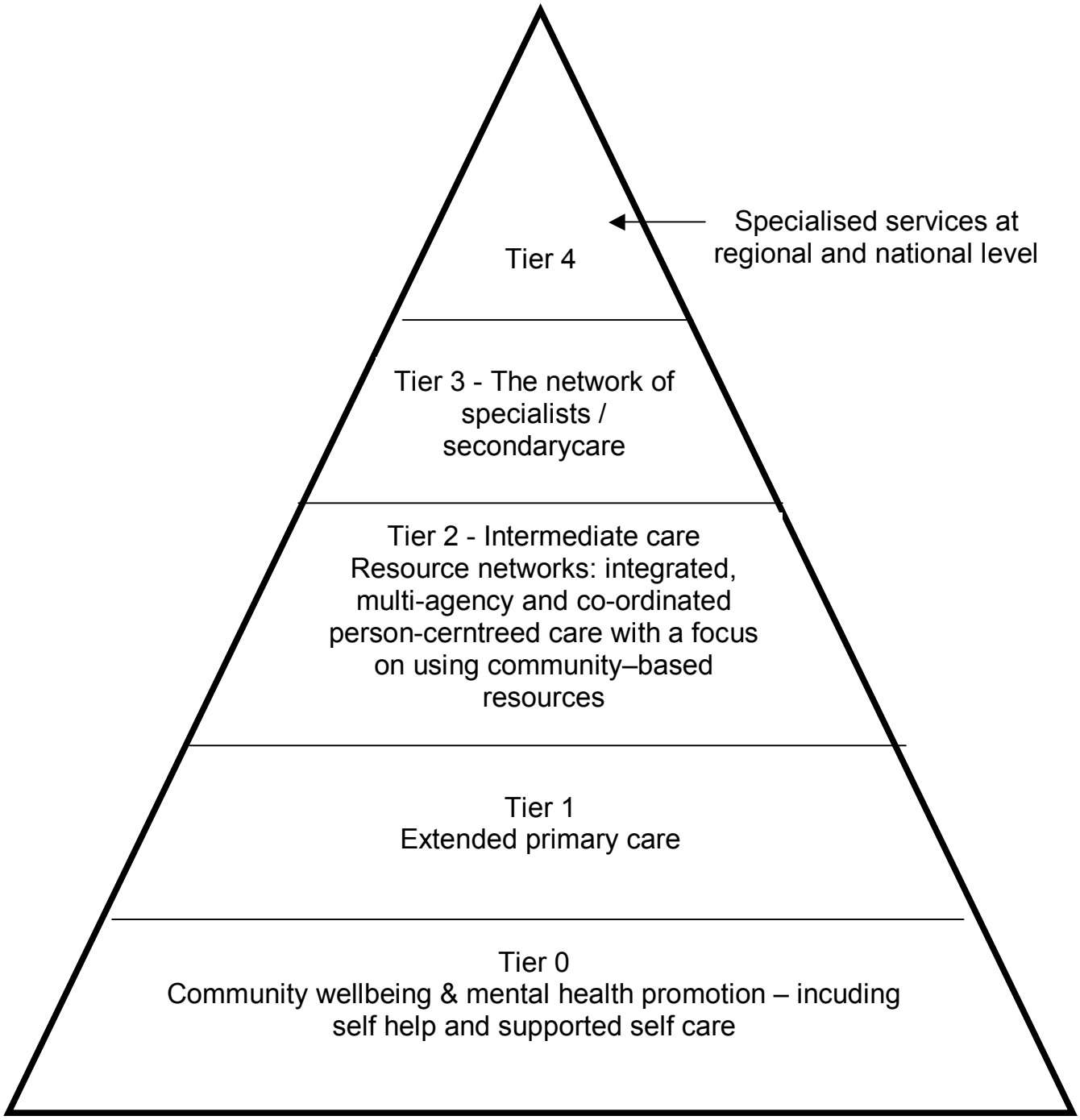
h) Service Framework

This section translates the vision into practice: it describes the functional model of services we should have in place using national policies and best practice guidance.

The challenge is to integrate the range of models: wellness, recovery, psychological and treatment, into a coherent set of supports and services that work together in the interests of the mental health of people in Shetland.

One way of describing this is as a tiered approach. The core service elements are described within each Tier in the National Framework on Mental Health[23] and reproduced here.

Tiered approach to mental health services:



Service Framework

This section of the strategy tries to set out a summary of current local service provision, identification of strengths and gaps related to local needs, and then plans for development towards the vision of future services, described using the tiered model. We recognise that many services cut across the tiers, which are not discrete entities but merge into one another, and that this is not meant to add organisational boundaries or barriers to patient experience. For instance, a local service such as Primary Care Counselling is provided in Tier 1 as an extended primary care service, but also offers some supports which would be categorised as Tier 2 and maybe on occasion Tier 3, and the service certainly plays its part within the local resource network described as the Tier 2 service. Nevertheless, the tiered model provides a structured approach to the understanding of gaps and unmet needs, and the development of services to meet the needs identified.

It is also compatible with the matched / stepped care approach outlined in Delivering for Mental Health.[24]

Matched/Stepped-care

Stepped care is a tiered approach to service provision, best described as pyramidal in structure, with high-volume low intensity interventions being provided at the base of the pyramid to patients with the least severe difficulties. Subsequent ‘steps’ are usually defined by increasing levels of case complexity, and increasingly intensive forms of treatment. In ‘matched’ stepped-care models, there is a system for matching the appropriate level of treatment to the level of complexity of the patient’s problem, and the patient receives the minimum input compatible with effective treatment. Within ‘steps’ there should be provision for patient choice.

In providing treatment to any patient population presenting with problems spanning a spectrum of severity, evidence suggests that a matched/stepped care model is the best way to make use of limited resources.

Core service elements have also been defined nationally within the National Framework, and these are used as the basis for setting out local gaps and the future vision.

THE INTERFACE BETWEEN SERVICES AND SUPPORTS

This table demonstrates how the care needs of people with mental health problems of different complexity and severity might be addressed.

Tier	Example	Likely course without treatment	Treatment available	Who best provides it	Likelihood of recurrence
0	Support for life events and the development of emotional resilience	Some people suffer unmanageable reactive distress, or have less personal capacity to cope	Support from families and friends, community networks, positive mental health promotion and awareness raising	Community, self-help.	Life time cycles
1	Disordered reactions to loss or bereavement (prevalence is increasing)	Spontaneous remission	Proven treatments are lacking. Support from families and friends is the most effective, but for some people support, practical help, time limited counselling is helpful.	Members of Primary Health Care Team (PHCT), self-help groups, voluntary sector counselling services.	Low
2	Phobic disorder, chronic fatigue syndrome, Post Traumatic Stress Disorders (variable prevalence), post partum depressive illness	Variable remission rates	Talking treatments (psychological therapy) based on cognitive methods fair to good response	Members of PHCT, with support from a member of Community Mental Health Team (CMHT) from time to time. Self-help groups	Some relapses will recur
3	Depressive or panic disorders (high prevalance – may take up to 1/3 of GP's time) and eating disorders	Low spontaneous remission rate	Medication and therapies based on cognitive methods give a good response. For more complex cases, other psychological therapies are recommended.	PHCT, but referral to CMHT if no response to first line treatment or if case is complex	High risk of relapse but some prophylactic treatments available
4	Severe and/or enduring mental health problems (low prevalence)	Very unlikely to remit spontaneously	Medication and psychological therapies (especially cognitive and support for carers) Fair to good response but treatment needed in long term Care Programme Approach likely to apply and Mental Health (Scotland) Act to be used	Care shared between PHCT and CMHT. Mental Health Officers will be involved when the Act is used or is considered. Special housing needs and additional social supports possible	High risk of self harm, relapses and/or chronicity without continued input by CMHT in liaison with PHCT

Adapted from National Framework[25]

PHCT – Primary Health Care Team
CMHT – Community Mental Health Team
CPA – Care Programme Approach

Service Framework

A local mental health service must provide a range of care to meet the mental and physical needs of individuals with mental health problems. Clearly, not all individuals will have needs in all the categories, but all elements should be provided in an overall service. Each is equally important; if needs are left unaddressed the effectiveness of the whole service will be affected. People receiving Tier 3 & 4 services will also need elements of the supports described in Tiers 1 & 2, and an individual with a specific mental illness or range of mental health problems may move through the tiers of service as their needs change.

The subsequent sections on specific elements of service – service profiles, attempt to pull together the range of needs and services across the tiers in those areas.

There are some requirements common to all services such as information about services and about mental health and illness; appropriate training for staff; the rights of people within services as partners to service delivery, and planning and the development of services. These are set out as principles in Chapter c) and reflected as strengths or gaps in this section. Where there needs to be development, the actions are set out within the action plan.

Tier 0

Community Health and Well Being in the Neighbourhood or Locality

Mental health improvement (sometimes called mental health promotion) involves any action to improve mental health.

Like mental health, it is an umbrella term that may include action to:

- Protect and promote the mental well-being of the whole population, including those experiencing mental illness (e.g. increasing self esteem and confidence, feelings of belonging, coping skills, resilience, cognitive skills, etc). Promoting well-being focuses on the building of competencies, resources and strengths and has a major contribution to make to personal and social development.
- Prevent mental illness – i.e. reducing risk factors for mental illness (e.g. lack of support services including transport, social and recreational facilities, neighbourhood violence and crime, socio-economic disadvantage, parental mental disorder, bullying, etc) and increasing protective factors (e.g. social support, community connectedness, good physical health, positive school environment, job control, infant attachment, etc). (See table below for further information on risk and protective factors).
- Improve the quality of life of those people experiencing mental health problems (e.g. recovery oriented services, reducing stigma and discrimination, job retention and rehabilitation, etc).

Mental health improvement therefore not only concerns the beliefs, attitudes and behaviours of individuals, but also broader socio-economic and environmental determinants.

Factors that can influence the development of mental illness or distress
Table adapted from WHO (2004) Prevention of mental disorders: effective interventions and policy options: summary report.[26]

SOCIAL, ENVIRONMENTAL AND ECONOMIC DETERMINANTS (FACTORS ASSOCIATED WITH) MENTAL HEALTH) **Risk factors:**
• Isolation and alienation. • Lack of education, transport, housing, recreational facilities. • Neighbourhood disorganisation, violence and crime. • Socio-economic disadvantage. • Poverty, poor social circumstances. • Work stress, unemployment. • Poor nutrition. • Social or cultural injustice and discrimination. • Peer rejection. • Violence and anti-social behaviour.

Tier 0 – Community Health and Well Being in the Neighbourhood or Locality

Protective factors:
• Empowerment. • Positive interpersonal interactions. • Social support and attachment to community networks. • Social responsibility and tolerance. • Access to social services and a variety of leisure activities. • Social participation and inclusion. • Economic security and access to meaningful employment.
INDIVIDUAL AND FAMILY DETERMINANTS OF MENTAL HEALTH **Risk factors:**
• Parental mental illness. • Loneliness, social isolation. • Parental substance misuse. • Low birth weight, birth complications. • Personal loss – bereavement. • Stressful life events. • Physical, sexual and emotional abuse. • Family conflict/discord/violence. • Substance misuse.
Protective factors:
• Ability to cope with stress. • Physical activity. • Good parenting, stable and supportive family environments. • Feelings of security, mastery and control. • Self-esteem. • Good physical health. • Social skills. • Positive attachment and early bonding. • Pro-social behaviour.

Mental health improvement at different levels
Mental health improvement works at a variety of levels:

Strengthening individuals
Mental health can be improved by increasing emotional resilience through interventions designed to promote self esteem, life and coping skills e.g. communication, negotiating, relationship and parenting skills, physical activity, stress management etc.

Strengthening communities
It can also be improved by increasing social support, inclusion and participation, improving community safety, neighbourhood environments, promoting childcare and self help networks, developing health and social services which support mental health, and improving mental health within schools and workplaces e.g. through anti bullying strategies, and mental health or stress management strategies.

Reducing structural barriers to mental health
Mental health can be improved through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support.

Each level is relevant to the whole population including individuals at risk and people experiencing mental illness.

All settings and related services therefore have a potential to influence mental health, including workplaces, housing, transport, health services, justice services, education and life long learning, community services, sport and leisure etc. In addition mental health improvement is applicable across all stages of life: infants, children, young people, younger adults and older adults.

The National Programme for Improving Mental Health and Well-being[27] covers Tier 0 and has four key aims:

- Raising awareness and promoting mental health and well-being
- Eliminating stigma and discrimination around mental ill health
- Preventing suicide and supporting people bereaved by suicide
- Promoting and supporting recovery from mental health problems.

Elements of core service currently provided:

Raising awareness and promoting mental health and well-being

Everyone needs to know what mental health is, what mental illnesses are, and where to go for assistance. This will ensure that people get the help and advice they need when they need it. It is important to understand that there are lots of ways to avoid mental health problems and maintain positive mental health.

In Shetland, training is currently offered in **ASIST**[28], **MHFA**[29], and **Suicide Talk**[30].

ASIST (Applied Suicide Intervention Skills Training) is a programme that offers suicide intervention training that is suitable for both professional and other caregivers. It focuses on developing 'first aid' skills that can be used for anyone who is at risk of suicide. It is being rolled-out in Shetland (as in Scotland) with an extensive programme funded nationally for 3 years from 2005.

Mental Health First Aid (MHFA) is a training programme on the help given to someone experiencing a mental health problem before professional help is obtained. MHFA does not teach people to be therapists. However, it does teach people:

- how to recognise the symptoms of mental health problems
- how to provide initial help
- how to guide a person towards appropriate professional help.

Suicide Talk is an awareness exploration session specifically designed to help members of the public avoid letting their fear of suicide govern what they do or don't do about preventing it. It does not aim to teach intervention skills. Its goal is to help make it easier to have open and honest talk about suicide.

There is also scope locally for offering training in promoting mental health improvement, evaluation of mental health improvement work, building evidence into practice, and mental health in the workplace. The **Healthy Working Lives**[31] (HWL) award scheme now includes a component on promoting postive mental health in the workplace.

Eliminating stigma and discrimination around mental ill health

Stigma and discrimination around mental illness make life even more difficult for those experiencing problems. The fear stigma causes stops people from seeking the help they need, whether from services or from friends and family.

Mind Your Head (MYH) is a local initiative whose main aim is to raise awareness of mental health issues in Shetland and help reduce the stigma that exists. It looks to work collaboratively with national and local organisations and help to bring the message to Shetland people. It works on the principle that local people may respond more readily to national materials/campaigns if they have a local association. MYH has already made contact with See Me, Choose Life and the Scottish Association for Mental Health[32] (SAMH).

The **See Me Campaign**[33] was launched in October 2002 to challenge stigma and discrimination around mental ill-health in Scotland. The campaign is funded by the Scottish Executive and combines an award-winning national publicity programme with local and national anti-stigma action developed in partnership with like-minded groups and individuals across all sectors of Scottish life. Individuals who have experienced stigma are involved in many aspects of the campaign, which includes those prepared to talk to the media about the impact stigma has had on their lives.

Workplace activities include:

Managing **Healthy Working Lives**
Supprting and developing emotional well-being through good working practices and policies
Tackling bullying / harassment – policies in place (links to social inclusion and diversity schemes).

Preventing suicide and supporting people bereaved by suicide

Preventing suicide is a high priority. Scotland has one of the highest suicide rates in Europe. More than two people per day die from suicide in Scotland. Suicide affects all ages, genders and cultures and suicide prevention is everybody's business.

Local services currently inplace include **ASIST/MHFA** training;
Choose Life Suicide Prevention Action Plan (see Chapter 8 for further details).

Promoting and supporting recovery from mental health problems

The majority of people can and do recover from periods of mental illness – even severe and enduring problems. Many others learn to live with their symptoms and lead full lives. This is what is meant by 'recovery' in the context of mental health and well-being.[34]

The Scottish Recovery Network aims to engage communities across Scotland in debate on how best to promote and support recovery from long-term mental health problems. Recovery is about more than the mere absence of symptoms and is a deeply personal process. However, international experience shows that developing an expectation of recovery and an understanding of what helps people regain control in their lives can have a powerful impact. One of the Network's main aims is to learn more about the sort of things that help people to recover and stay well. They are strongly committed to the principle that the best way to increase our knowledge is to ensure that people who have experienced mental health problems are involved throughout and that they are considered to be experts by experience. Learning about other people's thoughts and stories of recovery can inspire hope and challenge preconceptions.

Social support is offered locally through a variety of organisations including:
Shetland Youth Information Service (SYIS) which provides a Shetland wide range of services for Young People aged 12-25 which includes information, counselling and practical supports, formal and informal;
Shetland Community Bike Project which offers voluntary and employed placements to help people with mental health problems gain skills and confidence and enable them to get into mainstream employment;
Annsbrae which provides a skills centre and outreach,as well as a short-break facility. The Skills Centre and outreach work helps those with mental health problems with daily living, personal and social skills training. The emphasis is on empowering people with mental health problems to work towards recovery.
Shetland Link Up and **Women of Worth** which provide support to adults experiencing or recovering from mental distress or at risk from social isolation, through informal groups, via telephone and email, and activities to engage users in social interaction.
Sexual Abuse Survivors Group provide a women only survivor group, a mixed group for men and women and a parents group for parents of children who have been sexually abused by other people. These groups encourage the sharing and use of coping strategies.
Mellow Parenting Groups: Mellow Parenting[35] is a programme designed to help 'hard to reach' families; to engage families whose problems stretched beyond child conduct disorders to wider family difficulties, which might include parental mental illness, social isolation, domestic violence, parental literacy. It was designed to offer parental support and direct work on parenting – aiming to help parents understand their own behaviour and the barriers to change, and so to free them to set about changing communication with their child, increasing desirable behaviour and reducing undesirable behaviour. The programme is a structured 14 week intervention targetted at families with a child under 5. Outcomes of the programme to date have been largely favourable, and an evaluation of the locally run programme is underway.

There is a range of advocacy, befriending and support services in Shetland. These include:

Occupational / employment support via **Moving On Employment Project,** (see also Tiers 1 and 2, and Chapter 15 for more information);
Support in day, leisure & recreational activities;

Tier 0 – Community Health and Well Being in the Neighbourhood or Locality

Befriending: through **Shetland Befriending Scheme** which offers befriending support to young adults in the Shetland community to access every day activities.

There is also a range of services for ordinary living and long-term support (also in Tier 1);

Citizen's Advice Bureau – provides welfare rights, benefits advice, money and debt advice to all ages and areas of Shetland;
Other generic services e.g. housing, **Couple Counselling Shetland**, **Family Mediation;**
Long term social care support for people with more severe and enduring mental illness;

Advocacy (also in Tier 1): **Advocacy Shetland** is an independent organisation which provides trained volunteer advocates for vulnerable people and carers living in Shetland. Advocacy Shetland helps people voice their concerns about a wide range of issues.

Within the field of prevention, local strengths include:

Preventative approach in schools,
Good community development,
Sense of community coherence and responsibility and level of concern about people's lives,
Appreciation of local differences within local communities,
Small communities being strong communities.

Gaps Identified Locally

Assessment of overall mental health and well-being of Shetland's population is limited, as are the systems and indicators in place to assess the mental health of populations.

Incomplete mapping of mental health training needs – there are issues around the sustainability of current training programmes and gaps/overlaps in training providers.

Local pride in community could be harnessed more to increase inclusion and celebrate diversity, and to increase levels of voluntary help and support.

Greater emphasis on improving mental health is needed and needs to be seen as a greater priority. Community and preventative models need to be given a higher profile, along with health and wellbeing.

Language / Stigma / Media / Myths:

- Stigma and taboo surrounding mental ill health; people want to be able to speak more freely and acknowledge mental health problems.
- Fear of mental ill health.
- Need to increase feelings of inclusiveness in community for those with mental health problems.
- Need to increase the involvement of people with experience of mental illness in the development of action to reduce stigma.

Tier 0 – Community Health and Well Being in the Neighbourhood or Locality

Mind Your Head is looking to work collaboratively on these issues.

There is a perceived gap locally in more general support and the infrastructure for Befriending/Support, and specifically within employment. The challenge is for local organisations, perhaps within the voluntary sector, to decide who could deliver this. This needs to sit together with current general and more specialised services (Tiers 1 & 2). It also needs to complement the advocacy development plan.

We need to manage expectations of mental health services in Shetland – partly through development and ownership of the strategy, and partly through developing the model of recovery. Recovery is about understanding that people can and do recover control in their lives, even though they may live with ongoing symptoms of mental ill health. Recovery is about giving people the tools to become active participants in their own health care.

Accessability: there are services and supports in Shetland which are available but difficult to access eg from remote areas to a Lerwick based service. Many rural health centres serve large geographical areas with no public transport infrastructure. Often access to a Lerwick based service is easier. Trips to town can also include access to other services, shops and give opportunity for social contact. It can be less disruptive to employment to attend appointments in Lerwick. It can also be felt that confidentiality is better preserved and stigma reduced when attending Lerwick clinics. Home visits in some circumstances may confirm isolation and dependence, compound stigma and reduce confidentiality.

Developments driven by national policy which are relevant to our local needs

Development of support for the models of wellness and recovery;

Development of general inclusion and diversity programme for all services;

Developing resilience, and mental and emotional strength and well-being;

Challenge to develop a wider provision of the arts working in the mental health field in Shetland – a Mental Health Arts Strategy created jointly between the Mental Health Forum and Shetland Arts.

Actions proposed

Use the mental health and wellbeing indicators developed by NHS Health Scotland to develop a summary mental health profile for Shetland.

Provide better information and awareness raising to reduce stigma and develop mental health awareness, including better advertising of available services - a role for Mind Your Head.

Develop positive media relationships at local level.

Tier 0 – Community Health and Well Being in the Neighbourhood or Locality

Choose Life worked collaboratively with the National Union of Journalists (NUJ) Scotland and the National Programme for Improving Mental Health & Well-Being to develop a practical guide for journalists on the reporting of mental health and suicide by the media[36].

Develop a Mental Health Arts Strategy jointly between the Mental Health Forum and Shetland Arts.

Undertake Training Needs Assessment in mental health improvement training and develop action plan.

Promoting the model of Recovery within Shetland.

Link with Diversity action plans and promoting inclusion and tolerance.

To understand in more detail the local needs for befriending and support, including specific supports such as re-entering employment, with a view to supporting service development within the community / voluntary sector (see also Tiers 1 / 2).

Promote supported employment opportunities (see also Chapter 15).

Tiers 1 & 2

Extended Primary Care & Intermediate Care

Local services should be designed for the early recognition of, and appropriate response to, those with a serious mental Illness: via assessment and diagnosis within general practice, and the provision of an integrated range of community services, linked to more specialist day and in-patient services at Tier 3.

Elements of Core Service Currently Provided

Between 75 and 80% of people presenting with depression are treated within **primary care,** and **General Practices** in Shetland provide a range of care and support with diagnosis and treatments.

The new GP contract includes a range of measures intended to develop the way practices respond to specific illnesses or problems, including some aimed at people suffering from mental illness. Specifically, the Quality Outcomes Framework (QOF)[37] is intended to measure, encourage and support clinical care and a patient experience which is constantly improving, and gives practices a set of standards to achieve including:

Dementia: keeping a register of patients diagnosed with dementia, and the proportion whose care has been reviewed in the previous 15 months;
Depression: recording numbers of patients with a new diagnosis of depression, and using an assessment tool to assess the severity of their illness;
Mental Health – schizophrenia, bipolar affective disorder and other psychosis: keeping a register of people with these illnesses, recording regular reviews of their care which should include health promotion and prevention advice, aspects of their medication record, and having a comprehensive care plan agreed with themselves, their family and / or carers.

All practices in Shetland are now working to these standards of care.

In Shetland, primary care has extended services through the **Primary Care Counselling Service (PCCS)** which provides one to one short and long term counselling and psychotherapy to the 16+ age group, and primary care teams link closely with the **Community Mental Health Team (CMHT)** services. The CMHT provide home visits, out-patient clinics at general practice locations throughout Shetland, and a range of treatment services described in more detail in Appendix 6 and in the sections of the strategy on service profiles.

Advocacy services are available in Shetland (described in Tier 0).

Befriending, socialising and other services;

- **Shetland Befriending Scheme** – provides a one-to-one support service to vulnerable young people and young adults. Volunteers are recruited, trained and then matched to a client and meet either weekly or fortnightly doing a number of purposeful activities both will enjoy.

Tiers 1 & 2 – Extended Primary Care & Intermediate Care

- **Mental Health Family Support group** – provides group support for families and carers of people with mental health problems. Counselling can also be accessed for people who require it. The group meets monthly in Annsbrae.

- **Shetland Link Up** and **Women of Worth** provide support to adults experiencing or recovering from mental distress or at risk from social isolation, through informal groups, via telephone and email and activities to engage users in social interaction.

Services for ordinary living and long-term support (also referred to in Tier 0):

Mental Health and Employment:
We know that employment can be key to recovery for many people suffering from mental illness and programmes to maintain employment or to facilitate re-entry into the labour market can be very effective in supporting social inclusion. Local pilot work on initiatives in primary care and in particular labour markets will be evaluated and where appropriate the lessons applied more generally.

Moving On Employment Project provides a supported employment service for adults who have a recognised disability or mental health problem.

Condition Management Programme is run jointly by Jobcentre Plus and NHS Shetland to work with people with health problems and disabilities to establish the most appropriate ways to help them move back into work (where this is a realistic prospect).

Recovery Network – recovery approaches are already used within local services, but there is not a formal network in place, and no direct links to the national Network locally, thoug local services are working towards meeting the national indicators as mentioned in the next section.

The **Community Bike Project** offers voluntary and employed placements using partnership funding from Scottish Centre for Healthy Working Lives and Jobcentre Plus, to help people with mental health problems gain skills and confidence and enable them to get into mainstream employment. Referrals are also taken from Criminal Justice and local drug and alcohol misuse services.

Annsbrae House – provides outreach, a skills centre and a short-break facility via a Supported Accommodation & Mental Health Community Support Service managed by a multi-disciplinary team. This brings together Community Care, Housing, and CMHT management. Annsbrae House provides 8 supported tenancies and one short break place for people with mental health problems throughout Shetland. An outreach service is provided from Annsbrae which can be accessed through the CMHT. Outreach work can help people with daily living skills and provide support with and monitoring of their mental health**.**

The Skills Centre at Annsbrae provides personal and social skills training to those with mental health problems. Various groups are also held at Annsbrae, such as on symptom management training. The emphasis is on empowering people with mental health problems to work towards recovery and there is a tenant's forum to address housing needs.

Tiers 1 & 2 – Extended Primary Care & Intermediate Care

Echoes - Voice Hearers Support Group is a peer-support, self-help group that meets regularly at Shetland Link Up.

Depression Alliance - a local self help group offering mutual support, advice and information to people experiencing depression and their carers.

Sexual Abuse Survivors Group (SAS) provide a women only survivor group, a mixed group for men and women and a parents group for parents of children who have been sexually abused by other people. These groups encourage the sharing and use of coping strategies.

Shetland Youth Information Service (SYIS)
Provides a Shetland wide range of services for Young People aged 12-25 which includes information, counselling and practical supports, formal and informal.

Shetland Alcohol Support Services (SASS) aims to provide a high quality confidential service to all users and to tackle alcohol misuse in Shetland by the provision of a quality one-to-one counselling service for individuals who misuse alcohol.

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other in order to solve their common problem and help others to recover from alcoholism.

Shetland Community Drugs Team (SCDT) is a voluntary organisation offering confidential counselling, support, information, advice and practical help to anyone with a drug related problems, their family, partner or friends.

NB. Shetland Community Drug Team (SCDT) and Shetland Alcohol Support Services (SASS) are about to merge and rename as Community Alcohol and Drugs Services Shetland (CADSS).

Services specifically offering psychological therapies (see also Tiers 3 & 4):

include Psychological services within **general practice** and provided by the **Community Mental Health Team (CMHT)**,
Primary care counselors,
Shetland Art Therapy.

Shetland art therapy offers a range of services including, stress management for individuals, organisations and staff groups, individual art psychotherapy and counselling, group therapy, hypnotherapy and relaxation, supervision for those working in caring areas, and specialist help for a range of presenting issues. The service works with adults, adolescents and children throughout Shetland, mainly by referral from GPs, Social Workers or Schools, self-referrals are accepted in some cases. Therapy is provided at Market House or other places according to clients' needs.

For children and young people: the **Consultant Clinical Psychologist for Children and Young People**, and the **Community Psychiatric Nurse** (CPN) working within the **Child and Adolescent Mental Health Team** (see Chapter 17).

'Psychological Interventions' in this document refers to a range of skills, competencies and interventions based on identified psychological concepts and theory, which have been acquired through training and maintained through supervision. They can be delivered by a wide range of professionals who have undertaken such training, and who maintain skills through professional development and appropriate clinical and practice supervision. They can be delivered in different settings, and at differing levels of competency depending on the specific professional training of the person delivering the service, and at different levels of intensity depending on the persons needs and which service tier they fit into (For example, Clinical/Counselling Psychologists, Counsellors, Psychiatrists, Specialist and Mental Health Nurses, Psychotherapists, members of the primary care range of other Mental Health and non-Mental Health professionals working in a variety of services and settings.)

Services offering physical methods of treatment include prescribing via general practice and the CMHT (also in Tiers 3 & 4).

Gaps Identified Locally

There seems to be a gap locally between people coming off benefits and moving gradually and in a supported manner into work prior to getting and sustaining employment.

There is a need for a befriender/support type role to get the client 'ready' to access support say from Shetland Link Up or to take up employment via the Moving On Employment Project.

The issue of short-term funding within the voluntary sector is a problem for sustainability and long term planning.

Signposting and coordination – there is a need for better signposting to the range of services on offer, both for professionals and people themselves to help them access the appropriate service (though this might in part be the function of the Mental Heatlh Forum and Partnership).

At present there are no clinical psychology services available on island in Shetland for adults, other than elements of the Child and Adolescent service that works with families (this links to Tier 3 service provision).

Clinical psychology services aim to enable indvidual service user to have the necessary skills and abilities to cope with their emotional needs and daily lives in order to maximise psychological and physical well-being; to develop and use their capacity to make informed chocies in order to enhance and maximise independence and autonomy; to have a sense of self-understanding, self-respcet and self-worth; to be able to enjoy good social and personal relationships; and to share commonly valued and environmental facilities.

Clinical Psychology services aim to enable other users to develop psychologically-informed ways of thinking; to use psychological knowledge to enhance and develop their professional practice to the benefit of their clients; to be able to enhance their sense of self-understanding, self-respcet and self-worth; and to use psychological data to aid decision-making at a clinical, organisational and societal level.

Developments driven by national policy which are relevant to our local needs

Mental Health Delivery Plan Target

Peer support workers (expert patients) – trained staff who themselves have experience of mental illness as part of the care team – training programme nationally and employment in some Boards by 2008:

Shetland Link Up recently conducted research among their service users to discover what they had experienced as most helpful to them when distressed. Again and again it was reported that contact with others who had similar problems had been their most valued source of emotional and psychological support. Although since 2004 Link Up has employed people who are themselves recovering from mental health problems, it was decided, in response to the research, to establish three part-time posts specifically for Peer Support, without other duties or responsibilities. Recruitment is targeted at those already showing an interest and aptitude for this work by working as volunteers at Link Up, who are 'less far along the road to recovery' than other staff. Training will include ASIST and MHFA plus any training that may become available locally in Recovery.

National Commitment 3: We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes, who are identified under the new QOF arrangements.

National Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.

Actions proposed

To understand the role of peer support and explore a voluntary / community organisation based model of peer support workers in Shetland.

To develop the layered matched / stepped care approach through the primary care health worker model as it applies to Shetland. This role might include the coordination and signposting functions identified as local gaps.

> Mind Your Head are currently working with NHS Primary Care Counselling Service and the Community Mental Health Team to develop a new post – MYH Support Worker – who will provide information, signposting to other services, one to one support to individuals with mild to moderate mental health problems who can be encouraged to undertake self help programmes.

Introduction of formal assessment tool within general practice and Integrated care Pathway (ICP) for depression and anxiety within stepped care model.

Current GP counselling service, and Shetland Art Therapy, a well as the possiblities for future clinical psychology service provision, to be included in review of local provision of psychological therapies.

Tier 3

The network of specialists / secondary care

Elements of core services currently provided

Tier 3 describes the provision of an integrated range of community, day and in-patient services (some also described in Tier 2).

The local adult **Community Mental Health Team** (CMHT), consists of a Consultant Psychiatrist, Community Psychiatric Nurses (CPNs), and a specialist Social Worker. It provides both office based and home appointments, with out-patient clinics being held in all Health Centres throughout Shetland.

The CMHT provides appropriate services for adult patients over the age of 16 with serious mental health problems, including:

- Psychotic disorders
- Mood disorders including treatment resistant depression
- Disabling anxiety, obsessive-compulsive disorder, etc
- Suspected or established progressive cognitive impairment
- Alcohol or drug misuse coexisting with other serious psychiatric disorder.
- Asperger Syndrome when coexisting with serious psychiatric disorder

Local services for children and young people are described in Chapter 17.
NB There is close liaison and flexibility between the young people's and adult services for those between the age of 16 and 18.

Focused time limited interventions are delivered to people with mild and moderate mental health care needs, provided locally by primary care with support from the CMHT where appropriate.

The aim is to work as a resource network: integrated, multi-agency (joint health and social care team) and co-ordinated person-centred care with a focus on using community-based resources.

The team will provide care that is focused towards the values outlined in the Mental Health Nursing Review (Rights, Relationships and Recovery) and work towards meeting the indicators put forward by the Scottish Recovery Network. The team acknowledges that using a recovery-orientated approach is the best way of enabling people to return to living a meaningful and satisfying life.

Specialist visiting Consultants provide Clinical Psychology and Psychiatry Services to the Learning Disability Adult Client group and to the area of Neuropsychology for Adults.

Tiers 3 – The Network of Specialists / Secondary Care

The CPNs operate a liaison system for accessing urgent help and advice in a dedicated timeslot, Monday to Friday, 9-5.

The locally based consultant psychiatrist is available to provide advice and access to community and appropriate in-patient facilities – in-patient services provided in NHS Grampian at Aberdeen. This is available on a 24 hour, 7 day a week basis when (s)he is on call. At other times this service is accessed through the duty psychiatrist in Royal Cornhill Hospital. There is a “first contact” system for accessing a Mental Health Officer (MHO) on a 24 hour, 7 day a week basis.

Members of the CMHT provide an assessment service, including contributing towards or leading the Single Shared Assessment process and associated care management, using the Care Programme Approach – multi-agency care planning and delivery tailored to each individual service user, with involvement of the user and their families / carers.

The team also manage the requirements of the mental health legislation (see also Tier 4).

The CMHT services include psychological therapies (also referred to in Tiers 2 & 4), such as psychotherapy, hypnotherapy, cognitive behaviour therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), Thought Field Therapy (TFT), Schema Focussed Therapy and family therapy, and these therapies are used for a wide range of patients, both individually and in groups. At present there is no regular input to the team from clinical psychologists, unless specific out of area referrals are made to mainland services. With regards to using psychological assessment tools, the team routinely use Beck's Suicide inventory when assessing people presenting with self harm in the Gilbert Bain Hospital as well as using a Multimodal Life Inventory when assessing people with personality disorders. They also use tools such as the Hospital Anxiety and Depression Scale (HAD), the Beck Depression Inventory (BDI) and Mini Mental State Examination (MMSE) amongst others when relevant.

Regarding working with people with schizophrenia and other psychotic illnesses, the team are using psychosocial interventions through the joint work carried out at Annsbrae.

Symptom management courses are run regularly to enable patients to play a more active role in recognising and managing their illness which is seen as "psychological relapse prevention therapy".

Services also include offering physical methods of treatment eg prescribing (also referred to in Tiers 2 & 4).

The **Dual diagnosis service** for people who have a problem with alcohol misuse and co-existing mental health problems, offers advice on the medical management of alcohol dependency and mental health problems, and provides psychosocial interventions, as well as liaison with and referral into other services (see also Chapter 11.

Developments driven by national policy which are relevant to our local needs

National Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.

Recovery Indicators The values and principles of recovery are increasingly sited in mental health services. The development of recovery indicators will help to to assess the extent to which recovery principles are being realised in practice.[38] [39] The Scottish Executive Health Department is committed to delivering these indicators. The next stage of implementation will involve testing the adapted tool in four Health Board areas to assess it's appropriateness and to consider how best to ensure that its use promotes positive change. The tool should be in general use across Scotland by 2010.

National Commitment 8: Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009

Gaps identified locally

The current on-island specialist services are fragile with lone specialist practitioners working within the team (Consultant Psychiatrist, Consultant Clinical Psychologist for Children and Young People), and this poses potential problems for recruitment and retention, professional isolation, and for the sustainability of the service.

There is currently no on-island provision of Clinical Psychology services to adults including input to other services eg pain service.

There is insufficient trained staff time with specific skills, for example Cognitive Behaviour Therapy to use for treating eg people with depression, post traumatic stress disorder and eating disorders.

There is an identified need for more developed crisis response – support out of hours 24-hour, 7 day a week, for people in crisis including those presenting with self harm, with attempted suicide, and intensive community support as an alternative to hospital admission.

The possibility of the provision of a multi-agency resource centre with Day Hospital and appropriate Place of Safety facilities.

There is a gap in the lack of contribution of other therapy services such as occupational therapy, to the community mental health team.

Actions proposed

Review the range of psychological therapies available locally, with a view to redesigning the current service provision to increase the availablity of evidence-based therapies.

Tiers 3 – The Network of Specialists / Secondary Care

This may include considering the role of partner organisations such as the NHS24 proposal for the development of a Cognitive Behavioural Treatment (CBT) Service, which might include Telephone CBT Counselling, Computerised CBT, Bibliotherapy and signposting (into services).

It will also include future planning for availability of specialist clinical psychology services to adults (linked into workforce developments through current local training of graduate clinical psychologists, and the work of NHS Education Scotland (NES) in developing the psychology workforce nationally).

Review local crisis support services: an exercise involving assessing specific local needs for crisis intervention in relation to mental health and also other problem such as substance misuse. Also investigating numbers of 'workforce' currently available on 24 hour basis and what training needs they have.

Develop local crisis support services, including out of hours, working jointly between the local CMHT and voluntary organisations, on the basis of the local needs assessment, including the potential for a staffed residential service and alternatives (expressed as a perceived need), and the proposals for suicide prevention and attempted suicide crisis support.

Plan for best models for future staffing – clinical and management, considering the fragility and long-term sustainability of local specialist services. This may include seeking external help (such as the Joint Improvement Team – a Scottish Executive support), to develop a local model appropriate to the Shetland context, making the most of networking opportunites, and specifically addressing the needs of single-handed specialist practiioners (such as the Consultant Psychiatrist in the adult Mental Health Team, the Consultant Clinical Psychologist working with children and young people, and the Communtiy Psychiatric Nurse working with children and adole scents).

Tier 4

Specialist area-wide or supra-specialist services

Specialist services available locally include:

Co-ordinated and timely management of the requirements of the mental health legislation (also in Tier 3, see Chapter 16 for more detail)

Specialist services organized at national and regional levels include:

Forensic psychiatry and the treatment of mentally disordered offenders: adults within the criminal justice system who have mental illness are referred into the forensic psychiatry services via NHS Grampian, and in-patient facilities for these patients are organised regionally (for low and medium secure facilities) or nationally (for high security facilities). There are currently plans being developed for a Medium Secure Unit based in Tayside to serve the north of Scotland (at the stage of agreeing the Business Case via the North of Scotland Regional Planning Group).

Eating disorders service: currently there are no specialist in-patient services for people with eating disorders within the NHS in Scotland, and plans are in place to develop an NHS in-patient facility in Aberdeen for adults age 16+ with severe eating disorders (10 in-patient beds and 6 day cases). This service development will include networked support for services provided in local areas.

Access to in patient mother and baby services is via NHS Grampian.

Specialist in-patient Child and Adolescent Mental Health Services are provided regionally and nationally, and are detailed along with plans for development within the CAMHS strategy – summarised in Chapter 17.

Common Elements

In assessing the needs of a population for a comprehensive community based mental health service, in reshaping existing services, and in delivering services, there are certain processes which will have a critical impact on the success of the venture. These relate as much to the 'how' of what is done as to the 'what'.

These process elements are:

- the rights of people within services;
- the interface between primary care, secondary care and social work with clear access into services and support between / out of services – pathways involving people who receive services and those who care for them; particularly in transferring from in-patient services and aftercare/resettlement issues;
- joint commissioning;
- effective leadership and management;
- quality assurance;
- information systems which includes monitoring informaiton about services and their use, and information about services for users and about mental health and illness;
- staff supervision, development and training; and
- measurement of outcomes.

Some of these process elements are dealt with in other sections, with associated challenges or developments identified, but there are specific elements and actions that are described here and directly reported into the action plan.

1. Improve Patient and Carer Experience of Mental Health Services

In developing ‘Delivering for mental health’, the strongest message heard was that service users and carers still had experiences of the mental health system that did not match their expectations and the commitments of public and other bodies.

Some of this came through in the local needs assessment, with an expressed need to look at befriending schemes/advocacy schemes and other support including social and employment support, as a whole. The ideal would be for support of this type built into individual care plans on the basis of assessed need, and that client and carer based needs assessment findings would be used to influence development of strategy and services. We need to acknowledge that one size doesn’t fit all, so there needs to be a range of this type of service, including peer support, specifically developed through working with employers and the voluntary sector.

Vision

- Service users and carers are treated equitably and with respect (in terms of gender, age, race, sexuality etc).
- Service users and carers are given enough information to be able to make decisions about their care and supported in making decisions.

Common Elements

- Being able to meet the needs of all clients and age groups including those with specific needs.

The Scottish Executive has made the following commitments:

National Commitment 1: We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010.

National Commitment 2: We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas later that year.

There is a view in Shetland that there is a particular role for peer supporters who have developed expertise through experience, recognising that the Scottish Executive expects there to be an infrastructure within which they work which would include training and potentially employment.

Personal comment:
It seems to me that the big issue is the mismatch between "assessed need" (i.e. where primacy is given to the view of the professionals involved) and "expressed need" (i.e. the view of the service user/carer).

It is a truly radical idea to give genuine priority to people's experience of what helps them most (or that they expect to help them most), rather than what WE think will meet the needs that WE assess them as having; and we may fear that people will have irrational and excessive expectations, demanding resources that are costly and unjustifiable, and will have little impact on their condition.

Having a foot in both camps, I would challenge this fear. In my own case I have chosen to take much less than has been offered to me, and am content with my recovery. Thinking is increasingly moving towards the recovery model, where the subjective experience of quality of life is more important than the objective management of symptoms.
We would expect a woman to make her own decision about whether she will have her breasts removed, lose all her hair, or spend months on end feeling sick, because it may lengthen her life. The decision about whether she wants a longer life on such terms is a spiritual or existential one, not a medical or technical one. In the case of mental distress, there is often a similar (though perhaps less extreme) trade off between medical treatment and quality of life. Undoubtedly medication often improves a person's quality of life, but I get to meet quite a few people who are not so sure. Okay, folk can (if they are confident enough) exercise their choice to refuse treatment up to the point where compulsory powers get used (though this is far from inevitable!), but refusing the treatment that the professional thinks will meet their need can mean that they are labelled as uncooperative, incompliant, or somesuch, and find themselves on the margins, being offered no other kind of support. There is considerable pressure to submit to mental distress being medicalised - even the benefit system encourages a sick role.

It seems to me that there should be a dialectical relationship between service providers and service users. There must be a dynamic interplay between the experience and expertise of the 'expert by training' on one side and that of the 'expert by experience' on the other. In person-centred counselling, Carl Rogers speaks of the wisdom of the client; it is axiomatic that the client is the expert about themselves. To work with people in this way calls for patience and humility, and the acceptance that our particular service may not work for some/many people. Few would disagree with that idea in principle, but they might object if one then said that resources should go to what IS valued/needed/experienced as helpful and healing BY THE CLIENT.

So what am I saying? Not that I know best what people find (or have found) most helpful, but that we need to ASK them, in a way that is anonymous and independent, and we need to take seriously what they say. My experience of evaluating Art Therapy last year left me in absolutely no doubt of its merit in the view of those who have used it. It is cheap, highly valued by users, but if the Charitable Trust hadn't bailed it out, Art Therapy could have been lost.

I support the idea of looking at what everything costs and aiming to allocate resources to services in proportion to the number of people who value them as helping them, with the proviso that there is a statutory obligation to provide a basic level of certain services even if users do not often value them very highly (assessments under the mental health act come to mind).

To return to the issue at hand, if users and carers are disappointed in services, we need to do some serious and independent research and be prepared to follow and invest in what that research reveals - which also means being prepared to downsize or phase out the least valued services. At present very few services are evaluated by or answerable to their users. There is a huge power imbalance, users may be able to make decisions (even if it's only to 'take it or leave it'), but are they offered real choices??

Actions proposed

To understand the potential local role of peer support and explore a voluntary / community organisation based model of peer support workers in Shetland.

The development of Integrated Care Pathways (ICPs) with patient and carer involvement.

To comply with national quality assurance assessments eg on inclusion, user rights

The Scottish Recovery network[40] is developing a Performance Indicator tool on recovery which we will use in due course to assess our local services.

To develop links with the **Children's Rights Service.**

To develop links with **Deaf Club** – making sure people's voices and opinions are heard.

2. Tackling Stigma / Awareness Raising

Elements of services currently provided:

There are a range of local services described in Tiers 0 & 1 above:

See Me Campaign & guidance for journalists – a national publicity programme with local and national anti-stigma action. Individuals who have experienced stigma are involved in many aspects of the campaign, which includes those prepared to talk to the media about the impact stigma has had on their lives.

Mind Your Head campaign – a local initiative whose main aim is to raise awareness of mental health issues in Shetland and help reduce the stigma that exists.

Common Elements

Workplace activities including employment support / **Managing Healthy Working Lives.**

Programmes to develop emotional well-being.
Bullying/Harassment policies in place.
Links to social inclusion and diversity schemes.

Gaps identified locally

There continues to be stigma and taboo surrounding mental ill health. We need to be able to speak more freely and acknowledge mental health problems.

For some, there is fear of mental ill health.

We need to increase feelings of inclusiveness in our local community for those with mental health problems.

Actions proposed

Better information and awareness raising to reduce stigma and develop mental health awareness, including working with the press, and mental health services advertised better.

Develop positive media relationships campaign at local level.

Link with Diversity action plans in promoting inclusion and tolerance.

3. Training, Skills Development and Workforce Planning,

National policy includes:

> National sponsored Leadership Programme[41] - developing local mental health service clinical and management leadership.
>
> Mental Health Nursing national policy: Rights, Relationships and Recovery, The Report of the National Review of Mental Health Nursing in Scotland.[42]
>
> Workforce planning for psychology professionals.[43]
>
> Collaboratives: a method of improvement where teams, including front line staff use a variety of design tools and techniques to diagnose the cause of waits and delays and then test potential solutions through small scale rapid cycles of change.
> The Programme will also apply other collaborative ways of working, for example, by sharing ideas, information and change management knowledge.

National Commitment 2: We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas later that year.

Common Elements

There are a range of local training and skills development programmes in place across all the tiers of service, from community based training at Tiers 0 and 1, to networked links for mentoring and professional development between local specialist professionals and mainland specialist services for instance to NHS Grampian Cornhill Hospital for members of the Community Mental Health Team. National workforce development and training to implement Delivering for Mental Health has already provided local benefits, for instance by supporting local training of clinical psychology graduates.

Gaps identified locally

Incomplete mapping of mental health training needs – there are issues around the sustainability of current training programmes and gaps/overlaps in training providers.

We need a strategic approach to training to make best use of specialist expertise and available resources.

Specific gaps in training:

- Range of short course training on specific mental health topics for non-specialist staff
- Training for staff in Gilbert Bain Hospital in dealing with mental health emergencies
- Mental health nursing training in line with national policy
- A perceived need for training and support on mental health issues for staff in general services, and clearer referral routes into more specialised services
- The original remit of the specialist nurse in alcohol post included acting as a training resource for other staff. So far the clinical workload has made it impossible to develop this.

Specific workforce gaps:

The small scale of local specialist services, and the remoteness of Shetland from mainland specialist services mean that local services are fragile and vulnerable in terms of sustainability – in recruiting and retaining key staff, and in the isolation of specialist practitioners.

There are some specific gaps in the local workforce, for instance in the absence of Clinical Psychologists for adults, in peer support workers, and in the Primary Mental Health Worker role.

Actions proposed

Coordination and development of local training available to make best use of resources, including

- Training in initial mental health assessment of people presenting to Gilbert Bain Hospital by Senior House Officers and/or non-specialist nurses to determine pathway for management. This should tie in with ICPs once they have been developed.

Common Elements

- Develop and make available short course on depression, anxiety and stress – awareness raising for generic staff in other services.
- ASIST, MHFA Training & STORM development plans.
- Tapping into/ building on voluntary sector skills. For instance, Mind Your Head (MYH) is involved with ASIST through current training commitment and paying half the local delivery costs (given that ASIST fits well into MYH aims and objectives). MYH would like to be involved in the development of further training/ awareness raising workshops offered in the community.

Specific training actions for Child and Adolescent Mental Health Services (CAMHS) within the CAMHS strategy.

Rights, Relationships and Recovery Action Plan for mental health nursing to include:

- Values-based training to be provided for all mental health nurses
- Training in recovery-based practice for all mental health nurses
- Training in mental health nursing care of older people and crisis care
- Training in psychosocial interventions and psychological therapies for mental health nurses
- Nurse prescribing extended to mental health nurses
- Development of nurse consultants
- Increase numbers of mental health support workers and development of appropriate training for them.
- Access to leadership development for mental health nurses
- Clinical supervision training available for mental health nurses.

The development of Peer Support workers (expert patients) – trained staff who themselves have experience of mental illness as part of the care team as part of the national training programme. Plans within local voluntary sector – Shetland Link Up, to extend their current service model into a formal peer support worker scheme.

To review training needs associated with Crisis Care proposals.

To review models for future local specialist staffing, specifically psychiatry and clinical psychology, in terms of the strengthening and sustainability of the local service.

4. Information Sharing

Shetland **Data Sharing Partnership** is agreeing formal policies and procedures for data and information sharing between local agencies: a draft policy is currently in process.

An Integrated Assessment Framework for children and families has been developed and is being introduced. This is a multi-agency process which will identify the needs of a child or young person and a support plan will be agreed. This may result in links to specialist services, or into the Local Support Networks - a community based early intervention service for children and young people aged 0-20 who require planned input to ensure their fuller participation in community life.

A Single Shared Assessment process is in place for adults; it has recently been revised and training is being updated.

Specific work on looking at information sharing and learning lessons from sudden deaths in Shetland has taken place via the Sudden Deaths Group which has now been subsumed within the local Choose Life Group.

Gaps identified locally

Specialist assessments do not link well into the Single Shared Assessment (SSA) process: a Specialist Mental Health SSA would have been welcomed and has been suggested to the team revising the SSA. Some elements relating to people with Mental Health problems have been incorporated into the revised SSA, but a specialist one is not being considered at this time.

Actions proposed

Develop interagency information sharing protocol (currently in draft form) and its application within Integrated Care Pathways (ICPs).

Either develop the links between the Single Shared Assessmen (SSA) process and more specialist assessments or develop specialist Mental Health SSA, which could be developed alongside required new Mental Health assessment and recording documentation as a result of the development of ICPs.

Service Profiles

There are groups of individuals who share a pattern of more complex needs. The following section describes current services, gaps and future developments for each of these groups:

Adults with mental health problems

General services for adults with mental health problems are described as Tiers 1, 2 & 3 services.

5. Responding better to depression, anxiety and stress

Depression, together with the related conditions anxiety and stress, is the most common mental health problem or illness in western industrial nations. The World Health Organisation says that by 2020 it will be the number one form of disability.

In Shetland it is believed that there may be significant unmet need in relation to people suffering from depression. Because of the nature of the condition, particularly in small communities, it may be that people do not always present themselves for diagnosis and treatment. It may also be that there is considerable community resilience that means people are able to deal positively themselves with the situations that might present as depression. Or it may be that the range of therapies people would want to access are not available (for instance psychological therapies, or that people are reluctant to accept medication).

The current data gathered from general practice shows that 112 people were recorded as presenting to their GP with a new diagnosis of depression in 2006 – 07.

NICE guidelines gives the point prevalence (number suffering at any one time) of depression amongst 16 to 65 year olds in the UK as 17 per 1,000 for males and 25 per 1,000 for females. When anxiety and depression are mixed the prevalence rises to 71 and 124 per 1,000 in males and females respectively. Based on these rates, Shetland would have the following numbers at any one time:

Illness	Males	Females
Depression	125	522
Anxiety/Depression	174	858

The Scottish Executive has made the following commitments:

National Commitment 3: We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes, who are identified under the new Quality Outcome Framework (QOF) arrangements.

Of the people in Shetland recorded by their GP via QOF as presenting with a new diagnosis of depression, in 2006/07 62% were assessed using a formal assessment tool.

National Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.

Our vision and current provision of services can be described as:

Tiers 0 & 1: Work to promote resilience and capability to reduce the likelihood that people will develop these disorders;

Tiers 1 & 2: offer support to reduce their impact;

Tiers 2 & 3: offer an effective treatment and therapy response.

There is a significant body of knowledge supporting the use of specific psychological interventions in the treatment of common mental health problems such as depression and anxiety:

- awareness raising,
- information and advice leaflets,
- guided self-help,
- cognitive behavioural therapy, problem solving,
- interpersonal therapy and mindfulness.

The Doing Well by People with Depression[44] programme and the subsequent National Evaluation Report published in 2006[45] encourages us to address needs using a stepped care approach and provide a range of appropriate treatment and therapy options within an integrated care pathway for depression.

New patients presenting with depression will have a formal assessment using a standardized tool and a matched therapy according to need; in line with **NICE Guidelines on Management of Depression in Primary and Secondary Care – the Stepped Care Approach**. [46] ***47*** [48]

Treatment models will also be identified or developed for those with depression and anxiety and CHD / diabetes; with links to population approaches on exercise, diet and alcohol misuse. These will be monitored nationally and locally via the general practice Quality Outcomes Framework (QOF) indicators in the GP (General Medical Services - GMS) contract.

The Mental Health Delivery Plan gives us a target of:
Increasing the availability of and access to evidence-based psychological therapies and support for self-care.

The Mental Health Delivery Plan also now targets anti-depressant prescribing: to reduce the year-on-year increase in prescribing of anti-depressants and to improve the fit between guidance on best treatment and practice.

Situation in Shetland and services currently provided

- Attitudes to mental ill health have already changed and are changing further in raised awareness, and a rising profile for support (eg via the **Mind Your Head** campaign).
- The community informally supports people, but we know that there are individuals and households living in situations of deprivation or exclusion in Shetland that can exacerbate, or be exacerbated by mental illness and distress, including depression.
- Health Promotion – currently delivers **ASIST** and **Mental Health First Aid** training within Shetland. Provides advice and information on promotion of mental well-being.
- **Shetland Link Up** provides support to adults experiencing or recovering from mental distress or at risk from social isolation, through informal groups, via telephone and email.
- **Sexual Abuse Survivors** provide a women only survivor group, a mixed group for men and women and a parents group for parents of children who have been sexually abused by other people. These groups encourage the sharing and use of coping strategies. A local web-site www.sasurvivors.com has recently been launched.
- **Women of Worth** is a group run for women by women, particularly those who have had damaging relationships with men. Clients are aged mainly 20-65, Shetland wide, who have experienced emotional difficulties or problems with mental health and wellbeing.

GPs and **Primary Care Teams** in Shetland are currently the initial route for assessment, diagnosis and treatment for people with depression, anxiety and stress through the NHS, though people may self refer for support to voluntary sector organisations.

- **Primary Care Counselling Service** – provides one to one short and long term counselling and psychotherapy to the 16+ age group. This service currently has a long waiting list, with referrals being made only by GPs.
- **Community Mental Health Team** provide specialist mental health services including psychological and physical (prescribing) treatments. This would include medication management, symptom management, hearing voices work, Eye Movement Desensitisation and Reprocessing (EMDR), Thought Field Therapy (TFT), Hypnotherapy, limited CBT and psychotherapy approaches and Schema Focussed Therapy.
- Pre- and post-natal depression: **midwives** and **health visitors** are in a unique position to provide support to parents and families, and to link parents into additional support at an early stage. Some specific interventions are currently used in Shetland: local midwives routinely use the Edinburgh Postnatal Depression Scale (EPDS) to identify women at risk of depression, to then refer them into appropriate support services, and health visitors follow up vulnerable women and families from the first year of a baby's life.
- **Anti-social behaviour programme** – designed to reduce or prevent behaviour within the community that causes or is likely to cause alarm or distress to others.
- There are also links to be made with **substance misuse** and **dual diagnosis services.**

Gaps identified locally

- More commitment from generic services and non-mental health specialists to address mental health needs within their areas of practice, for instance identifying risks such as self harm and suicide, directing people to appropriate services, offering direct support, training and awareness in bullying, dealing with stress or aggression, management and workplace policies, developing resilience and emotional intelligence.
- Support to access activities: social, employment etc to alleviate loneliness, anxiety and depression, including befriending for people with mental health problems. For instance the Moving On service gets referrals from individuals who are not yet ready for Moving On's service and there is no befriending available for individuals to help them get to readiness for formal services.
- Identifying levels of mental illness such as depression within local communities to get a true picture of the extent of unrecognised and undiagnosed mental illness in Shetland.
- Earlier and effective intervention for depression / anxiety / stress through assessment and awareness raising.
- Development of a stepped approach within an Integrated Care Pathway – so that someone presenting with depression/anxiety can readily access initially self-help and supported self care, be formally assessed and then be offered an appropriate range of therapies within a reasonable and agreed time period
- The challenge of the national commitment to increase the range of psychological therapies in place – recognising that current provision in Shetland is patchy and not strategically planned or co-ordinated. This would need to include specific interventions such as Cognitive Behavioural Therapy (CBT) for people with mild to moderate depression.
- 24 hour Crisis support - Working group to be established to explore actual needs and how best to meet them.

Actions proposed

- Develop ongoing local needs assessment to build up a true picture of the pattern of mental illness including depression in Shetland, specifically to inform local service development against the national targets.
- Develop resources for supported self-help e.g. prescribing library, and development of localised promotional material.
- Promote the local development of the **Recovery Model**[49].
- Work with employers to have a better understanding of mental health issues to provide a healthy work place, via the **Healthier Working Lives** programme. This will include raising awareness regarding depression/anxiety/stress among employers and other agencies in Shetland; for example, a significant number of literacy learners have reported depression. Volunteer and sessional literacy tutors would find a 2/3 hour session on depression, anxiety and stress helpful in supporting these learners and developing their decision making skills.
- Develop an integrated care pathway for depression.
- Work with GPs to ensure that all new patients presenting with depression have a formal assessment using a standardised tool (in line with national guidance) and a matched therapy appropriate to the level of need via the stepped care approach[50]

Common Elements

- Review the availability of and access to evidence based psychological therapies*: including reviewing GP counselling service, community mental health team provision, bereavement support, art therapy, and other voluntary sector provision. This will be considered in the context of the stepped care approach and the development of a local ICP, and training issues will also be considered as part of this work. It will also take into account the national work in National Health Education for Scotland (NES) which is developing training and support for practice in this area, focussing initially on improving service capacity to deliver psychological therapies for the adult patient population in primary care with mild-moderate mental health problems (principally anxiety and depression). The NES work will also review the needs of young people with mental health difficulties in primary care and the role of health psychologists in public health.
- Local multi-agency work on developing guidelines for professionals working with young people on responding to self-harm or suicidal behaviour will be re-activated and is included as an action in the Child and Adolescent Mental Health Strategy action plan.
- Review prescribing of anti-depressants within the care pathway and against evidence-based best practice guidance.
- We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes, who are identified under the new QOF arrangements. This may include consideration of the role of an adult clinical psychologist or a health psychologist.

6. Improving the physical health of people with mental illness

Those who suffer from mental illness have greater risk of, and higher rates of, heart disease, diabetes, respiratory disease and infections. They also have higher rates of smoking, alcohol consumption and drug misuse. They die younger and have a poorer quality of life.

People with a physical illness who present to a general hospital who have a mental health problem, including those who self harm, are recognised within the national framework as a target group who have complex needs.

The Local Delivery Plan for Mental Health:
National Commitment 5: we will improve the physical health of people with severe and enduring mental illness by ensuring that every such patient where possible and appropriate has a physical health assessment at least once every 15 months.

The services provided to meet this commitment are described within Tiers 1 and 2: that is within general practice and community services, but this commitment applies to people receiving services across all the Tiers.

Situation in Shetland

The general practice **Quality Outcomes Framework** (QOF) gives practices standards for the services they provide to meet Commitment 5, and we currently know that 76% of people in Shetland suffering from psychoses as defined within QOF (schizophrenia,

* This will include developing a common understanding of what is meant by 'psychological therapies'. See Appendix 1 for definitions.

bipolar affective disorder and other psychoses) have had a review within the last 15 months that has included health promotion and prevention advice.

Anecdotally there is good continuity of care between patients and practices particularly in the rural areas. Shetland has a more stable population than many other areas of Scotland. The **Men's Health project** has succeeded in getting GP practices in touch with a greater number of patients not routinely seen, but the local research on Deprivation and Social Exclusion in Shetland[51] also identified a number of individuals and households who were excluded from mainstream services, and whose physical and mental health were issues in their exclusion. Though an audit of people who were registered as homeless in Shetland undertaken as part of the local Health and Homelessness strategy showed that 100% were registered and actively in contact with GP services.

There are local chronic disease management programmes in place, which have developed from Managed Clinical Networks on the topics of Coronary Heart Disease (CHD), stroke and diabetes, and are now being planned within the Community Health Partnership (CHP) as the **Long Term Conditions (LTC)** programme. Development of the programme includes completing a baseline assessment of the existing services which support long term conditions management. This baseline review has been completed against national standards set out in the **CHP Long Term Conditions Toolkit.**

The CHP LTC baseline review is the basis from which a structured approach to LTC services will be developed across Health and Community Care services. This initial project was completed in May 2007 and the wider aim is to develop an overarching strategy and service model for all services aligned to LTC management by the end of 2008. This work is being undertaken as an interagency project and is directed through the CHP management team.

The LTC strategy and associated action plan will therefore include the objectives and deliverables set in other strategies which support long term conditions including the mental health strategy. The LTC model also strives to strengthen links between existing services, map clinical pathways and agree the process through which the whole population can be stratified to ensure that resources are targetted at appropriate service development. These should address the targetting of vulnerable groups including those with mental illness within their programmes.

There are also a range of general health promoting programmes and initiatives in Shetland, which have a direct effect on the health of people taking them up, though services do not generally monitor uptake specifically for people with mental illness. Examples include **smoking cessation support** services, and the **exercise on referral scheme.**

Mind Your Head have established links with **Shetland Recreational Trust** (SRT) in relation to the **Annual Spiggie Fun Run/Walk**. While this is a fund raising activity it is more importantly an awareness raising opportunity. This year SRT have offered discounts at all leisure centres to all those signing up for the event. While people with mental health difficulties have not been specifically targeted, promotional activites have included statistical and evidence-based information relating to mental health, suicide and the benefits of physical activity in relation to positive mental health. MYH aims to continue building on the links made locally and nationally.

There are also some specific local initiatives that are helping improve the physical health of people with mental illness: for instance results from the evaluation of the pilot of the job crew approach to supported employment within the Moving On project showed clients felt that their health problems and fitness levels had improved.

The Gilbert Bain Hospital give immediate care to people presenting with self harm, and themn liaises with the Community Mental Health Team (or the Child and Adolescent Mental Health Team) for assessment and follow-on care.

Gaps identified locally

Increase in physical problems may require more support at home/residential care for older people or those with severe physical disabilities, who also have a mental illness. Theoretically care homes can provide this support but in practical terms there may be problems in looking after peoples mental ill-health as well as their physical needs which need additional training or staff supervision.

Management of Self Harm – local procedures need to be developed and agreed jointly between the Community Mental Health Team and Gilbert Bain Hospital service, to formalise the current arrangements, and to ensure that appropriate crisis support is available at all times.

Some training has been delivered in managing self harm, but this needs updating and a more active programme developed.

Actions proposed

To review, with GPs and the Community Mental Health Team, contact with people with severe and enduring mental illness, to include physical health assessments.

To work with GPs to implement physical health assessment for all people with severe and enduring mental illness every 15 months where possible and appropriate.

Work is developing in NHS Grampian on diet and exercise for service users which will benefit Shetland residents who are staying in Aberdeen services as in-patients.

To consider the options for developing a project such as the Well-Being Support programme run by South London and Maudsley NHS Trust.[52] The aim of the programme is to improve general physical health and also to detect any underlying physical conditions that require treatment. It works with people with serious mental illnesses, such as schizophrenia or bipolar affective disorder to educate and motivate people and work with them to achieve a healthier lifestyle as well as addressing any side effects they may be experiencing because of their medication.

Ensure that treatment models for those with depression and anxiety and CHD/diabetes link to population approaches on exercise, diet and alcohol misuse, and that the chronic disease management programmes monitor and target vulnerable and potentially excluded people, including those with mental illness.

7. Better management of long-term mental health conditions

People with severe and enduring mental illness: a diagnosis of severe and/or enduring clinical depression, bipolar affective disorder, schizophrenia and other psychoses, have a pattern of illness that may require life long care, and are particularly vulnerable in terms of accessing service for their physical health. They also have the highest risk amongst the population of committing suicide.

National Commitment 6: NHS QIS will develop the standards for Integrated Care Pathways (ICPs) for schizophrenia, bi-polar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.

Standards for Integrated Care Pathways (ICPs) for schizophrenia, bi-polar disorder, depression, dementia and borderline personality disorder are being developed by NHS Quality Improvement Scotland (NHS QIS) to be completed in 2007. An ICP sets out the process of assessment, care and treatment for service users with similar diagnoses or symptoms. It lets service users know what they should expect from services. It should set expectations for the local management and organization of care and act as a point of comparison for treatment and care provided. A good ICP will look beyond treating the disorder and will focus on the full range of needs and capabilities of the individual.
NHS QIS are not writing national ICPs, but are describing the functions of the services and setting standards which individual boards will need to meet to be accredited.
QIS will support NHS Board areas in the preparation and implementation of local ICPs and will accredit that process. The ICP standards will have three elements: process standards for developing an ICP, care standards for the content, and the service standards for demonstrating quality improvements. These will be in place by the end of 2007.

The implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 has particular implications for some people with severe long term mental illness.

Situation in Shetland and current services

- Many people with mental health issues have support within the community in Shetland, both informally and via community groups and voluntary organisations - **Tier 1 & 2 services.**
- Local services are evolving and changing to improve.
- The perception of most service providers is that most people with severe and enduring illness receive the support they need, using the care programme approach.
- There are specific support services in place:
  Annsbrae House – support to tenants and an outreach service prevents the need for hospital or 24 hour residential care.
  Local **Echoes** – voice hearers support group which provides informal peer support.

- Of the people currently identified by GPs in Shetland as having the major mental illnesses of schizophrenia, bipolar affective disorder and other psychosis, who require and have agreed to regular follow up, 76% were recorded as having had a review in the previous 15 months. These reviews include general health advice, and also details of their individual care plan as agreed between the individual, their

family and / or carers as appropriate. The QOF standards also encourage practices to follow up those people with the major mental illnesses who do not attend for review or mental therapy follow-up..

Gaps identified locally

- More promotion of healthy lifestyle choices for people with long-term mental health conditions.
- Promote the concept of recovery from long term mental illness and support people to take responsibility for their own health.
- Housing - There is not high demand for specialist housing, as most people prefer to stay in own homes with support. The expansion of Annsbrae service would mean greater access to support out of office hours.
- Better understanding and awareness of early intervention and support within community services.

Would like to see these services based within the community to give it the feel that mental health is everyday life and not a clinic you pop to when it's too late.

Quote from needs assessment

- Services tend to be centralised in Lerwick, and there is a perceived lack of support of services in remote and rural areas outwith Lerwick, both generally such as transport services to work or social events, and specifically eg access to specialised services.

You can try to get an appointment to fit in with the weekly bus trip - you have to plan when you're going to be ill!

Quote from local Deprivation Research Project[53]

- A perceived need for training and support on mental health issues for staff in general services, and clearer referral routes into more specialised services.
- Consistency of care through the different stages of care – which will be addressed by the local development of ICPs.
- Improve interagency information sharing protocol to benefit clients and improve provision for them.
- A recognition that off-island services can be seen as a problem for people eg needing in-patient admission or the more specialised **Tier 3 & 4** services.
- A perceived need has been raised for the development of locally based 24 hour supported accommodation for those with more severe mental health problems, which might include options for adult fostering for people with long-term mental health conditions, and links into the need for crisis support.

Challenges

We recognise that not all Tier 3 & 4 services can be based locally, because of specialist expertise available in regional or national centres, or within services that serve a larger population (regional and national services):

- what more can we do with the expertise and resources we have on-island to prevent referrals off-island eg In-Patient admissions – crisis support, intensive community case management, earlier intervention, preventative work?
- what can we do to improve the experience of people receiving services off-island to counter the negative effects of the experience – tele-visiting, after-care, information about services, ICP for smooth transitions?

Actions proposed

- To make sure this strategy considers the range of care and treatment options available including on island, off island, 24 hour supported accommodation, hospital based, community based, with a view to best using the available resources and expertise to provide as much range and choice of effective service as possible.

- Action on Crisis support: as in Tier 2 services above: Develop local crisis support services, including out of hours, working jointly between the local CMHT and voluntary organisations, understanding local needs, including the potential for a staffed residential service and alternatives (expressed as a perceived need).

- Develop and implement integrated care pathways (ICPs) for schizophrenia, bi-polar disorder, depression, dementia and personality disorder.

- Develop interagency information sharing protocol (currently in draft form) and its application within ICPs.

8. Early detection and intervention in self-harm and suicide prevention

This chapter is based on Choose Life[54] - a Scottish Executive-led 10 year plan aimed at reducing suicides in Scotland by 20% by 2013. It forms a key part of the National Programme for Improving Mental Health and Well-Being Action Plan[55] in Scotland.

The strategy and action plan aims to ensure we take action nationally and locally to build skills, improve knowledge and awareness of 'what works' to prevent suicide, improve opportunities to prevent premature loss of life and provide hope and optimism for the future

Choose Life Objectives

- Early prevention and intervention
- Responding to immediate crisis
- Improving support for hope and recovery
- Providing support to those who are affected by suicidal behaviour or a completed suicide
- Awareness raising and encouraging people to seek help early
- Supporting the media in reporting of suicide
- Knowing what works

Choose Life Priority Groups

- Children (especially looked after children)
- Young people (especially young men)
- People with mental health problems
- People who have attempted suicide
- People affected by the aftermath of suicidal behaviour or completed suicide
- People who abuse substances
- People in prison

Evidence shows that people with a mental illness are the highest ‘at risk’ group for suicide, with a rate of suicide 10 times that of the general population. In terms of diagnosis and risk, the most at risk groups are those with a diagnosis of severe and/or enduring clinical depression, followed by bipolar affective disorder, schizophrenia and other psychoses.

Commitment 7: Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes. 50% of target staff will be trained by 2010.

Current situation & services currently provided

The activities in Shetland aimed at preventing suicide and self-harm are planned and monitored within Shetland’s Choose Life Strategy and Action Plan, which is supported by a local co-ordinator and overseen by a multi-agency group which now reports into the Mental Health Partnership.

Common Elements

- **Mental Health First Aid (MHFA)** is the help given to someone experiencing a mental health problem before professional help is obtained. The aims of MHFA are:

  - to preserve life where a person may be a danger to themselves or others
  - to provide help to prevent the mental health problem developing into a more serious state
  - to promote the recovery of good mental health
  - to provide comfort to a person experiencing a mental health problem.

  MHFA does not teach people to be therapists. However, it does teach people:

  - how to recognise the symptoms of mental health problems
  - how to provide initial help
  - how to guide a person towards appropriate professional help.

- **ASIST training:** ASIST (Applied Suicide Intervention Skills Training) was developed in Canada. It offers a suicide intervention training programme that is suitable for both professional and other caregivers. It focuses on developing 'first aid' skills that can be used for anyone who is at risk of suicide. It is being rolled-out in Shetland (as in Scotland) with an extensive programme funded nationally for 3 years from 2005.

- Generic mental health and other services in Tiers 1, 2 & 3 (including **general practice**, the **Community Mental Health Team**, the **Child and Adolescent Mental Health Service** and **Primary Care Counselling**) provide support to people with mental illness who are at risk of suicide or self harm, and prevent escalation particularly in those with severe and enduring mental illness.

- Within **Annsbrae** there is a temporary 0.5 WTE social care worker employed through Choose Life. Their role is to provide a rapid response to people referred to the CMHT or currently accessing the CMHT who are in crisis and at risk of suicide or self harm. The funding for this post will cease in January 2008.

- A second temporary 0.5 WTE post has just been recruited to to provide social care and support to people who abuse alcohol and have mental health problems (**Dual Diagnosis**). This person will be based in the CMHT and work with the Specialist Nurse for Alcohol and the Dual Diagnosis CPN.

In addition there are a number of specific support services not necessarily targetted at suicide prevention but providing services that will help with this issue or working with the priority groups:

- **Shetland Youth Information Service** provide a young persons' counselling / support service. They aim to increase access to counselling to reduce the risk of suicide and deliberate self-harm, increase self-esteem, and increase self-confidence and enhance coping skills among young people.

- **Shetland Link Up** provide support to adults experiencing or recovering from mental distress or at risk from social isolation, through informal groups, via telephone and email.

Common Elements

- **Shetland Bereavement Service** aim to increase access to bereavement counselling to reduce the risk of self-harm and suicide and to increase people's coping skills following a bereavement.

- **Sexual Abuse Survivors (SAS) Group** provide a women only survivior group, a mixed group for men and women and a parents group for parents of children who have been sexually abused by other people. These groups encourage the sharing and use of coping stragegies . They also aim to increase confidence knowledge and self-esteem among people affected by childhood sexual abuse and increase access to support services to reduce the risk of self-harm and suicide.

- Within the CMHT one CPN has completed training in Eye Movement Desensitisation and Reprocessing (EMDR Level 2) which is essential for working with people who suffer from complex traumas caused by sexual abuse. This has increased the CPN's ability in treating people who have experienced complex traumas and are suffering from post traumatic stress disorder (PTSD). It also provides increased support for existing and new SAS Group members which in turn will reduce incidents of self-harm and suicide among survivors of sexual abuse; increase coping skills of members.

- **Shetland Alcohol Support Service** (SASS) aims to provide a high quality confidential service to all users and to tackle alcohol misuse in Shetland by the provision of a quality one-to-one counselling service for individuals who misuse alcohol; advice support and counselling to families friends and partners; the promotion of alcohol awareness and health education in alcohol matters; the provision of education training and advice on alcohol and sensible drinking and a drop-in service.

- **Shetland Community Drugs Team** (SCDT) is a voluntary organisation offering confidential counselling, support, information, advice and practical help to anyone with a drug related problems, their family, partner or friends. They also provide an education and information outreach service and a mobile needle exchange service to drug users not currently accessing SCDT's Lerwick based services, to be able to respond to immediate crisis, ensure that those experiencing crisis will have access to appropriate and prompt support outwith Lerwick and outwith SCDT hours if appropriate and to increase access to support to reduce the risk of self-harm and suicide.

  NB. Shetland Community Drug Team (SCDT) and Shetland Alcohol Support Services (SASS) are about to merge and rename as Community Alcohol and Drugs Services Shetland (CADSS).

- Self-harm/suicide response guidelines are being written by multi-agency group for children and young people.

- Follow up after suicide is sometimes done by family GPs in Shetland, particularly if an existing relationship exists with the person or family (more common in rural areas). Similarly for the Community Mental Health Team. There is not a standard or 'norm'. However, Shetland does have guidelines on support for the newly bereaved in Shetland within its Palliative Care Strategy[56] which focusses on bereavement due to cancer, and this policy could be extended to include suicide/sudden deaths.

Gaps identified locally

- Awareness and education for families and the community about mental illness, suicide risks and supports.
- Awareness about mental health and specifically about suicide risks in general services including the police.
- Access to services – better public transport.
- Making the most of primary care services in assessment and early intervention eg a request for longer appointment with GPs to enable fuller discussion and assessment.
- Waiting times for counselling – at present people have a long wait to be assessed within the Primary Care Counselling Service. This varies from health centre to health centre – as of June this can be as long as 5 months in Scalloway, Levenwick and Brae and currently 4/5 months in Lerwick. The service would like to undertake a redesign to make it possible to give everyone an assessment within 2 weeks of referral - this would then aid signposting to self help, other agencies etc. This ties in with the proposed Mind Your Help pilot project (see Chapter on Service Tiers 1 & 2) .
- Specific supports for people at immediate risk of suicide or around episodes of self harm.

Actions proposed

- Continued public debate and awareness raising is needed, linked to other actions on tackling stigma – making best use of the media and awareness raising:
    - using opportunities such as 'speakeasy' on local radio;
    - Continue to use media guidelines re. reporting suicide – these work well in Shetland

See also actions in Tier 1 and service profile on stigma and awareness raising.

- Guided self-help – needs to be developed

- Building community capacity using tools such as ASIST, MHFA and STORM

- **STORM:** Skills based training on Risk Management (STORM) is a suicide prevention training package for frontline workers in health, social and criminal justice services. It focuses on developing, through rehearsal, the skills needed to assess and manage a person at risk of suicide. The STORM package is designed to be flexible and adaptable to the needs of a service. Training is cascaded throughout an organisation, with four members of staff becoming facilitators and delivering STORM to the remainder of the workforce. This is currently being assessed for its appropriateness to Shetland.

- Training in suicide prevention for front-line staff:

  ASIST: The evaluation of ASIST highlights the importance of concentrating additional efforts on those groups at highest risk of suicidal behaviour. This includes people with mental illness. The plan is to extend ASIST training and target suicide prevention training to those working in the frontline of mental health care services, primary care and accident and emergency services. This will concentrate on improving the

assessment and management of risk of suicidal behaviour and self-harming behaviour, particularly people whose self-harming behaviour puts them at high risk of suicide.

- Develop a pathway and immediate support services for suicide prevention and management of attempted suicide.

- Understand better the immediate response to suicide/sudden death for practical support and offer of emotional support. Extend the 'Support for the newly bereaved in Shetland' policy which focusses on bereavement due to cancer, to include suicide/sudden deaths.

9. Manage better admission to, and discharge from, hospital

Ensuring that local crisis services are functioning effectively: to have rapid, same day response times, provide intensive specialist input of assessment, treatment and risk management including that for self-harm, in a community setting, and focus on those people who might otherwise require admission to hospital.

The National Standards for Crisis Services[57] are now published (developed by the Mental Health Foundation and the Scottish Association for Mental Health) as of November 2006. http://www.sehd.scot.nhs.uk/mels/HDL2006_62.pdf

Commitment 8: Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009.

Commitment 9: We will establish acute inpatient forums across all Board areas comprising service providers, service users and carers as well as other stakeholders such as Local Authority colleagues.

Local situation and services currently provided

The functions of an acute admission ward are to provide support and treatment in an acute phase of illness when it is no longer possible to provide safe effective care in the community.

At present, the Community Mental Health Team in Shetland manages patients in crisis or with worsening mental illness, and liaises with the in-patient service in Aberdeen for admissions and discharges back into the community in Shetland.

Patients awaiting transfer to Aberdeen are cared for within the Gilbert Bain Hospital which acts as the local place of safety, specifically also in the terms of the Mental Health Act for people detained under section.

Gaps identified locally

There is a local issue around provision of a formal place of safety on Shetland – there are limits to the current provision in Gilbert Bain Hospital, for patients/clients pending transfer to mainland in-patient service.

Common Elements

See other sections, specifically: Better management of long-term mental health conditions, Tier 3 services and the proposals for crisis support.

Crisis Service Proposal from Shetland Link Up

Shetland Link Up have developed a proposal for a crisis service, which aims to:

a) Respond immediately to requests for help
b) Avert the onset of an 'acute episode' or 'relapse' by earlier response to distress
c) To reduce the number of people presenting to the Accident and Emergency Unit whose needs do not include emergency medical treatment.
d) To shorten the length of stay in psychiatric hospital for some patients by providing a staging-post for reintegration into the community, during which time local support networks can be (re)activated.
e) To enable children to maintain contact with their parent.
f) To provide a place of safety, a refuge or sanctuary, away, if possible, from burdensome responsibilities and stressful relationships, but accessible to supportive relationships.
g) To help people formulate and start to implement plans to resolve their state of crisis and find better ways to stay well.
h) To allow and encourage clients to retain and recover as much independence and responsibility for themselves as possible.
i) To offer a flexible and creative response to individuals' needs and circumstances, giving priority to their perspectives, hopes and fears.
j) To dedicate staff time to respond directly to clients and not be distracted or diluted with other duties.
k) To facilitate access to and uptake of other supportive services within Shetland.

Actions proposed

Monitor admissions and repeat admissions to in-patient services on a regular basis to help understand the effectiveness of local services.

Support the review of crisis support and out of hours services, including the development / introduction of the Crisis Support service proposal, and consideration of the possibility of locally staffed beds, and Out of Hours CPN cover. This will take into account the National Standards for Crisis Services to ensure that local service comply with the standards.

Establish active participation in the NHS Grampian Cornhill Hospital acute inpatient forum, and ensure that locally feedback and participation of service users and carers in service planning and redesign (via the Mental Health Partnership and Forum) takes account of in-patient experience.

10. Enhancing specialist services

The range of specialist services provided regionally and nationally include: forensic, eating disorders, specialist child and adolescent and perinatal services. National and regional planning has included analysis of specialist service needs and the actions required to meet those needs are being introduced.[5859]

Shetland is participating in this work via the North of Scotland Regional Planning Group, which plans specialist services on a regional basis for Highland, Grampian, Tayside, Shetland, Orkney and the Western Isles.

National programmes:
National Commitment 12: We will implement the new Care Programme Approach for all restricted patients by 2008.

Mentally disordered offenders

Following a public consultation on the creation of Community Justice Authorities (CJAs) in April 2005[60], eight local Community Justice Authorities (CJAs) have been established in Scotland to provide a co-ordinated approach to planning and monitoring the delivery of offender services by planning, managing performance and reporting on performance by local authorities or groups of local authorities. Their aim is to target services to reduce reoffending and to ensure close co-operation between community and prison services to aid the rehabilitation of offenders. Shetland is represented via the northern CJA based in Aberdeen.

Sections 10 and 11 of the Management of Offenders etc (Scotland) Act 2005 and Guidance on the Implementation of the Multi Agency Public Protection Arrangements (MAPPA) in Scotland[61] requires NHS Boards and Local Authorities to co-operate with the police and the Scottish Prison Service to jointly establish arrangements for the risk assessment and management of restricted patients, and offenders who are not restricted patients, including but not only mentally disordered offenders. This builds on previous guidance on sex offenders, and locally is enacted through a multi-agency group with health representation.

The number of violent mentally disordered offenders in Shetland is small. There is an inter-agency approach involving Social Care, Health and the Police, working with both violent and vulnerable mentally disordered offenders.

More specialist health services for mentally disordered offenders for Shetland are provided off-island within specialist in-patient **Tier 4** services with potential links back into community care. For instance, currently arrangements are in place for the provision of medium secure beds at the Orchard Clinic in Edinburgh, while more detailed plans are being made to develop this service in Tayside to serve the north of Scotland. Shetland joins in regional and national planning for these and other highly specialised services via the North of Scotland Planning Group.[62]

Common Elements

Details of the national planning and professional collaboration on forensic services can be found via the National Forensic Mental Health Services Managed Care Network (Forensic Network) website www.forensicnetwork.scot.nhs.uk.

Gaps identified locally

- Need for medium secure accomodation in the north of Scotland.
- Need for NHS in-patient eating disorder services across Scotland.
- Specialist CAMHS services – in-patient children and young peoples facilities, to be developed within network approach to Tier 2,3 & 4 services.

Actions proposed

To make sure that Grampian includes Shetland in it's local provision for mother and baby services.

To include formalised communications and links with Grampian in the NHS Service Level Agreement.

To agree a local pathway for assessments between the local Community Mental Health Team and the local Court and Criminal Justice service.

To ensure compliance with legislation and guidance on the management of mentally disorderd offenders.

Contributing to regional development of medium secure facilities – funding for this is already included within the Local Delivery Plan.

> Current plans are to develop the Murray Royal Hospital site to incorporate reprovision of existing NHS Tayside secure care services with the added provision of a medium secure care service available to the populations of the North of Scotland NHS Boards including Shetland. Plans for the secure care development have been based on national policy and guidance, Mental Health (Care and Treatment) (Scotland) Act 2003 legislation and accepted best clinical practice. Aspects such as building design, functionality and proposed models of care are underpinned by national standards and benefit from experience gained from visiting a number of similar projects elsewhere in Scotland and the UK. Consultation has taken place with a wide range of stakeholders to help ensure the best possible outcome. The Scottish Executive approved the Outline Business Case in May 2006 and with a projected operational date of between late 2010 and spring 2011, the new clinic will be the third in Scotland providing regional medium secure care.

Contributing to regional planning for young peoples in-patient mental health services.
Contributing to national planning for childrens in-patient mental health services (see CAMHS strategy for more detail).

11. People with mental health problems who misuse substances or alcohol

National Commitment 13: We will translate the principles of Mind the Gaps[63] and a Fuller Life[64] into practical measures and advice on what actions needs to be taken to move the joint agenda forward and support joined-up local delivery by the end of 2007.

The Scottish Executive is currently consulting on the guidance to implement this commitment.[65]

Evidence suggests that alcohol misuse is strongly connected with mental health problems and vice versa. The relationship between these conditions is highly complex. Alcohol misuse often complicates the diagnosis and treatment of mental health problems, and people with mental health problems are less likely to have their alcohol problem diagnosed. Outcomes of treatment for this complex group with a "dual diagnosis" are significantly poorer, including worsening of psychiatric symptoms, increased use of institutional services, poor medication adherence, poor social outcomes and increased risk of violent and suicidal behaviour[66].

There are a number of pathways that can lead to an individual having coexisting mental health and alcohol problems:

- individuals who are mentally unwell may drink to self medicate, either to alleviate psychiatric symptoms or to counter side effects of medication;
- individuals with mental health problems often become socially isolated and alcohol may be used to facilitate social interaction or as a method of coping with the experiences associated with a mental health problem;
- alcohol is a depressant and long term alcohol misuse may lead to feelings of depression which can be impossible to distinguish from primary clinical depression;
- hangovers can have very powerful effects on mood and alcohol withdrawal can cause confusion, extreme anxiety and psychosis;
- longstanding alcohol misuse can lead to permanent organic brain damage;
- in addition, the family members of problem drinkers show high rates of attendance at primary care often with symptoms related to anxiety and depression.

The current service

NHS Shetland Alcohol Services are based in the Community Mental Health Department at the Health Centre in Lerwick.
The NHS service in Shetland consists of three elements:

- The **Dual Diagnosis Service** for people who have a problem with alcohol misuse and co-existing mental health problems, offers advice on the medical management of alcohol dependency and mental health problems, and provides psychosocial interventions. It refers on to other mental health and alcohol support services.
- The **Alcohol withdrawal service** for people who may need medical assistance to withdraw from alcohol is provided by the Specialist Nurse in alcohol misuse. This includes assessment and advice, supervised planned withdrawal in the community, and advice to GPs supervising community withdrawals, as well as liaison with other services.
- The **CRAFT** programme is a brief skills based programme for relatives or friends supporting individuals with alcohol problems.

- **Shetland Alcohol Support Service** (SASS) aims to provide a high quality confidential service to all users and to tackle alcohol misuse in Shetland by the provision of a quality one-to-one counselling service for individuals who misuse alcohol; advice support and counselling to families friends and partners; the promotion of alcohol awareness and health education in alcohol matters; the provision of education training and advice on alcohol and sensible drinking and a drop-in service.

- **Shetland Community Drugs Team** (SCDT) is a voluntary organisation offering confidential counselling, support, information, advice and practical help to anyone with a drug related problems, their family, partner or friends. Where access to project based services is problematic arrangements may be made to meet you in your own home or another mutually convenient and confidential place. They have recently undertaken work to provide an education and information outreach service and a mobile needle exchange service to drug users not currently accessing SCDT's Lerwick based services. The purpose of this is to be able to respond to immediate crisis, ensure that those experiencing crisis will have access to appropriate and prompt support outwith Lerwick and outwith SCDT hours if appropriate and to increase access to support to reduce the risk of self-harm and suicide.

  NB. Shetland Community Drug Team (SCDT) and Shetland Alcohol Support Services (SASS) are about to merge and rename as Community Alcohol and Drugs Services Shetland (CADSS).

Gaps identified locally:

- Significant numbers of unplanned ad hoc and relatively unsupported alcohol withdrawals are still taking place within Shetland, losing an opportunity to encourage people to plan realistically for the post withdrawal period and reduce their chance of future relapse.
- The specialist nurse in alcohol misuse post is single-handed and has no long term funding attached (funded until May 2008). There is no provision for providing the service during leave periods and the geography of Shetland means that it is not possible to provide an equivalent level of assessment, monitoring and support for patients in the more remote rural areas, especially the island populations. An attempt has been made to identify and train members of the community nursing team to provide some support for the specialist nurse, but so far with limited success.
- The original remit of the specialist nurse post included acting as a training resource for other staff. So far the clinical workload has made it impossible to develop this.
- Geography and transport difficulties are likely to make it impossible for the part time support worker to provide on going psychosocial support for people in the more remote rural areas. For the same reasons these are also the people for whom access to the voluntary sector agencies such as the Shetland Alcohol Support Services and Alcoholics Anonymous (AA) is most difficult.
- Limited capacity of the current services to cater for people with severe need requiring inpatient withdrawal and/or residential rehabilitation. There are strict limits on the number of residential placements that can be funded each year. It is currently impossible to admit people for planned inpatient alcohol withdrawal within Shetland and the difficulties of travel down to an inpatient unit on the mainland for

an alcohol dependent patient and travel back at the time of maximum vulnerability to relapse when the need for seamless supportive psychosocial care is at its greatest, poses particular problems for this group.

- There is no agreed protocol in Shetland for the use of naltrexone as second line relapse prevention drug for patients in whom acamprosate is either ineffective or contraindicated – governance of one aspect of the pharmological management of drug dependancy.
- Uptake of the the CRAFT programme for the supporters of people with problematic alcohol use has so far been low, which we suspect is due to lack of awareness rather than absence of need.
- There are currently no formal services to support people with a dual diagnosis of drug misuse and mental health problems.

Actions proposed

- Consider the development of formal dual diagnosis provision for people with drug dependency and mental health problems.
- Support clinicians within Shetland in encouraging patients to embark on planned and adequately supported alcohol withdrawals.
- To develop a sustainable service through securing long term funding and staffing support for the post of specialist nurse alcohol misuse and the support worker post.
- To develop an agreed protocol for the pharmacological management of drug dependencies.
- To work towards developing capacity to provide planned inpatient withdrawal within Shetland.
- NHS Shetland Alcohol Services to continue to work to develop collaborative working with Shetland Alcohol Support Services.
- increase public awareness of the availability of the CRAFT programme for the supporters of people with problematic alcohol use.

12. Improving services for older people with mental health problems, including early onset dementia

Mental health and ageing

People's experience of mental health in later life is influenced by many factors. These include personal beliefs and societal attitudes, culture and ethnicity, class, geographical location and marital or family status, as well as physical and mental health, financial security and access to support and services.

The challenges for society and for services are to:

- Promote age equality in all services
- Work with the media to improve portrayals of, and public attitudes towards ageing and older people
- Educate and train all staff who have direct contact with the public to value and respect older people

Common Elements

- Promote intergenerational activities to strengthen understanding and respect between younger and older people
- Teach younger people about ageing so that they can prepare themselves for good mental health and well-being in later life
- Ensure that health promotion: active ageing programmes promote mental as well as physical health and well-being in their design, delivery and evaluation
- Ensure that mental health promotion programmes include and provide for older people
- Encourage work practices that support a healthy work-life balance for employees, as a contribution to long-term mental health and well-being
- Provide pre-retirement information and support for all employees
- Encourage and support older people to take advantage of opportunities for meaningful activity, social interaction and physical activity; and provide information, advice and support to enable people to claim the benefits to which they are entitled.

National Commitment 14: We will work with the Dementia Services Development Centre at Stirling University and NHS Forth Valley to undertake a pilot programme in improving dementia services. The pilot will be evaluated in 2008.

"**Older and wiser**"[67] detailed findings from the Mental Welfare Commission report on visits to NHS continuing care wards for older people. Key messages for service providers included:

- The assessment and provision care for people in continuing care wards should be driven by need, not by resources. While adequate resources are essential not all improvements are expensive. Small changes can make big improvements to the quality of life for people living in continuing care wards.
- Staff want to provide excellent care in the right kind of environment but feel constrained by limited resources. Staff need support to improve existing care environments.
- Many of the wards visited did not provide information to patients and relatives in an accessible manner.
- The information available in all of the wards we visited was only in English.
- Relatives we spoke to were very positive about staff but thought that they should be able to spend more time with patients.
- Service providers should take a fresh look at the environment of their continuing care wards and use the extensive guidance available to see how their facilities match up to best practice standards.
- Methods of the assessment of care needs varied greatly between different wards providing essentially the same service. The introduction of the NHS Quality Improvement Scotland Integrated Care Pathway standards for dementia care will provide an opportunity to ensure best practice in assessment.
- Greater use of life histories would help in the assessment and provision of care and treatment.
- Nutrition and hydration are essential to care. Too many wards reported difficulty in making sure that patients are getting all the help they need with eating and drinking.
- Physical and mental activities for patients are valued by patients themselves, relatives and staff. However, options appear to be limited in many wards and too few patients are involved.

A local action plan had been developed to work on the findings which have relevance to local services, and key points are summarised in the actions proposed below.

Dementia:

In Shetland, the Dementia Services Redesign Project was established in April 2006 with a remit to:

"Assess and redesign services for people with Dementia living in Shetland, specifically -

- All stages of dementia excluding mild cognitive impairment;
- Investigations and interventions in which direct benefit to the patient can be demonstrated; and
- Palliative care in advanced disease."

The project has described local needs and plans for people with dementia. It concluded March 2007 with a final report, since which a management response to the issues raised within the Project has been agreed, with actions agreed and progress to date as well as a way forward to address the outstanding issues of concern. These are specifically two substantial pieces of work still to be done to explore:

- Future models of service delivery
- Future accommodation options.

The work will be linked to the Long Term Care Review that will identify options for future models of service provision to replace two local care homes, one of which (Viewforth) currently provides specialist care to people with dementia.

Some of the recommendations from the project and actions arising are detailed below.

Actions proposed

Links made within health promoting activities for mental health and older people.

Consideration of the needs of older people in the development of specialist mental health services – for instance psychological therapy for clients who are older and who have neurological damage and degenerative conditions, and the need for cognitive therapy for older people with depression.

Action plan to implement 'Older & Wiser' findings of the Mental Welfare Commission report on visits to NHS continuing care wards for older people that includes:

> A Hospital Capital Plan that would see the relocation of our continuing care ward from Montfield Hospital to the Gilbert Bain site. As well as bringing about a number of patient benefits, the proposed relocation of continuing care beds will look to provide an care environment that enhances service quality and improves the patient's experience of health care.
>
> Development of written information provided to patients receiving continuing care.

Action plan to implement the redesign of services for people with dementia.

13. People with a learning disability who have mental health problems

National policy in Delivering for Mental Health poses the following challenges to local services for people with a learning disaibility who have mental health problems:

- Age appropriate (under 18) community and inpatient services - in place and available.
- Good access to adult Learning Disability inpatient assessment and treatment beds. (No use of inappropriate general psychiatry in- patient beds).
- Local Authority able to support appropriate provision for those no longer requiring in patient treatment.
- Full range of treatment services in the community including crisis response services.

This builds on earlier policy that has guided local agencies in the delivery of overall services to people with learning disabilities, such as The Same as You?[68].

Current Services

A Learning Disability nurse provides local services within NHS Shetland.
A visiting Consultant provides Clinical Psychology Service to the Learning Disability Adult Client group.
The Child Psychologist sees children and young people with learning disabilities.

There are an extensive range of care and support services in place in Shetland for people with learning disabilities, and these are detailed in the Shetland Extended Local Partnership Agreement and Community Care Plans.

Gaps identified locally

People with learning disability who have challenging behaviour and mental health needs require improved access to evidence based support and services. Evidence shows that challenging behaviour does not respond to short and medium term interventions and requires a sustained approach over decades, with amongst professionals, an emphasis on the need to share and build on positive practice.

There is a feeling that people with Asperger's Syndrome fall between mental health and learning disability services. We need acknowledgement that they may need Mental Health services – all services need to take responsibility for trying to meet these needs.

Actions proposed

- Shetland Islands Council is continuing to develop a range of accommodation and day opportunities for people with learning disabilities. A full description is available in the Partnership in Practice (PiP) agreement.

- Given the extremely low numbers of people with learning disabilities to date who cannot be supported in Shetland within established resources, their needs can be considered on a case by case basis between the relevant agencies and appropriate solutions agreed.

- More consistent access to primary healthcare by people with learning disabilities will be promoted by work being carried out via the CHP.

- Members of the Community Learning Disabilities Team will be participating in a local exercise to promote awareness of the needs of people with Asperger Syndrome to frontline staff.

14. Homeless people with mental health problems

The Local Health and Homelessness strategy[69] and planning within Shetland's Housing and Homelessness strategy[70] outline current services and development for homeless people, including those with mental health problems.

Housing Outreach Support Services are available to all those who are homeless or at risk of homelessness. The service is registered with the Care Commission. The outreach workers provide a range of support to their clients including help with day to day tasks such as budgeting and cooking and also support them to access other services including health services. There is also access to independent advocacy services for all homeless applicants.

There are initiatives to improve the social networks for homeless people, for example the Shetland Islands Council has a Service Level Agreement with the Shetland Befriending Scheme to ensure that all homeless young people aged 18-25 can access befriending services. There is also a football team for homeless people and a token scheme to enable them to access the leisure centres, both provided through the Outreach Service.

Housing staff are invited to mental health training courses such as Mental Health First Aid and ASIST, and they are also keen to encourage clients to attend these courses.

In addition, there are links between the Outreach Service and the local Drug and Alcohol support services.

An audit of homeless people in Shetland reported that 100% of those registered as homeless at that time were registered with a GP and in active contact with health services.

15. Mental Health & Employment

We know that a range of the factors that can influence the development of mental illness and promotion of mental well-being, both in terms of risk and protection, are related to work and employment. We also know that employment can be key to recovery for many people suffering from mental illness, and programmes to maintain employment or to facilitate re-entry into the labour market can be very effective in supporting social inclusion. For many people, a significant component of positive mental health is productive employment.

Common Elements

There are specific actions that employers can take to improve mental health within workplaces e.g. through anti bullying strategies, and mental health or stress management strategies.

Employment has a role in improving the quality of life of those people experiencing mental health problems, for instance in job retention and rehabilitation.

Occupational Therapy in Mental Health is concerned with helping people to recover ordinary lives that have been affected by mental ill health[71]. Occupational Therapy practice in the field of Mental Health is based on an understanding of the relationship between occupation, health and wellbeing, and a belief in the potential of people with mental health problems to learn and grow. Health and wellbeing are supported by engagement in a balanced range of occupations that are chosen and valued by the individual. In order to meet the occupational needs of the people they serve, Occupational Therapists work in partnership with clients, carers and colleagues to provide creative solutions to problems of daily living.

Under the Mental Health Care and Treatment Act 2003 2.1 'Local authorities have a duty to assist individuals to begin or continue in work including helping to prepare for employment, move into employment or find the support individuals need to continue in employment'.

Local situation and services currently provided

Workplace activities identified in Shetland to promote positive mental health and well-being (Tier 0 services) include:

Supporting and developing emotional well-being through good working practices and policies.

Tackling bullying / harassment – policies in place (links to social inclusion and diversity schemes).

The **Healthy Working Lives**[72] (HWL) award scheme is in place in Shetland and now includes a component on promoting postive mental health in the workplace. The scheme is one programme within the national initiative of the Scottish Centre for Healthy Working Lives, which was set up to improve the health of working age people in Scotland by ensuring healthier and safer workplaces, promote healthier lifestyles and to develop the field of employability throughout Scotland.

Within existing NHS Shetland Occupational Therapy services, the individual service user's mental health issues are identified as important in relation to their impact on occupational performance and addressed by implementation of appropriate interventions or advice sought from other professional colleagues to ensure a holistic approach.

The Moving On Project: The core functions of Moving On are to offer a client centred, confidential employment service which is unique to Shetland, by identifing suitable work, employer matching and providing hands on support to assist the individual in settling into their work placement as long as is required. Also to actively target employers with the capacity and resources to offer meaningful employment opportunities for service users to develop their skills, confidence and self esteem. Over 50% of the Moving On Employment Project's caseload of over fifty individuals have mental health problems.

Moving On has developed the job crew approach to supported employment where teams of clients with disabilities including mental health problems, support workers and volunteers work together as a group on environmental projects, aiming to increase an individuals' confidence, employability skills and abilities. The project promotes social inclusion by using mobile and flexible job crews in remote and rural areas to undertake work in communities.

On evaluation clients appear to benefit greatly from the service offered from Moving On, with 84% of those who responded stating they were helped a great deal or quite a bit by the advice and support given, with 92% satisfied with all aspects of the service provided and stating that gaining employment has resulted in much or some improvement in how they feel about themselves and their self confidence.

Condition Management Programme: this programme is being developed to be run jointly by Jobcentre Plus and NHS Shetland to work with people with health problems and disabilities to establish the most appropriate route to help them move back into work (where this is a realistic prospect).

The **Community Bike Project** offers voluntary and employed placements using partnership funding from Scottish Centre for Healthy Working Lives and Jobcentre Plus, to help people with mental health problems gain skills and confidence and enable them to get into mainstream employment. Referrals are also taken from Criminal Justice and local drug and alcohol misuse services.

Gaps identified locally

There seems to be a gap locally between people coming off benefits and moving gradually and in a supported manner into work prior to getting and sustaining employment.

There is a need for a befriender/support type role to get the client 'ready' to access support say from Shetland Link Up or to take up employment via the Moving On Employment Project.

The potential for Occupational Therapy service provision within Mental Health remains undeveloped at this time in Shetland, due in part to resource and manpower issues, but also the requirement to develop this service from inception with appropriate levels of professional consultation.

Actions proposed

To understand in more detail the local needs for befriending and support, including specific supports such as re-entering employment, with a view to supporting service development within the community / voluntary sector (see also Tiers 1 / 2).

Promote supported employment opportunities

Include the development of the Occupational Therapy service to people with mental health needs in collaboration with the Community Mental Health Team, in future planning for Occupational Therapy in Shetland.

16. Implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003[73]

The Mental Health (Care and Treatment) (Scotland) Act 2003[74] came into effect in October 2005. The Act contains much more than simply legislation for new forms of compulsory power and safeguards. Its underpinning principles herald a new era of rights-based care for people who use mental health services. The Act also has profound implications for service delivery. As well as providing care and treatment, services are now required to promote social inclusion and a wider citizenship agenda.

In 2005, 17.7% of males and 12.7% of females admitted to mental illness specialties in Scottish hospitals, were admitted under the Act.

Requirements of Act:

The Act covers a range of requirements and services, from the national function of the Mental Welfare Commission and the Mental Health Tribunal for Scotland, through Specialist Services such as the provision of Forensic services, to Local Authority and local NHS Board functions to implement the legislation on people with mental illness. It includes the requirements for emergency detentions and compulsory treatment orders,

In Shetland, Mental Health Officers employed by Shetland Islands Council work within the Community Mental Health Team, and along with (usually) the Consultant Psychiatrist who is an Authorised Medical Practitioner, are responsible for the detention of people with mental illness who need assessment or treatment under the Terms of the Act. This involves close liaison with the in-patient services in Aberdeen. The Gilbert Bain Hospital is used as a formal place of safety to look after people who are awaiting transfer to mainland services.

The Act describes the duties of Local Authorities in terms of care and support services, services to promote well being and social development, assistance with travel to access support services, and assistance with employment.

The requirements of the Act have raised a number of issues for the local service:

In the fragility of local specialist services, recognising the difficulties in recruitment and retention of the local Consultant Psychiatrist and the appointment of MHOs, given their importance in meeting statutory requirements.

In training: to continue to give local staff sufficient training and understanding relevant to their role, including generic staff eg in the Gilbert Bain Hospital in relation to its function as a place of safety.

We need to develop a robust approach to Named Person/Advance Statements.

We need to develop our support for patients receiving services under the terms of the Act, and their carers, where their care is in mainland services and the geographical situation of Shetland causes logistical difficulties in for instance Mental Health Tribunal hearings.

Video-conferencing facilities have been used to allow relatives to contribute to hearings in mainland services.

17. Children and Young People with mental health or behavioural problems

This chapter is a summary of the full Child and Adolescent Mental Health (CAMHS) Strategy, which has been developed in parallel with the Mental Health Strategy.

The vision for Child and Adolescent mental health services in Shetland is that our community itself, as well as all agencies and organisations, have a role in supporting the mental health of children and young people. We aim to address the whole continuum of mental health – from the promotion of mental health and well-being, through preventing mental illness, to supporting, treating and caring for those children and young people experiencing mental health difficulties of all ranges of complexity and severity.

The CAMHS Strategy involves the following key components:

- A continuum of care and support from pre-natal care through into adult services
- Supporting parents and children/young people at key transition points in development
- Developing resilience in children and young people as a core life skill
- A greater emphasis on supporting families, particularly families in which an adult has mental health problems
- The development of shared processes and protocols across agencies to complement the network of excellent personal relationships that exist across Shetland
- Working in partnership between the statutory sector services and the voluntary sector, along with the active involvement of children and young people themselves, and their families in both planning and delivery of services
- Creating a series of 'virtual teams' based around the network of local High Schools operating on the basis of joint responsibility and shared information, based on informed consent of children/young people and their parents
- Developing and sustaining greater capacity amongst generic staff in schools and community settings to allow more people to work with and support the emotional development of children and young people
- Developing and sustaining the capacity of specialist services, to make best use of resources and the local workforce.

National Policy

The key document guiding the development of the CAMHS Strategy is the National Framework**: The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care.**[75] This outlines the policy context in which we are operating for children and young people's mental health. It covers the range of children and young peoples health, from specialist services, additional and specific supports to community-based activity, with sections on school years and early years. There are many other relevant policy documents; information about these can be found in the full strategy document.

Epidemiology

As with all other mental health, Child and Adolescent Mental Health is difficult to measure, but national research and studies show that, in 2004, one in ten (10%) of children and young people aged 5–16 had a clinically diagnosed mental disorder: almost 4% were anxious or depressed, almost 6% had a conduct disorder, 1.5% had a hyperkinetic disorder, and 1% had a less common disorder[76] .

Up to one in three children with a conduct disorder had been excluded from school (ONS 2004).

Looked after children aged 5–10 were at least five times more likely than children in the general population (42% versus 8%) to have mental health problems. Among 11–15 year olds, the contrast was slightly less marked (49% versus 11%) (ONS 2004).

There are a range of risk factors that are known to contribute to poor emotional and mental well-being in children and young people.

Early Years

Interventions focused during pregnancy and at the time around birth are likely to be the most effective in preventing mental health problems of a child. Midwives and health visitors are in a unique position to provide support to parents and families, and to link parents into additional support at an early stage as it is recognised that good parenting is fundamental for the development of a child's mental health and wellbeing. There are a range of generic positive health improvement activities in Shetland, as well as a range of more specialised supports available. The Child Development Initiative exists for children with identified complex health needs as a multi-disciplinary, multi-agency assessment and care planning process led by the visiting Consultant Paediatrician, and supported by the locally based GP with a Special Interest in Child Health.

Some gaps include:

Access to services in remote areas
Childcare for children aged 0-3
Recruitment, training and support for foster and adoptive parents
Parenting Strategy.

Schools

NICE draft guidance on promoting the mental wellbeing of children in primary schools[77] suggests that schools can use whole schools approaches (universal), and indicated and targeted activities, focusing on particular types of behaviour or particular groups of pupils, in order to promote mental health and well-being for children and young people

The outcomes we are seeking include:

- emotional well-being (including happiness and confidence, and the opposite of depression)
- psychological well-being (including autonomy, problem solving, resilience, attentiveness/involvement)
- social well-being (good relationships with others, and the opposite of conduct disorder, delinquency, interpersonal violence and bullying).

Common Elements

The Health Promoting Schools programme is being rolled out in Shetland with a target of all schools included by December 2007. A pilot of outreach services to schools across Shetland is testing a model of 'link team' joint working between health visitors and schools with particular emphasis on mental health and well-being, and sexual health and other related topics.

Gaps include:

- development and promotion of a culture of resilience and emotional literacy;
- development of a more integrated approach between the Child Development Initiative (CDI) and Additional Support for Learning (ASL) - which should be achieved through the introduction of the Integrated Assessment Framework for children;
- a need to develop stronger involvement of young people themselves in promoting and supporting positive mental health.

Commitment 10: We will improve mental health services being offered to children and young people by ensuring that by 2008:

- *A named mental health link person is available to every school, fulfilling the functions outlined in the Framework.*
- *Basic mental health training should be offered to all those working with, or caring for, looked after and accommodated children and young people.*

Community

Local authority community learning and development workers (including youth workers), and those in the voluntary sector who work with young people, including volunteers, have an important role in promoting and supporting the mental health and emotional wellbeing of children and young people. General community capacity building work and adult learning provide valuable opportunities for those working and living with children and young people to develop a better understanding of what good mental health is, and how it might be improved in their own communities.

The *Step It Up*[78] materials, commissioned by the Scottish Executive in 2001, describe the purpose of youth work as:

• Building self-esteem and self confidence
• Developing the ability to manage personal and social relationships
• Creating learning and developing new skills
• Encouraging positive group atmospheres
• Building the capacity of young people to consider risk, make reasoned decisions and take control
• Developing a "world view" which widens horizons and invites social commitment.

Shetland has a strong and well resourced set of community resources for social activities such as music, drama and physical activity.

Some gaps include:

- A more integrated and planned approach to training needs

Common Elements

- Resources for supported self-help / resilience / development of emotional literacy
- Involvement of youth & community services in training and support

Additional and Specific Supports

Evidence suggests that some groups of children and young people are at greater risk of developing mental health problems than their peers. There is also evidence to suggest that some groups are likely to find more difficulty accessing support and help that they need. Additional or specific action is required to ensure that these children and young people are able to access support for their emotional and mental health and wellbeing across promotion, prevention and care.

The vision is that services work together to provide emotional and mental health support to vulnerable children and those with specific needs, and that all health assessments on children and young people include an assessment of their mental health, and link into appropriate support mechanisms.

Gaps include

- Establishment of formal shared assessment protocols and clear service/treatment pathways – within care pathways (now under development within the CAMHS team).
- More extensive provision of general training, consultation and support on the emotional and mental health needs of particular groups for the range of staff working with them including residential care workers, foster carers and adoptive parents, social workers, youth justice teams and, police.
- Accessible and confidential support for looked after and accommodated children and young people, those adopted from care, and those who have been abused.
- More extensive and systematic training, consultancy and support for staff dealing with vulnerable children and young people, and on specific issues such as self-harm, aggressive behaviour, ADHD.
- Early identification of children/young people with emotional difficulties and needs.
- Developing the role of Art and Music Therapy as specific responses/interventions for children and young people.

Specialist CAMHS

The primary function of specialist child and adolescent mental health services (CAMHS) throughout Scotland is to develop and deliver services for those children and young people (and their families and carers) who are experiencing the most serious mental health problems. Specialist CAMHS staff also have a very important role in supporting what the SNAP report called the “mental health capacity” of the wider network of children’s services.

Proposals are already in development nationally for a new Managed Clinical Network for children with severe and complex mental health problems, which Shetland will play in to.

Strengths:

- The local specialist CAMHS team is now supported by a visiting Child and Adolescent Psychiatrist who is providing clinical and strategic leadership to the team.

Common Elements

- There are strong working relationships between the local CAMHS team and other services, and the CAMHS team sits within the adult Community Mental Health Team, which should provide the opportunity for additional support and strong transitional arrangements into adult services.
- There are adult services in place that also support children & young people such as the Art Therapist.

Gaps include:

- Developing the resource within the CAMHS team to meet currently unmet needs
- Freeing up time of the specialist CAMHS team to support / supervise / train network of other workers – through the Primary Mental Health Worker model
- The need for the development of Family Therapy in Shetland
- Recognizing that more intensive local interventions may prevent the need for off island services including in-patient admissions.

Commitment 11: We will reduce the number of admissions of children and young people to adult beds by 50% by 2009.

An annual increase in primary mental health work which will account for 25% of specialist CAMHS activity by 2015

Summary and action plan

Overall, there is a strong foundation of services in Shetland, but there are key problems in capacity of the more specialised services within the Child and Adolescent Mental Health Team, which limits the delivery of support, training and resource development to those delivering universal and specific support services both within the NHS and in other agencies such as education.

There also needs to be more integrated working across disciplines locally, across the tiers of service and via linking into the development of regional and national networks.

General points are themes through the action plan:

Sustainable funding and therefore sustainable services.

The profile of children's mental health needs to be raised and maintained – the strategy should offer one lever for this.

A greater understanding of different professional and agency roles and responsibilities.

The need for much more multi-agency and multi-disciplinary training and development programmes.

Key actions for children and young people are included in the Action Plan to this strategy. A detailed Action Plan is included in the main Child and Adolescent Mental Health Strategy, and will be incorporated into the Integrated Children and Young People's Plan in future years.

i) ACTION PLAN

NB The Action Plan is written with the headings used in the main strategy document. Because of this, there are some repetitions of actions within different sections, included to ensure completeness, and a comprehensive approach within each subject area. The key actions in terms of service redesign or development are highlighted in bold.

Action	**Outcome**	**Lead Responsibility**	**Timescale**
Tier 0 services:			
Use the mental health and wellbeing indicators developed by NHS Health Scotland alongside local needs assessment to develop a summary mental health profile for Shetland	Understanding of local needs to inform local service development	Director of Public Health	Summer 2008 – subject to national timescale
Better information and awareness raising to reduce stigma and develop mental health awareness, including working with the press - positive media relationships campaign, and mental health services advertised better.	A positive and inclusive approach to mental health and mental illnesses in Shetland – so people feel able to ask for help and know where to go to get it.	Mental Health (MH) Partnership / Health Promotion Dept.	Strategy lifetime
Develop a Mental Health Arts Strategy jointly between the Mental Health Forum and Shetland Arts.	For the arts in Shetland to actively contribute to improving mental well-being	Mental Health Forum	Strategy lifetime
Undertake Training Needs Assessment in mental health improvement training & develop action plan.	A co-ordinated approach to achieve staff trained to actively improve mental health	Health Promotion Dept	December 2008
Promoting the model of Recovery within Shetland.	Attitudes to mental ill-heatlh and distress, and practice in mental health services promote recovery	MH Partnership	Strategy lifetime

Action Plan

Action	**Outcome**	**Lead Responsibility**	**Timescale**
Link with Diversity action plans and promoting inclusion and tolerance.	That people receive services that recognise and value their diversity	All	Strategy lifetime
To understand in more detail the local needs for befriending and support, including specific supports such as re-entering employment, with a view to supporting service development within the community / voluntary sector **see also Tiers 1 / 2**.	To have appropriate supports available to help people be included in social activities and employment	MH Partnership / local voluntary organisations	2008/09
Promote supported employment opportunities.	For everybody who wants it to be able to take up employment	Moving On	Strategy lifetime
Tiers 1 & 2 services:			
To understand the role of peer support and explore a voluntary / community organisation based model of peer support workers in Shetland.	To have peer support available within local organisations delivering mental health services	Shetland Link Up	2007 / 2008
To develop the layered / stepped care approach locally through the addition of the primary health care worker model	**To have good links between services, sign posting, and supported self-help in place**	**Joint Mental Health Management Team (JMHMT)**	**2007/2008**
Introduction of formal assessment tool within general practice for depression and anxiety within the stepped care model and Integrated Care Pathway (ICP).	For all people with depressions and anxiety presenting for help to primary care to be assessed and signposted to appropriate services and supports	JMHMT / Community Health Partnership (CHP) Clinical Lead	2007/2008

Action	Outcome	Lead Responsibility	Timescale
Current GP counselling service, and Shetland Art Therapy to be included in review of local provision of psychological therapies.	That we make best use of all local resources in developing services	JMHMT Working Group / Director of Clinical Services (DCS)	2007/2008
Audit antidepressant prescribing in primary care, within the local ICP for depression.	That people with depression get offered effective medication support / treatment where appropriate	Pharmacy / CHP	2007/2008
Tier 3 services:			
Review the range of psychological therapies available locally, with a view to redesigning the current service provision to increase the availablity of evidence-based therapies.	**People with mental illness and distress able to access an appropriate range of psychological therapies**	**JMHMT Working Group / DCS**	**March 2008**
Develop local crisis support services, including out of hours, working jointly between the local Community Mental Health Team (CMHT) and voluntary organisations, understanding local needs, including the potential for a staffed residential service (expressed as a perceived need) and alternatives. This will take into account the National Standards for Crisis Services to ensure that local service comply with the standards.	**People receiving appropriate, effective and timely crisis support in a service as close to home as possible.**	**DCS / JMHMT Working group**	**Initial scoping work December 2007. Redesign 2008/09**
The development of Integrated Care Pathways (ICPs) for schizophrenia, bi-polar disorder, depression, dementia and personality disorder.	**People with these complex and often recurring or life-long conditions (and their families / carers) will receive appropriate services, with full participation, knowledge of, and clear**	**JMHMT**	**December 2007**

Action	Outcome	Lead Responsibility	Timescale
	information about the steps and choices for assessment, treatment and support.		
Planning best models for future staffing – clinical and management, considering the fragility and long-term sustainability of local specialist services.	**A sustainable model of local specialist services**	**DCS / Medical Director (MD)**	**March 2008**
Tier 4 services / Enhancing specialist services:			
To formalise communications and links with Grampian in Service Level Agreement including admission and discharge to hospital, the role of specialist services in ICPs, and the provision of specialist services such as mother and baby services.	To have good links with, and support from, mainland specialist services	NHS Commissioning Team	2007 / 2008
Contribute to regional planning and development of: forensic services including medium secure facilities – funding within Local Delivery Plan; eating disorder services. Via membership of North of Scotland Regional Planning Group (NoSPG)	People on Shetland will have access to national and regional specialist services including Medium Secure facilities and in-patient eating disorder services.	Chief Executive (CE) & Director of Public Health (DPH) NHS Shetland	2007/8 - 2013
To ensure compliance with legislation and guidance on the management of mentally disorderd offenders.	Safe multi-agency arrangements	DPH / Consultant Psychiatrist	Ongoing
Agree a local pathway for assessments between the local Community Mental Health Team and the local Court and Criminal Justice service.	Good liaison between local services, with appropriate assessments and referrals taking place.	Consultant Psychiatrist	2007 / 2008
Contribute to regional planning for young people's in-patient mental health services. Contribute to national planning for childrens in-patient	Appropriate access to regional and national specialist services	DPH as Director of Planning	2007 - 2010

Action	Outcome	Lead Responsibility	Timescale
mental health services (see Child and Adolescent Mental Health Services (CAMHS) strategy for more detail).			
Improve Patient and Carer Experience of Mental Health Services:			
To understand the role of peer support and explore a voluntary / community organisation based model of peer support workers in Shetland.	For people using local mental health services, to have peer support available.	Shetland Link Up	2007 - 2008
The development of Integrated Care Pathways (ICPs) for adult services for schizophrenia, bi-polar disorder, depression, dementia and personality disorder. For CAMHS for depression in adolescents, Attention Deficit and Hyperactivity Disorder (ADHD), self harm and anxiety disorders.	So that service users will have knowledge of and clear information about the steps and choices in assessment, diagnosis, treatments and care.	JMHMT and CAMHTeam	December 2007
Comply with national quality assurance assessments eg on inclusion, user rights: Scottish Recovery Network Performance Indicator tool Mental health QOF indicators	That service users will receive services that comply with national standards	JMHMT	Depending on national guidance
Develop links with Children's Rights Service. Develop links with Deaf Association.	Making sure people's voices and opinions are heard.	All	Strategy lifetime
Tackling Stigma / Awareness Raising			
Better information and awareness raising to reduce stigma and develop mental health awareness, including working with the press, and mental health services advertised better.	That people feel able to ask for help and support on mental health issues, and know where to go to get it.	Health Promotion Dept.	Strategy lifetime

Action Plan

Action	Outcome	Lead Responsibility	Timescale
Develop positive media relationships campaign at local level.	Press contributes to a positive mental health & well-being culture locally, promoting inclusion and acceptance.	MH Partnership	Strategy lifetime
Link with Diversity action plans in promoting inclusion and tolerance.	That people receive services that recognise and value their diversity	All	Strategy lifetime
Training & Skills Development			
Coordinate local training available to make best use of resources.	A more co-ordinated and strategic approach to training to support the delivery of the MH strategy	Mental Health Partnership Training sub-group	Within timescdale of strategy. Plans in place 2007/08.
Training in initial mental health assessment of people presenting to the Gilbert Bain Hospital (GBH) as part of the Integrated Care Pathways for key conditions	To ensure that people presenting as emergencies or out of hours, including at GBH, are appropriately assessed and receive appropriate services.	Mental Health Partnership Training sub-group	2007/08
Develop and make available short course on depression, anxiety and stress – awareness raising, eg for volunteer and sessional literacy tutors on depression, anxiety and stress to support learners and develop their decision making skills.	To extend the knowledge and capacity of generic services and the local community on mental health issues	Mental Health Partnership Training sub-group	Within timescale of strategy.
Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA) Training & STORM development plans.	A community and workforce knowledgeable and skilled in dealing with mental health issues.	Health Promotion Dept.	Within timescale of strategy. Plans in place 2007/08.

Action	Outcome	Lead Responsibility	Timescale
Mental Health Nursing Action Plan.	Patients receiving care from appropriately skilled and trained nurses.	Nurse DIrector	Within timescale of strategy.
To review models for future specialist staffing, including the development of management capacity and leadership skills, within the Joint Mental Health Team	To develop strengthened and sustainable local specialist services in line with the strategy.	DCS / MD / JMHMT	2007 - 2008
Specific training actions for CAMHS within CAMHS strategy.	A more co-ordinated and strategic approach to training to support the delivery of the CAMH strategy	CAMHS training sub-group	Strategy lifetime
Information Sharing			
Develop interagency information sharing protocol (currently in draft form) and its application within ICPs.	Services to patients that share information effectively, with due regard to confidentiality and people's rights	Shetland Inter-agency Data Sharing Partnership	April 2008
Responding better to depression, anxiety & stress			
Audit of prescribing in general practice to work towards meeting unmet needs, and to inform work to meet national targets.	That anti-depressant medication is used appropriately and effectively by GPs in Shetland	Pharmacy/CHP	December 2008
Develop resources for supported self-help e.g. prescribing library, and development of localised promotional material.	That people can access or be sign posted to support for self-help	JMHMT	2007-10
Promote the local development of the Recovery Model.	Attitudes to mental ill-heatlh and distress, and practice in mental health services promote recovery	MH Partnership	Strategy lifetime
Working with employers to have a better understanding of mental health issues including depression to provide a healthy work place, via the Healthier Working Lives programme.	Raised awareness and support regarding depression/anxiety / stress among employers and other agencies.	Health Promotion	2007-10

Action Plan

Action	Outcome	Lead Responsibility	Timescale
Develop an Integrated Care Pathway (ICP) for depression	That people with depression will receive appropriate services, with full participation, knowledge of, and clear information about the steps and choices for assessment, treatment and support.	JMHMT / CHP	December 2007
Improving the physical health of people with mental illness			
To improve the uptake of reviews provided by primary care teams for people with severe and enduring mental illness, to include physical health assessments.	People with severe and enduring mental illness are physically well.	CHP	2007-10
Work with carers (formal and informal) to support older people and those with severe physical disabilities, who also have a mental illness; this may include training and staff supervision.	Older people and people with severe physical disabilities have appropriate help and support for mental ill-health	Care services	Strategy lifetime
Ensure that treatment models for those with depression and anxiety & CHD/diabetes link to population approaches on exercise, diet and alcohol misuse, and that the chronic disease management programmes monitor and target vulnerable and potentially excluded people, including those with mental illness.	That people with physical and mental illness are supported to prevent ill-health, and to actively promote physical and mental health and well-being	CHP	2007-10

Action Plan

Action	Outcome	Lead Responsibility	Timescale
Better management of long-term mental health conditions			
To consider the range of care and treatment options available including on island, off island, 24 hour supported accommodation, hospital based, community based, with a view to best using the available resources and expertise.	Strategy for mental health services to provide as much range and choice of effective service as possible.	MH Partnership	Strategy lifetime
Develop local crisis support services, including out of hours, working jointly between the local CMHT and voluntary organisations understanding local needs, including the potential for a staffed residential service and alternatives.	People receiving appropriate, effective and timely crisis support in a service as close to home as possible..	DCS / JMHMT Working group	Initial scoping work December 2007. Redesign 2008/09
Develop and implement integrated care pathways for schizophrenia, bi-polar disorder, depression, dementia and personality disorder	So that service users will have knowledge of and clear information about the steps and choices in assessment, diagnosis, treatments and care.	JMHMT	December 2007
Develop interagency information sharing protocol (currently in draft form) and its application within ICPs.	That information is appropriately shared between services with due regard to confidentiality and users rights.	Director of Service Improvement	2007/08
Early detection and intervention in self-harm and suicide prevention			
Continue public debate and awareness raising, linked to other actions on tackling stigma – making best use of the media and awareness raising: - using opportunities such as 'speakeasy' on local radio; - Continue to use media guidelines re. reporting suicide.	Shetland community has a tolerance, understanding and acceptance of mental illness and promotes positive mental health, supported by the media	All / With specific actions from Mind Your Head and health promotion	Lifetime of the Strategy

Action Plan

Action	Outcome	Lead Responsibility	Timescale
Develop guided self-help and supported self-care.	That people can access or be sign posted to support for self-help and self-care	JMHMT	2007-10
Building community capacity using tools such as ASIST, MHFA and STORM	That the public have the knowledge and skills to help promote mental well-being and prevent distress	Choose Life Shetland	Strategy Lifetime
Training in suicide prevention for front-line staff.	That front-line staff are able to intervene effectively to help reduce suicides in Shetland	Choose Life Shetland	2007-2008
Understand better the immediate response to suicide/sudden death for practical support and offer of emotional support.	People affected by a suicide or sudden death are appropriately supported	Choose Life Shetland	2007-2009
Manage better admission to, and discharge from, hospital			
Monitor admissions and repeat admissions to in-patient services on a regular basis	To help understand the effectiveness of local services and prevent hospital admissions where appropriate.	JMHMT	Ongoing
Support the development / introduction of the Crisis Support service proposal.	People receiving appropriate, effective and timely crisis support in a service as close to home as possible.	DCS / JMHMT Working group	Initial scoping work December 2007. Redesign 2008/09
Establish active participation in the NHS Grampian Cornhill Hospital acute inpatient forum.	To best support people admitted to hospital	JMHMT	2007/08
Mental Health and Substance Misuse			
Consider the development of formal dual diagnosis provision for people with drug dependency and mental health problems.	Local support services in place	Dual diagnosis team	2007-10

Action Plan

Action	Outcome	Lead Responsibility	Timescale
Support clinicians within Shetland in encouraging patients to embark on planned and adequately supported alcohol withdrawals.	Extended range of local support services in place	Dual diagnosis team / CHP	Lifetime of strategy
To develop a sustainable service through securing long term funding and staffing support for the post of specialist nurse alcohol misuse and the support worker post.	Sustainability of local support services	MH Partnership / Shetland Alcohol and Drug Action Team (SADAT)	2007-08
Develop agreed protocol for the pharmacological management of drug dependency (medication support for withdrawal and abstinence in people with substance dependencies).	Extended local service in place	Dual diagnosis team	2007-09
Work towards developing capacity to provide planned inpatient withdrawal within Shetland.	Extended local services to prevent travel to mainland services.	Dual diagnosis team	2007-10
Improving services for older people with mental health problems, including early onset dementia			
Considering the needs of older people in the development of specialist mental health services	Extending the range of services available, and including older people in all available services as appropriate	JMHMT	Strategy lifetime
Action plan to implement 'Older & Wiser' findings of the Mental Welfare Commission report on visits to NHS continuing care wards for older people.	Better standards of care for older people living in continuing care wards	DSI	Plan in place
Action plan to implement the Dementia Redesign project	Sustainable, good quality services for people living with dementia and their families and carers.	Nurse Director	Plan in place

Action Plan

Action	Outcome	Lead Responsibility	Timescale
People with a learning disability who have mental health problems			
More consistent access to primary healthcare by people with learning disabilities	Including people with learning disabilities in mainstream services	CHP	Strategy lifetime
Mental Health & Employment			
To understand in more detail the local needs for befriending and support, including specific supports such as re-entering employment	Full social inclusion and employment for people with mental illness	MH Partnership / local voluntary organisations	2008/09
Promote supported employment opportunities	For everybody who wants it to be able to take up employment	Moving On / MH Partnership	Strategy lifetime
Include the development of the Occupational Therapy service to people with mental health needs in collaboration with the Community Mental Health Team, in future planning for Occupational Therapy in Shetland.	Extended local services and support for people to get back to work	JMHMT / NHS Occupational Therapy service	Strategy lifetime
Children and Young People with mental health or behavioural problems			
Action plan for the development of Children and Young People's Mental Health Services (CAMHS), agreed by the Integrated Children and Young Peoples Services Planning Group (ICYPSPG) as part of the local Children's Plan	To implement the Strategy	CAMHS strategy group / ICYPSPG	Strategy lifetime
The development of Integrated Care Pathways (ICPs) for Child and Adolescent Mental Health Services for depression in adolescents, Attention Deficit and	So that service users will have knowledge of and clear information about the steps and choices in	CAMHS team	December 2007

Action Plan

Action	Outcome	Lead Responsibility	Timescale
Hyperactivity Disorder (ADHD), self harm and anxiety disorders.	assessment, diagnosis, treatments and care.		
To develop the layered / stepped care approach locally through the addition of the primary health care worker model	**To have good links between services, sign posting, and supported self-help in place, with best use of specialist resources, and a sustainable local service.**	**CAMHS team**	**2007/2008**

j) DEFINITIONS

'Psychological Interventions' in this document (the National Framework definition) refers to a range of skills, competencies and interventions based on identified psychological concepts and theory, which are designed to help people modify their thinking and/or behaviour in order to relieve distress or dysfunction, and which have been acquired through training and maintained through supervision. They can be delivered by a wide range of professionals who have undertaken such training, and who maintain skills through professional development and appropriate clinical and practice supervision. They can be delivered in different settings, and at differing levels of competency depending on the specific professional training of the person delivering the service, and at different levels of intensity depending on the persons needs and which service tier they fit into (For example, Clinical/Counselling Psychologists, Counsellors, Psychiatrists, Specialist and Mental Health Nurses, Psychotherapists, members of the primary care range of other Mental Health and non-Mental Health professionals working in a variety of services and settings.)

Definition from the Primary Care Counselling Service:There is a fair degree of confusion around the terms "counselling" and "psychotherapy" in the public mind - the widely received consensus *within* the field by most, if not all professional bodies, is that the terms are used and understood interchangeably.

It is common for the same individual to be variously described as a counsellor, psychotherapist or therapist. If there is a distinction it is usually applied to function rather than role - i.e. short-term, problem specific work is called "counselling" and more in depth, developmentally focussed longer term work is called psychotherapy. As a "therapist" I perform both functions - "counsellor" and "psychotherapist" - and in any given interaction the most appropriate function is determined by the needs of the patient. What begins as "counselling" may need to become "psychotherapy" to enable the patient to achieve a satisfactory outcome.

The NES report "Increasing the Availability of Evidence-Based Psychological Therapies in Scotland" is worth considering:
There is a recognition that the phrase 'Psychological Therapies' is used to describe a wide range of practices, and that there is a degree of confusion over the meaning of the term. At the higher tiers, staff may be accredited to a specialist level in one of the major therapeutic approaches. Further down the pyramid they may simply be required to use circumscribed elements of any particular approach.

Appendix 1: Definitions

Consultant Clinical Psychologist for Children & Young People

When attending a Mental Health Service within the NHS the range of staff who work there will be different in terms of their qualifications and way of working. There has been for a very long period of time different models or ways of understanding emotional distress or mental illness. This gives variety in the service and for individuals choice about how they receive help for their difficulties. The dominant model in the NHS is historically the medical model, where illness is seen as a way of understanding ill health, be it physical illness or mental illness. This means the patient is offered treatment and there is a search for a cure or long-term treatment to eradicate or to cope with symptoms. Clearly if your view is about disease then treatment is often physical, that is, the prescription of medication may be the outcome of your appointment. The medical model has as its routes a belief in the importance of the cause being biological or genetic. Hereditary factors are viewed as important. The professional will see you as the patient and take account of symptoms. The language used by professionals who are trained in the medical model will be of a particular nature – illness, disease, symptoms, diagnosis, prognosis and aetiology.

Since the early 1970s in the NHS there has been employment of Clinical Psychologists. Clinical Psychologists have a different model of understanding emotional well-being. The model of understanding is about looking at people's life experiences so far, their relationships and their style of coping. Psychological Assessment would precede Psychological Therapy. This is a "talking" approach, the importance of the relationship between the person and the Psychologist is essential to bring about positive change in the person's life. In Therapy you would discuss how it is best to understand your difficulties and how you can take control and move forward in a positive way. There is strong evidence of psychological approaches being effective and this might fit better than a medical model based approach for some individuals. How we learn and what we experience shapes how we cope, learning to take control of that can change peoples lives enormously, the emphasis in therapy may be on your behaviour, your thinking or your feelings, most likely all three. Seeing a Clinical Psychologist may not be a long-term relationship as evidence is strong in the fact that short term therapy can be very effective, and individuals would not necessarily start on a journey of long term involvement with the service. Taking control of your own life and not being dependent on somebody else is a goal, and learning that emotional pain is somethig that we all experience and it is the very essence of being human.

Severe and enduring mental illness: the national framework describes this as those individuals who:

- have a mental health problem (typically people with schizophrenia or severe affective disorder, but including dementia);
- experience a substantial disability as a result of their mental health problems, such as an inability to care for themselves independently, sustain relationships or work;
- are either currently displaying obvious and severe symptoms; **or** have a remitting/relapsing condition;
- have experienced recurring crisis leading to frequent admission/intervention;
- occasion significant risk to their own safety or that of others.

Appendix 1: Definitions

Dementia

Dementia is a syndrome of intellectual deterioration (reduction in mental capacity and capability) severe enough to interfere with occupational (work) or social (lifestyle) performance. It may be caused by a number of disorders, including Alzheimer's disease, vascular dementia, and Lewy body dementia. Dementia is most usually progressive in nature. Whilst many hypotheses exist as to what might cause the different types of dementia, no definitive cause for all of these has yet been identified. Similarly, no cure as such exists for dementia.

Key Messages from
Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland:

Culture and values - strengthening the climate for care

- Mental health nursing is focused on caring about people, about spending time with people, and on developing and maintaining helpful relationships with service users and their families and carers.
- We need to continue to develop rights-based and person-focused mental health care by promoting values and principles-based practice in mental health nursing.
- The recovery approach should be adopted as the model for mental health nursing care and intervention, particularly in supporting people with long-standing mental health problems.
- We need models of practice that are centred on relationships between mental health nurses and people, maximise nurses' contact time with service users, families and carers, and promote rights and recovery-based working.

Practice and services

- We need to support the development of mental health nurses' roles in priority areas of acute inpatient, crisis care and intensive home treatment services.
- In particular, we need to support and develop the role of mental health nursing in acute inpatient care.
- Mental health nurses will continue to have a key role in contributing to supporting people with long-term and complex mental health problems and need to adopt strengths-based approaches to working with people towards recovery.
- Mental health services and mental health nursing must make the support of older people with mental health problems a priority. We need to make sure mental health nurses are prepared and developed to deliver this.
- The role of mental health nursing in providing early intervention to people at risk of developing mental health problems needs to be developed and enhanced.
- Mental health nurses must continue to develop their roles in health improvement, health promotion and tackling inequalities.
- People who use mental health services want more access to 'talking therapies' such as psychosocial interventions and psychological therapies, but demand outweighs supply. We need to increase opportunities for mental health nurses to be developed to deliver these therapies.

Education and development

- We need to attract the right people into mental health nursing and make sure they are prepared in the right way. A national framework that will ensure consistency of content and standards throughout Scotland is necessary to achieve this.
- All mental health nurses, whatever their area of work, need opportunities to continue to learn and develop.
- We need to actively involve service users, families, carers and practitioners in the design and delivery of education programmes for mental health nurses.
- We need to develop the role of health care support workers in mental health, matching the roles and skills of heath and care workers to people's needs.
- Leadership is the key ingredient to realising the potential of mental health nursing in Scotland. We need nursing leaders at every level of the profession, not just the top echelons - people who lead through example in their practice and are prepared to

challenge obstacles to achieving their goals for service users and their families and carers.

- We need to continue to strengthen capability for research and evaluation in mental health nursing.
- The mental health nursing community in Scotland is relatively small. It should be able to, and must, share and build on existing innovation on a national basis to inform developments. We need to develop a much more robust learning climate across the mental health nursing community, enabling innovations to be shared and a common approach to finding solutions to challenges to develop.

To make this happen

- Everyone involved in mental health services needs to play their part and work together to form strong alliances to bring about change.

Mental Health Policy Summary

In addition to those documents detailed in Chapter e), the following are all relevant to the delivery and improvement of mental health services.

"See Me" campaign (2005)

On 27 January 2005 the "See Me" campaign to eliminate stigma and discrimination associated with mental health problems (see http://www.seemescotland.org), launched a new strand, specifically aimed at children and young people. This includes a television cartoon-style advertisement, showing a girl with an eating disorder who has been harassed by other children, with the message: "see me...I'm a person. Just like you". Two cartoon posters with the same message are being widely distributed, and the campaign is supported by leaflets and website information (see http://www.justlikeme.org.uk) to direct children, parents and teachers to relevant sources of support.

New Ways of Working for Psychiatrists (2005)

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4122342&chk=RbKb2y
Final Report from National Steering Group, cochaired by NIMHE and RCPsych. The Report provides a framework for mental health services to help them develop new ways of working for psychiatrists that supports the delivery of person centred care and provides satisfying and sustainable role making best use of this valuable, finite resource.

British Psychological Society Info Leaflet 6: Guidance on Clinical Psychology Workforce Planning

http://www.bps.org.uk/document-download-area/document-download$.cfm?file_uuid=1B293526-7E96-C67F-D5D653143CD4091A&ext=pdf
Guidance advising clinical psychologists and their local colleagues on methods of clinical psychology workforce planning, and providing information to help to persuade others of the value of an appropriate clinical psychology workforce within local health services.

Doing Well by People with Depression: Programme Proposal. Centre for Change and Innovation. Edinburgh: Scottish Executive, 2003

www.show.scot.nhs.uk/sehd/publications/DC20030521Depression.pdf

Evidence to Practice – A Guide to Help Develop Services for the Management of Depression. Edinburgh: Scottish Executive, 2005.

http://www.scotland.gov.uk/Publications/2005/07/2994711/47119

National Evaluation of the Doing Well By People With Depression Programme. Edinburgh: Scottish Executive, 2006.

http://www.scotland.gov.uk/Publications/2006/07/12090019/0

Partnership for Care (2003)

www.scotland.gov.uk/library5/health/pfcs-00.asp
This Scottish Executive Health Department's white paper was published on 27 February 2003. There are a number of items with particular relevance to the work of the mental health information programme:

- Joint working
- Change and innovation
- Integrated workforce development
- Development of an eHealth culture/ clinical information systems

Choose Life : A National Strategy and Action Plan to Prevent Suicide in Scotland (2002)
www.chooselife.net
The Scottish Executive's Choose Life strategy was launched in December 2002 and forms a key part of the National Programme for Improving Mental Health and Well-Being Action Plan in Scotland.
Choose Life is a 10 year plan aimed at reducing suicides in Scotland by 20% by 2013. It is the product of over 2 years work which drew on the experience and expertise of a broad range of partners. The strategy and action plan aims to ensure we take action nationally and locally to build skills, improve knowledge and awareness of 'what works' to prevent suicide, improve opportunities to prevent premature loss of life and provide hope and optimism for the future.

Our National Health: a plan for action, a plan for change (2000)
www.show.scot.nhs.uk/sehd/onh/onh-00.htm
The plan affirms the central position mental health occupies together with coronary heart disease and cancer, in the Scottish Executive's targets for health improvement in Scotland. The plan moves the discussion from policy to delivery of change, setting priorities for investment. It charts the rise in importance of community mental health problems and service issues.
"We will accelerate the implementation of the Framework for Mental Health ... People want modern mental health services that make a difference by improving the speed, responsiveness and the quality of care.
We acknowledge that severe and enduring mental illness is only the tip of the iceberg. Anxiety and depression contribute to a much wider community health problem. We will support further development of extended mental health services in primary care settings and encouraging the development of crisis services and community mental health initiatives'.

Framework for Mental Health (1997)
http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm
The framework sets outs in a tiered service system, the essential features of a local mental health strategy for people with severe and/ or enduring mental health problems, including those with dementia. The Framework does not address the needs of those with learning disabilities, or alcohol and/ or substance misuse, unless there are concomitant mental health problems.
Other documents with particular relevance to mental health policy are:

Review following Bennett report
In 1998 David Bennett died while he was a psychiatric inpatient in the care of Norfolk, Suffolk and Cambridgeshire Health Authority. He had been restrained by staff following an altercation with another patient. A full independent inquiry report on the incident, and follow-up, with recommendations and next steps is available at:
http://image.guardian.co.uk/sys-files/Society/documents/2004/02/12/Bennett.pdf.
The inquiry report does not address Scotland, however a review was undertaken, here in Scotland, of what action is underway (or planned) in the areas of the 22 recommendations of the English report. This review involved the Mental Welfare Commission for Scotland, Quality Improvement Scotland, the National Resource Centre for Ethnic Minority Health and NHS Education Scotland. The Scottish review was recently completed and a letter

summarising the work is available at
http://www.show.scot.nhs.uk/sehd/publications/DC20041217SafeCare.pdf

Community Health partnerships (CHPs) - Improving the health and wellbeing of people with learning disability and/or autistic spectrum disorder (ASD)
An advice note entitled Community Health partnerships (CHPs) - Improving the health and wellbeing of people with learning disability and/or autistic spectrum disorder (ASD) has been released. It is intended to inform the development of local arrangements to deliver the policy objectives of CHPs and Joint Future in relation to services for people with learning disabilities and/or ASD. It supports the aims and expected service outcomes set out in the CHP statutory guidance. See
http://www.show.scot.nhs.uk/sehd/chp/CHPadvicefinalLDAS201205.pdf

Scottish Recovery Network (SRN)
The Scottish Recovery Network (SRN) have a website that is a valuable tool in the drive to learn and share information about recovery. Features include the chance for people to share their own recovery story, information on the SRN narrative research project and a range of resources from SRN events. See www.scottishrecovery.net

Appendix 4: Remits

MENTAL HEALTH STEERING GROUP (MHSG) – subsequently renamed **MENTAL HEALTH PARTNERSHIP REMIT**

The MHSG will take an over view of all mental health services. In addition the MHSG will produce a new mental health strategy. This new strategy will be for the next three years and include the full range of mental health services.

The strategy will have a multi agency approach with the help of user's, carer's and the voluntary sector. Also the strategy will be used in the long term by the 2020 vision project.

Responsibility for the strategy will rest with the MHSG. The MHSG will work with its partners to implement the strategy. When preparing the strategy consideration will be given to:

Relevant national policies;
Guidance for adults and children;
The national framework for Mental Health services;
The findings of national monitoring;
The findings of recent needs assessment;
Recommendation from the resource centre;
Capacity within the Mental Health service;
Making links to specialists services at a regional and national level;
Agreeing joint spending plans;
The variety of funding sources.

The Joint Mental Health Services Management Team (JMHSMT) and the Mental Health Forum (MHF) will provide support to the MHSG. In return the MHSG will feed back its results to the JMHSMT and the MHF.

The MHSG will seek approval from the Community Planning Board (CPB) to take over the "Choose Life" funding.

The MHSG will also be responsible for the Suicide Prevention Action Plan (SPAP).

The JMHSMT will supervise the Joint Local Implementation Plan (JLIP). The MHSG will in turn supervise the JLIP.

The MHSG will promote good communication between all agencies working on mental health issues.

Agreed at Mental Health Steering Group on 14th July 2005.

MENTAL HEALTH FORUM REMIT

The Mental Health Forum will contribute to the delivery of actions from the Improving Mental Health and Wellbeing Strategy Action Plan and monitor progress. The Mental Health Forum will contribute to development of overarching mental health strategy through feedback to the Shetland Mental Health Partnership. The Mental Health Forum will continue to co-ordinate mental health improvement work and sharing good practice.

JOINT MENTAL HEALTH SERVICES MANAGEMENT TEAM: TERMS OF REFERENCE

Purpose

To manage mental health services for Shetland using delegated authority for strategic decisions within approved budget levels (Ref: JFIG 6 November 2003).

Remit

- To take a proactive approach to the joint management of mental health services.
- To be responsible for the Joint Local Implementation Plan (JLIP) for the Mental Health (Care and Treatment) (Scotland) Act 2003.
- To link with and support Shetland Mental Health Partnership
- To monitor existing service provision and ensure Best Value.
- To plan for changes in service provision to meet anticipated future needs and comply with MH legislation and guidance.
- To review budget provision for mental health services including Mental Health Specific Grant (MHSG) and JLIP funding.

Membership

Consultant Psychiatrist – lead clinician
Community Mental Health Team Manager
CHP General Manager (Chair)
Service Manager Community Care Fieldwork, Social Work
Service Manager Adult Services, Social Work

Meetings

The group will meet on a regular basis and report to the Joint Future Joint Management Team (JFJMT).
There will be at least 4 meetings each year.
All meetings will be minuted and the minutes will be available under the Freedom of Information (Scotland) Act 2002.

The Agendas will cover the following:
- National developments
- Local developments: Action Plans & progress
- JLIP
- Future needs and capacity
- Budgets
- Other resources: fixed assets etc.

Appendix 5: Proposal for Needs Assessment

SHETLAND MENTAL HEALTH PARTNERSHIP

Outline for Mental Health Needs Assessment

INTRODUCTION

Population based needs assessment is designed to understand the nature and extent of mental health problems within a community, and the range of services required to address the identified needs.

This needs assessment is intended to inform the development of a Mental Health Strategy for Shetland. A comprehensive Mental Health Promotion & Well-being Strategy was developed in 2001, and this strategy will include that work and develop it to include the needs of, and services for people with mental illness.

METHODS OF NEEDS ASSESSMENT

The three main methods of assessing the level of needs relating to mental health and illness are:

- Epidemiological approach – using data obtained from research, surveys and studies on rates of illness and specific disorders, applied from national work to estimate numbers within the local population, and predicting likely service usage. It can take account of local demographic information about the population to record or predict specific factors that might affect local communities (such as age, other issues that might inter-act with mental health like health problems, alcohol misuse, economic or social factors).

- Corporate needs assessment: Information from services and those working in the field of mental health – description of current services, routinely collected information on use of services, activity within services, and the views of professionals working within services, comparison with services in other areas, identifying gaps or weaknesses in local services.

- Information from users, carers and the community (participatory / consultative needs assessment) – qualitative information – feed-back on current services by those with direct experience of them, the experience of living with mental illness or distress, and the needs and aspirations of those affected by mental illness for future improvements and developments.

It is proposed to use information from all three sources, and this outline suggests a process and timescales for doing this in Shetland.

Agreeing the principles of needs assessment in Shetland:
Early discussion in the Mental Health Partnership outlined some principles for the development of the local strategy which are relevant to the needs assessment:

- focus on client based feed back
- doing this early on so it shapes what we do
- using local media to reach people and invite views
- how do we reach the hardest to reach including families and carers?
- links to inequalities.

Some information has already been collected which can be the starting point for the needs assessment:

- Directory of services
- Mental Health Promotion (Well-being) Strategy

- Service based needs assessment done by the Community Mental Health Team
- Evaluations / reviews of current services eg Art Therapy service, GP Counselling service, inspections of statutory services (QIS – NHS external peer review quality assessment process), GP services
- Work done for related topics:
- Disability strategy

National Policies and Strategies

- Review of Mental Health Nursing in Scotland
- Workforce Review
- Routine Statistics
- National service pathways
- 1st phase Choose Life Evaluation - June

PROPOSAL

	Responsibility	Timescale
First Phase: information collection		
Participatory		
Process for collecting client-based feedback – from all services working in the field – via Mental Health Forum *need standardised format* –draft format for discussion by Mental Health Forum –	ER	MHF to decide timescale and feed back to partnership
Process for seeking views of hard to reach groups – links into related services eg carers support networks – CF/MJ	MHF	
Use of media	MHF	
Use current processes to gather relevant additional information– eg CHP roadshows & locality profiling for general community and primary care / community services contributions	CHP GM / DPH	Dec 06
Corporate		
Gather additional information on service use and detail using Directory of Services as a baseline	ER	Dec 06
Gather information from existing local strategies & plans, and from national policies	DPH and joint NHS SIC P&I Officer	Dec 06
Epidemiological		
Gather epidemiological information including relevant demographic data	Dept of Public Health	Sept 06
Ensure specific groups of individuals are included in above, or add in specific pieces of work: including those who share a pattern of more complex needs defined within the national framework as including: - adults with mental health problems; - children and young people with mental health or behavioural problems; - older people with mental health problems, including early onset dementia; - mentally disordered offenders; - homeless people with mental health problems; - people with mental health problems who misuse substances or alcohol;	PH	

- dementia - people with a learning disability who have mental health problems; and - people with a physical illness who present to a general hospital who have a mental health problem, including those who self harm. - perinatal mental health		
Sudden death stats	KS	
Suicide audit	AM	
Men's health data, GP practice and locality profiling data	Public Health Dept.	
Second Phase – Collation & Analysis		
Suggested lead responsibility	Public Health Dept.	Sept/Oct
Third Phase – Development Of Strategy		Oct 06 – summer 07
Identification of gaps and weaknesses in services from needs assessment		
Taking account of Core Service Elements defined in national service framework: o information and access to services; o individual planning of services; o services to promote personal well-being and social development; o services for ordinary living and long-term support; o services offering psychological therapies, including clinical psychology, and o services offering physical methods of treatment And tiers of service from self-help to tertiary specialised services.	All	
Proposals for developments / redesign to fill gaps (meeting unmet needs)	All	
Prioritisation	MH Partnership	
Consultation	MH Partnership & Forum	April – July 07

Dr Sarah Taylor
Director of Public Health 07.09.06

Primary Care Counselling Service

Referral Guidelines

Counsellors will receive referrals from the GPs in the practice(s) in which they are based. The Department of Health has produced guidelines[1] as to the broad types of patients that should be referred to counselling and psychological therapy services in primary care:

- Mild, stress-related problems, adjustment to life events, illnesses, disabilities or losses are appropriate for treatment in primary care;
- Generic counselling is not recommended as the main intervention for severe and complex mental health problems or personality disorders.
- The guidelines do not make specific recommendations about the types of patients who are best treated in primary care (as opposed to those who are best referred to secondary care) as there is a lack of high quality evidence on this issue, and appropriateness depends in part on the levels of skill, support and supervision available in each setting.
- General principles are suggested e.g. referral out of primary care (to CMHT) is appropriate for patients with a history of severe trauma, previous unsuccessful treatment in primary care, and patients with complex social problems, severe depression, anxiety or co-morbidity.
- In the absence of local secondary care psychotherapy services more complex client work may need to be carried out in the primary care setting. In such circumstances the GP will need to take into account the individual training and experience of the counsellor they wish to refer to.

The British Association for Counselling and Psychotherapy (BACP) and Counsellors and Psychotherapists in Primary Care (CPC) have also produced guidelines[2], which are concerned with the types of patients who may benefit from counselling in primary care. Suitable patients need to meet the following criteria, and assessment would be required in all cases:

1. Their problems affect their ability to cope with daily life, or the quality of their life and relationships.
2. Their problems are causing current distress.

Indications of whether they will be able to use counselling effectively are:

1. Able to engage in conversation and willing to disclose personal information.
2. Capacity for reflection and some motivation for change.
3. Willingness and ability to make a regular commitment to attend appointments.

Patients amenable to counselling or psychological therapy in primary care are likely to be those in the following categories:

- Pathological bereavement
- Coping with injury or illness
- Depression - reactive, circumstantial
- Developmental or life crises
- Appropriate emotional, physical or sexual abuse issues
- Family relationship issues
- General anxieties and phobias
- Lack of direction, alienation, existential problems
- Loss e.g. relationship, employment, health etc
- Self-image and identity issues
- Stress and trauma (pre- and post-event)
- Issues of sexuality

It is important to note that not all patients may be suitable for counselling or psychological therapy in primary care. The counsellor has a duty not to counsel a patient if they consider that he/she is unsuited. In such cases the patient will be referred back to the GP.

The following conditions may not be suitable for primary care counselling, unless the counsellor has specific, relevant skills and/or is supported by the CMHT and primary care colleagues:

- Sexual dysfunction
- Poor communication ability
- Self-destructive behaviour which, over time, has shown very little change, i.e. prolonged substance misuse, eating disorders
- Severe mental disorders
- Severe challenging behaviours, i.e. aggression, violence, severe learning disabilities

In summary, the key criteria for referral are the patient's ability to change and their ego strength. The very fragile may well find counselling too challenging. Those who have too much invested in remaining the same may also find counselling too challenging.

The counsellor may well, after assessment, re-refer the patient as "inappropriate for counselling"; suggest a referral to the CMHT or, if appropriate, some other agency (e.g. Cruse for the recently bereaved).

1. Department of Health. *Treatment Choice in Psychological Therapies and Counselling: Evidence based clinical practice guidelines*. London. Department of Health, 2001.
2. Counsellors and Psycholtherapists in Primary Care (CPC). Professional Counselling and Psychotherpay – Guidelies for Protocols. Bognor Regis. CPC, 2000.

NHS Shetland Alcohol Services

NHS Shetland Alcohol Services are based in the Community Mental Health Department at the Health Centre in Lerwick.
The NHS service in Shetland consists of three elements:

- The **Dual Diagnosis Service** for people who have a problem with alcohol misuse and co-existing mental health problems.
- The **Alcohol withdrawal service** for people who may need medical assistance to withdraw from alcohol.
- The **CRAFT** programme is a brief skills based programme for relatives or friends supporting individuals with alcohol problems. This programme is provided by the specialist nurse in alcohol misuse and the CPN attached to the dual diagnosis service.

The team consists of:
Specialist nurse in alcohol misuse – full time post. The specialist nurse accepts referrals from GPs, other members of the community mental health team, clinicians at the Gilbert Bain Hospital and the criminal justice team.
The specialist nurse conducts a comprehensive assessment of people referred to the service and offers advice about their alcohol use, need for a medicated withdrawal and ongoing support and rehabilitation needs. Where appropriate she arranges and supervises a planned withdrawal in the community, liaising with the patient's GP if withdrawal medication is prescribed. Whenever possible she arranges daily monitoring and supportive visits for the period of the withdrawal. She works with the clinicians at the Gilbert Bain Hospital to assist with the care of patients withdrawing from alcohol on the wards. At the end of the withdrawal period she makes recommendations about a programme of aftercare, which may involve referral on to the Dual Diagnosis Service or voluntary sector organisations such as Shetland Alcohol Support Services, Alcoholics Anonymous. In addition she is involved in the assessment of patients who may require admission for planned inpatient withdrawal and residential aftercare programmes. She can provide advice to GPs in outlying areas of Shetland who are supervising community withdrawals for their patients.

The **Dual Diagnosis Service** is provided by
GP with a special interest in mental health – one session per week
Community Psychiatric Nurse – part time.
The Dual Diagnosis Service accepts referrals from GPs, the Alcohol Support Service, staff at the Gilbert Bain Hospital and the Community Mental Health Team.
The service offers advice on the medical management of alcohol dependency and mental health problems, and psychosocial interventions such as anxiety management, relaxation skills, assertiveness, self esteem and social skills training. Some patients are referred on to other members of the community mental health team for specific therapies such as cognitive behavioural therapy and the management of post traumatic stress disorder.
Ongoing follow up by the service is offered to patients with identified mental health needs. Many patients will also be referred on for assessment by the specialist alcohol misuse nurse to plan an alcohol withdrawal. Patients who are felt not to have an identifiable mental health problem are referred on or encouraged to make contact with Shetland Alcohol Support Services for ongoing counselling support or with the local branch of AA.

Using funding from Choose Life a new **part time support worker post** has just been added to the NHS Alcohol Service.

Appendix 6: Service Profiles

The aim of this post is to increase the capacity of the service to provide longer term psychosocial input for people who have a problem with alcohol use and also identified mental health needs.

Many people with a history of alcohol misuse, while not necessarily having a formal psychiatric diagnosis, have significant mental health needs. Many are socially isolated, often with poor social and assertiveness skills, low self esteem and frequently problems with chronic anxiety and low mood. Many are unemployed and there is often a history of attempted self harm. Failure to address these social and mental health needs increases their risk of relapse back to problematic alcohol use.

The services offered to each person will be tailored according to their individual needs. The support worker will assist in providing relaxation training, assertiveness training, anxiety management, social skills training and support in the initial stages of involvement with community groups or activities. These would be provided in conjunction with continuing work on maintaining motivation, building self esteem and education about alcohol.

Glossary of Terms and Abbreviations:

AA	Alcoholics Anonymous
ADHD	Attention Deficit Hyperactivity Disorder
ASIST	Applied Suicide Intervention Skills Training
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
CHD	Coronary Heart Disease
CHP	Community Health Partnership
CPN	Community Psychiatric Nurse
CMHT	Community Mental Health Team
COPE	Community Opportunities for Participation in Enterprise
EMDR	Eye Movement Desensitisation and Reprocessing
GMS	General Medical Services
IAF	Integrated Assessment Framework
ICP	Integrated Care Pathway
IP	Inpatient Admissions to hospital
MAPP	Multi Agency Public Protection Arrangements
MCN	Managed Clinical Network
MHFA	Mental Health First Aid
MHO	Mental Health Officer
MYH	Mind Your Head
NES	NHS Education Scotland: the national NHS body responsible for developing professional training and education for health professional
NHS 24	The national NHS body responsible for first-line out-of-hours response services
NICE	National Institute of Clinical Excellence
PTSD	Post Traumatic Stress Disorder
QIS	Quality Improvement Scotland
QOF	Quality Outcomes Framework
SADAT	Shetland Alcohol and Drug Action Team
SAMH	Scottish Association for Mental Health
SASS	Shetland Alcohol Support Services*
SCDT	Shetland Community Drugs Team*
SHO	Senior House Officer
SNAP	Scottish Needs Assessment Programme
SRT	Shetland Recreational Trust
SSA	Single Shared Assessment
STORM	Skills Based Training On Risk Management
TFT	Thought Field Therapy
WHO	World Health Organisation

Appendix 8: References

References

[1] World Health Organisation: *Investing in Mental Health 2003*
http://www.who.int/mental_health/media/investing_mnh.pdf

[2] World Health Organisation, *Prevention of Mental disorders – Effective interventions and policy options*, 2004, p. 40
http://www.who.int/entity/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

[3] World Health Organisation: Fact sheet N°218 2001 *Mental health problems: the undefined and hidden burden*

[4] Scottish Executive Health Department: *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care.* 2005.
http://www.scotland.gov.uk/Publications/2005/10/2191333/13337

[5] Scottish Executive Health Department: *Choose Life, a National Strategy and Action Plan for Preventing Suicide in Scotland.* 2002.
http://www.chooselife.net/nmsruntime/saveasdialog.asp?lID=1000&sID=58

[6] Scottish Executive Health Department: *Delivering for Mental Health*. 2006
http://www.scotland.gov.uk/Publications/2006/11/30164829/0

[7]Scottish Executive Health Department: *Delivering for Health: Delivering for Mental Health National Standards for Crisis Services: November 2006*
http://www.sehd.scot.nhs.uk/mels/HDL2006_62.pdf
http://www.scotland.gov.uk/Resource/Doc/155438/0041730.pdf

[8] Scottish Executive Health Department: *Delivering for Mental Health*. 2006
http://www.scotland.gov.uk/Publications/2006/11/30164829/0

[9] Scottish Advisory Committee on Drug Misuse (SACDM) & Scottish Advisory Committee on Alcohol Misuse (SACAM): *Mind the Gaps – Meeting the needs of people with co-occurring substance misuse and mental health problems – A Report of the Joint Working Group (2003)*
http://www.scotland.gov.uk/Publications/2003/10/18358/28079

[10] Scottish Executive Health Department & Dementia Services Development Centre: *A Fuller Life – Report of the Expert Group on Alcohol related brain damage* (2004)
http://www.nhshealthquality.org/mentalhealth/projects/1/Alcohol/d_9.html

[11] Scottish Executive Health Department: *Delivering for Health*. 2005
http://www.scotland.gov.uk/Publications/2005/11/02102635/26356

[12] Scottish Executive Health Department: *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland (2006*)
http://www.scotland.gov.uk/Publications/2006/04/18164814/0

[13] Scottish Executive Health Department: *Delivering for Mental Health*. 2006
http://www.scotland.gov.uk/Publications/2006/11/30164829/0

[14] Scottish Executive Health Department: *Building A Health Service Fit for the Future*
http://www.sehd.scot.nhs.uk/nationalframework/Reports.htm

[15] Scottish Executive Health Department: *Delivering for Health*. 2005
http://www.scotland.gov.uk/Publications/2005/11/02102635/26356

[16] Scottish Executive Health Department: *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)*
http://www.scotland.gov.uk/Publications/2005/10/2191333/13337

[17] *National Programme to Improve the Mental Health and Well Being of the Scottish Population*
http://www.wellscotland.info

[18] Scottish Executive Health Department: *A Framework for Mental Health Services in Scotland (1997)*
http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm

[19] Mental Health (Care and Treatment) (Scotland) Act 2003
www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm

[20] Scottish Executive Health Department: *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland (2006*)
http://www.scotland.gov.uk/Publications/2006/04/18164814/0

[21]Regier, D. A., Farmer, M. E., Rae, D. S., et al*: Comorbidity of mental disorders with alcohol and other drug abuse*. *JAMA*, **264**, 2511–2518 (1990)

[22] HNA Depression, Lanarkshire Public Health Annual Report (2005)

[23] Scottish Executive Health Department: *Framework for Mental Health Services in Scotland (1997)*
http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm

[24]Scottish Executive Health Department: *Delivering for Mental Health* 2006
http://www.scotland.gov.uk/Publications/2006/11/30164829/0

[25] Scottish Executive Health Department: *Framework for Mental Health Services in Scotland* (1997)
http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm

[26] World Health Organisation: *Prevention of mental disorders: effective interventions and policy options: summary report* (2004)

[27] National Programme to Improve the Mental Health and Well-being of the Scottish Population
http://wellscotland.info

[28] Applied Suicide Intervention Skills Training (ASIST) www.wellscotland.info/suicide-prevention.html

[29] Mental Health First Aid (MHFA) www.wellscotland.info/mentalhealth/campaigns/mental-health-first-aid.html

[30] LivingWorks Education *SuicideTALK* (2002)

[31] Scottish Executive Health Department: *Healthy Working Lives Strategy* (2005)

[32] Scottish Association for Mental Health (SAMH) www.'samh.org.uk

[33] See Me Campaign www.wellscotland.info/mentalhealth/campaigns/see-me.html

[34] Scottish Recovery Network. www.scottishrecovery.net

[35] Mellow Parenting submission to NICE http://guidance.nice.org.uk/page.aspx?o=272140

[36] Choose Life Guidelines for reporting a suicide
http://www.chooselife.net/web/FILES/guidelines_for_reporting_a_suicide_sept_05.pdf

[37] Quality Outcomes Framework (QOF) www.primarycarecontracting.nhs.uk

[38] Mancini, A.D., & Finnerty, M.T.: *Recovery Oriented Practices Index* (ROPI): (2005).

[39] *Recovery-Oriented Practices Index*, unpublished manuscript, New York State Office of Mental Health

[40] Scottish Recovery Network www.scottishrecovery.net

[41] Leadership Programme - Scottish Executive Health Department: *Delivering for Mental Health*. 2006 http://www.scotland.gov.uk/Publications/2006/11/30164829/0

[42]Scottish Executive Health Department: *Rights, Relationships and Recovery, The Report of the National Review of Mental Health Nursing in Scotland* (2006)
http://www.scotland.gov.uk/Publications/2006/04/18164814/0

[43] Elizabeth Jamieson. *Delivering for Health and Applied Psychology: Current workforce, future potential*. NHS Education for Scotland (NES) 2006.
http://www.nes.scot.nhs.uk/documents/publications/classa/280906Workforce_Report.pdf

[44] Centre for Change and Innovation. *Doing Well by People with Depression: Programme Proposal.* Scottish Executive 2003.
http://www.show.scot.nhs.uk/sehd/publications/DC20030521Depression.pdf

[45] Scottish Executive 2006. *National Evaluation of the Doing Well By People With Depression Programme*. http://www.scotland.gov.uk/Publications/2006/07/12090019/0

[46]National Institute of Clinical Excellence: *Depression: management of depression in primary and secondary care - NICE guidance* 2004
http://guidance.nice.org.uk/CG23/?c=91523

[47] Scottish Executive Health Department: *Delivering for Health: Delivering for Mental Health Using Self-help in Primary Care and Community Based Services - A guide to everyday service delivery for mild to moderate psychological problems (Lessons from the Doing Well by People with Depression Programme)* December 2006
http://www.scotland.gov.uk/Resource/Doc/924/0044326.pdf

[48] *Evidence to Practice – A Guide to help services for the management of depression.* Scottish Executive 2005. http://www.scotland.gov.uk/Publications/2005/07/2994711/47119

[49] www.scottishrecovery.net

[50] National Institute of Clinical Excellence: *Depression: management of depression in primary and secondary care - NICE guidance* 2004
http://guidance.nice.org.uk/CG23/?c=91523

[51] E.Perring *Deprivation & Social Exclusion in Shetland* Shetland Islands Council 2005
http://www.shetland.gov.uk/datashare/upload/documents/FINALSOCDEP290506_1.pdf

[52] http://www.slam.nhs.uk/news/detail.aspx?id=32

[53] E.Perring *Deprivation & Social Exclusion in Shetland* Shetland Islands Council 2005 http://www.shetland.gov.uk/datashare/upload/documents/FINALSOCDEP290506_1.pdf

[54] Choose Life – A national strategy and action plan to prevent suicide in Scotland http://www.chooselife.net

[55] National Programme for Improving Mental Health and Well-Being Action Plan http://wellscotland.info

[56] Shetland Palliative Care Strategy

[57] Scottish Executive Health Department: *Delivering for Health: Delivering for Mental Health National Standards for Crisis Services: November 2006* http://www.sehd.scot.nhs.uk/mels/HDL2006_62.pdf http://www.scotland.gov.uk/Resource/Doc/155438/0041730.pdf

[58] NHSQIS*: Eating Disorders in Scotland - Recommendations for Management and Treatment.: Edinburgh. 2006.*

[59]Scottish Executive Health Department: *Forensic Mental Health Services HDL(2006)48* www.forensicnetwork.scot.nhs.uk

[60] 'Supporting Safer, Stronger Communities'

[61] HDL(2007)19. Sections 10 and 11 of the Management of Offenders etc, (Scotland) Act 2005. Implementation of the Multi Agency Public Protection Arrangements (MAPPA) in Scotland

[62] Regional planning documents on current plans for the development of regional medium secure care and national State Hospital plans. North of Scotland Planning Group Mental Health Developments Project http://www.tayside.scot.nhs.uk/nospg

[63] Scottish Advisory Committee on Drug Misuse (SACDM) & Scottish Advisory Committee on Alcohol Misuse (SACAM): *Mind the Gaps – Meeting the needs of people with co-occurring substance misuse and mental health problems – A Report of the Joint Working Group (2003)* http://www.scotland.gov.uk/Publications/2003/10/18358/28079

[64] Scottish Executive Health Department & Dementia Services Development Centre: *A Fuller Life – Report of the Expert Group on Alcohol related brain damage* (2004) http://www.nhshealthquality.org/mentalhealth/projects/1/Alcohol/d_9.html

[65] Scottish Executive (2007) *Delivering For Mental Health: Mental Health And Substance Misuse: Consultation Draft* http://www.scotland.gov.uk/Publications/2007/06/29120532/0.

[66] Centre for Addiction Research and Education Scotland (CARES) report on co-morbidity

[67] Mental Welfare Commission for Scotland: *Older and wiser - Findings from our unannounced visits to NHS continuing care wards*

[68] Scottish Executive *The Same as You?* 2000

[69] NHS Shetland Health and Homelessness Strategy and Action Plan 2002. Updated 2007 - 2008

[70]Shetland Local Housing Strategy and Shetland Homeless Strategy http://www.shetland.gov.uk/housing

[71] College of Occupational Therapists (2006) *Recovering ordinary lives: the strategy for occupational therapy in mental health services, a vision for the next 10 years. (Core) London: COT*

[72] Scottish Executive Health Department: *Healthy Working Lives Strategy* (2005)

[73] Mental Health (Care and Treatment) (Scotland) Act 2003 www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm

[74] The Mental Health (Care and Treatment) (Scotland) Act 2003 www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm

[75] Scottish Executive Health Department: *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)* http://www.scotland.gov.uk/Publications/2005/10/2191333/13337

[76] Mental health of children and young people in Great Britain, ONS 2004 http://www.statistics.gov.uk/downloads/theme_health/GB2004.pdf

[77] NICE Guidance on promoting the mental wellbeing of children in primary schools (in progress 2007) http://guidance.nice.org.uk/page.aspx?o=350205

[78] Scottish Executive *Step it Up: Charting Young People's Progress* (2003)

NHS Shetland

Shetland Islands Council

To: **Shetland NHS Board** **16 October 2007**
SIC Services Committee **18 October 2007**

From: **Head of Community Care**

Report No: SC10-07F

Carer Information Strategy

1. Introduction

1.1 This report introduces the 2007 revision of Shetland's Joint Carer Information Strategy for approval.

2. Links to Corporate Priorities

2.1 *Benefiting People and Communities* - The effective support of family and unpaid carers contributes to the general health and well being of the community.

2.2 *Sustainable Economic Development* - A reduction in demand for care services will help to keep the revenue budgets within sustainable limits

3. Background

3.1 NHS Boards are required by Scottish Ministers to produce a Carer Information Strategy for 2007-2010.

3.2 The Council and NHS Shetland first produced a Joint Carer Information Strategy in April 2005.

3.3 The Strategy was updated with comments from a wide range of stakeholders in 2006 and submitted to the Scottish Executive in accordance with national guidance in October 2006.

3.4 The strategy was approved by Scottish Ministers in March 2007 subject to additional information being provided by 31 October 2007.

3.5 The strategy has been revised in light of the comments received and further consultation with stakeholders locally has taken place. Consultation has included discussions at strategic planning groups, with carers through the work of the Carers' Link Group and with members of NHS100.

3.6 The strategy complements Shetland's Carers' Strategy and Young Carers' Strategy. The Young Carers' Strategy is currently being finalised. Once this is complete, it is intended that an overarching summary report will be prepared.

3.7 Implementation of the strategy is being taken forward by the Community Health Partnership.

4 Proposals

4.1 It is proposed that the revised strategy document is submitted to the Scottish Executive by 31 October 2007.

4.2 The Community Health Partnership (CHP) will continue to take the lead on implementing the Strategy and report progress via the CHP Committee.

5. Financial Implications

5.1 There are no financial implications arising directly from this report.

5.2 The costs of publishing the final strategy document will be met from within existing Council and NHS budget provision.

6. Policy and Delegated Authority[1]

6.1 All Social Work matters stand referred to Services Committee. The Committee has delegated authority to make decisions on matters within its remit and for which the overall objectives have been approved by Council, in addition to appropriate budget provision in accordance with section 13 of the Council's Scheme of Delegations.

[1] SIC Services Committee only

NHS Shetland

Shetland Islands Council

7 Conclusions

7.1 The NHS is obliged to produce a Carer Information Strategy and submit this to the Scottish Government in line with national guidance. The latest revision must be submitted no later than 31 October 2007.

7.2 The Council and NHS Shetland have worked together since 2004/05 to produce a joint Carer Information Strategy for Shetland.

7.3 Significant progress has been made in implementing the actions identified in the strategy through the work of Shetland's Community Health Partnership.

8 Recommendations

I recommend that Shetland NHS Board and SIC Services Committee:

8.1 Approve the Carer Information Strategy at Appendix 1 for submission to the Scottish Government and for publication.

Date: 25 September 2007 Report No SC10-07D1
Ref: CF/an

NHS Shetland

Shetland Islands Council

Carer Information Strategy

2007 - 2010

Ref: CF/AN
July 2007

Contents

Executive Summary

Recent research emphasises the need for good information and advice services as part of a range of resources and supports for carers.

The aim of the Carer Information Strategy is to provide better support for unpaid/family carers to enable them to continue in their caring role for as long as they are willing and able to do so, by identifying carers at an early stage and at any point of contact with NHS Shetland or the Council and providing them with the information and advice they need.

Shetland's first Carer Information Strategy was produced in April 2005. The Strategy was revised during 2006 and reissued in October 2006. The Scottish Executive approved the Strategy in March 2007 subject to further information being provided. The gaps identified in their evaluation have been addressed in the latest revision.

The Strategy states the principles adopted by both agencies when working to support carers. These reflect the specific needs of young carers (aged under 16) and carers from black and minority ethnic groups.

Areas for future service developments have been identified and include ideas for new information materials such as information packs for care at home services or residential care; displays in public places; "Quick Guides" to services; an interactive web site for carers; videos and audio tapes.

The strategy highlights the need for early identification of carers. Key posts are identified within NHS Shetland and the Council to act as Carer Identification Officers with responsibility within their area of work for carer identification and the promotion of information to carers, in particular their potential right to an assessment of their needs as a carer.

Carer awareness training for staff from the statutory agencies and independent sector will be developed and included in staff induction training.

A training programme for carers will be developed and cover topics such as moving and assisting, medication, stress management and benefits advice.

Shetland's Single Shared Assessment has a section devoted to carers' assessments and Joint Future Local Improvement Targets include carers' assessments as a priority.

The Carer Information Strategy complements and should be read alongside the Shetland Young Carer's Strategy and Carers' Strategy.

Introduction

Scottish Ministers require all NHS Boards in Scotland to prepare and submit to them for approval a "Carer Information Strategy".

Shetland's first Carer Information Strategy was prepared jointly by NHS Shetland and Shetland Islands Council as part of the implementation of the Joint Future Agenda locally. This was published in April 2005. Since then the Strategy has been updated and a new section summarising progress made on the implementation of the strategy has been added.

The Strategy helps NHS Shetland to:

- Meet the statutory duty of the NHS under the terms of the Community Care and Health (Scotland) Act 2002 to inform carers of their potential right to an assessment of need; and
- Meet the requirement of the Patient Focus Public Involvement (PFPI) initiative to have a strategy that meets the information needs of patients, relatives and carers.[1]

Objectives

Carers are identified at an early stage and at any point of contact with NHS Shetland or the Council and provided with the information and advice they need.

The specific information needs of young carers (aged under 16); of older carers and of carers from black and minority ethnic groups are met appropriately.

Carers are supported so that they can continue to perform their caring role for as much and as long as they are willing and able to do so.

[1] NHS Shetland is the generic name for Shetland NHS Board

Consultation

The Strategy was drafted by staff working with Shetland's Community Health Partnership drawing on work with colleagues in the Council; the wider NHS; voluntary and independent sector service providers; service user and carer representatives and the local carers support group.

The Strategy and later revisions have been circulated for comment in draft form to a number stakeholder groups. These include :-

- Voluntary and Independent Sector Organisations operating in Shetland
- NHS 100
- PFPI (Patient Focus Public Involvement) Steering Group
- Older People's Strategy Group
- Disability Strategy Group
- Shetland Mental Health Partnership

All comments received by 30 September 2007 will have been considered in finalising the latest revision of the strategy.

Progress made in implementing the strategy is monitored via the Joint Future management arrangements and reported regularly to the NHS Shetland's CHP Committee and Council 's Services Committee. An annual report will be produced and submitted to the Scottish Executive in line with current national guidance.

The Carers' Strategy and Young Carers' Strategy will be updated by end of September 2007 and an executive summary covering all three strategy documents will be produced and published.

Background

There are 660,000 unpaid carers in Scotland[2]. The 2001 census shows that 1,968 people in Shetland identified themselves as carers. Of these, nearly 60% are female, just over 66% are in employment and nearly 3% are under 16 years of age. Shared Care Scotland in their newsletter for January 2005 draws attention to research which demonstrates that unpaid carers are more likely to have health problems than non-carers and that this can be attributed in part to a lack of information and support[3].

The theme for National Carers week in June 2006 was "In Sickness and in Health" and emphasised the importance of carers' health and emotional well-being. Of 5,600 carers who took part in the 2006 Carers Week National Survey, 9 out of 10 thought that carers should be offered an annual health check.

A key feature of effective support services for carers is early access to information and advice.

Information Needs

Service users and carers need information to:

- Understand their health and care needs
- Know what services are available to them
- Participate fully and effectively in assessments of care needs and reviews
- Access and use care services appropriately
- Participate in the delivery of care
- Complain about services if they are unhappy about the care they receive
- Access other related services such as benefits advice

Work done previously in Shetland

In 1999, NHS Shetland and the Council completed a review of information available to service users and their carers. Staff worked with a carers' representative nominated through Shetland Voluntary Care Forum to produce a report, which made a number of recommendations. These included:

- Review of existing leaflets
- Better systems for distributing leaflets ensuring up to date copies were on display
- Developing new leaflets based on care group sections in the Joint Community Care Plan.
- Developing a web-site for social work incorporating links to other agencies web-sites including voluntary sector organisations operating in the care sector.

Currently work on the information needs of service users and carers is being taken forward through the PFPI initiative and a Carers' Link Group where carers meet with representatives of the Council, NHS Shetland and the voluntary sector. The Carers' Link Group is chaired by a carer.

[2] 2001 Census
[3] Shared Care Scotland News, January 2005

Information on services and service developments is made available routinely on the Council and NHS Shetland websites. This includes publication of all reports, policies, procedures and strategies as well as minutes of meetings and a number of discussion papers.

Work to identify carers generally has proved difficult as frequently carers ask to not have their needs considered separately from the cared for person and as in other parts of the country, many people do not see themselves as carers and it is thought locally that this is particularly true of young carers and those from minority ethnic groups in Shetland.

A working group has been set up reporting to the Children and Young People's Strategic Planning Group to develop the Young Carers' Strategy, which is available separately. Work is being rolled out across schools and through Shetland's shared assessment frameworks to identify young carers. Training on Shetland's Single Shared Assessment includes a session on carer identification focussing on the needs of young carers and those from minority ethnic and other equality groups. This will be a key strand in the promotion of the revised strategy in 2007/08.

Policy Framework

Nationally

This strategy has been developed within the context of national developments and legislation affecting carers. Key national policy documents and legislation include:

- Social Work (Scotland) Act 1968
- NHS & Community Care Act 1990
- Carers (Recognition and Services) Act 1995
- Children (Scotland) Act 1995
- Strategy for Carers in Scotland 1999
- Adults with Incapacity (Scotland) Act 2000
- Race Relations Amendment Act 2002
- Community Care and Health (Scotland) Act 2002
- Fair For All, 2002
- Mental Health (Care & Treatment) (Scotland) Act 2003
- Scotland's Health White Paper "Partnership for Care" 2003
- Delivering for Health 2005
- Getting it Right for Scotland's Children 2005
- Changing Lives 2006
- Delivering for Mental Health 2006

Links are demonstrated through the work of the Joint Future management and consultation framework. Carers' issues are an integral part of the work done on plans for community care client groups and are considered in their own right through the work of the Carers Link Group and a sub-group of the Children and Young People's Strategic Planning Group.

Locally

The Carer Information Strategy complements and should be read alongside Shetland's Joint Carers' Strategy, Shetland's Extended Local Partnership Agreement and Community Care Plans, Shetland's Local Delivery Plan for Health, Shetland's Joint Health Improvement Plan and Shetland's Young Carers' Strategy. These contain additional information relating to the services available to support carers locally and service developments planned for the future.

The **Young Carers' Strategy** identifies a number of objectives and planned actions to achieve these under the following headings:

- Identifying young carers and assessing their needs
- Reaching full potential
- Encouraging good physical and mental health
- Allowing choice and control for young carers

Shetland's **Joint Future Extended Local Partnership Agreement** www.shetland.gov.uk/socialwork-health/documents/ShetlandsJointFuture-ELPA2007-2010.pdf sets out joint management and resourcing arrangements for Joint Future services including services for carers. Service developments are initiated and progressed through the Joint Future management framework, which is linked to the CHP and is set out in the Scheme of Establishment for the CHP.

Race, Gender, Age and Disability Equality Schemes (website links www.shetland.gov.uk/equalopportunities/documents/EqualityDiversityStrategy1.pdf) for NHS Shetland and the Council have been developed co-operatively under the auspices of the Community Planning Board and the principles are reflected in this strategy.

Definitions

"**A carer** is generally defined as a person of any age who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live without the carer's help due to frailty, illness, disability or addiction. The support a carer provides may include moving and handling, help with feeding, personal hygiene and administering medication as well as providing emotional support, acting as an advocate or guardian for the cared-for person and enabling the person with support needs to access leisure and recreation."[4]

Adult Carers are recognised by the Scottish Executive as "**key partners** in providing care" with local authorities, the NHS and other support agencies.

Young Carers i.e. carers aged under 16, are recognised as a distinct group with specific needs. There is a multi-agency Young Carers' Strategy for Shetland that has been developed by the Children and Young People's Services Planning Group. Specifically all agencies are committed to ensuring that a child does not have a level of caring responsibilities that may undermine their ability to participate in education, leisure or social activities.

Carers have a **right to an assessment** to establish their "ability to provide or continue to provide care" for another person. Assessments for carers are an integral part of the Single Shared Assessment process and are available to anyone who provides "**a substantial amount of care on a regular basis**" – Community Care and Health (Scotland) Act 2002.

The definition of what comprises "**a substantial amount of care on a regular basis**" is left to each local authority to determine. Locally Shetland's Joint Future partners consider the contribution the care provided makes to the care plan and level of risk to the client if the level of care provided could not be maintained on a case by case basis so that the circumstances of the individual carer can be taken into account.

[4] Introduction of NHS Carer Information Strategies Draft Guidance – August 2004

Principles

- **Adult carers will be recognised and treated as key partners in the provision of care.**

  This means that:

  - Carers knowledge and expertise will be taken into account to ensure the cared-for person receives services that are right for their needs.

  - NHS and local authority staff will share information equally with carers provided the cared-for person has given their consent.

- **Young Carers under the age of 16 will be recognised first and foremost as children.**

  This means that:

  - Young carers will be supported so that their caring role does not have an adverse affect on their own social, leisure and educational opportunities.

  - Young carers will not have a greater caring role than they want.

  - Young carers will be informed of their right and eligibility for an appropriate assessment.

  - Staff in the NHS and the local authority will be sensitive to possible tensions between young carers and their parents/guardians.

- **Older carers will be supported to enable them to fulfil their caring role for as much and as long as they wish and are able to care.**

  This means that:

  - NHS and Council staff recognise that caring is likely to demand more of an older carer.

  - NHS and Council staff will focus on the impact of the caring role on the individual carer.

- **All carers will have access to information, advice and guidance in a format appropriate to their needs.**

  This means that:

  - General information will be made available in formats and languages that are accessible to, for example, young carers, carers with learning disabilities or sensory impairment, older carers and carers from black and minority ethnic groups.

  - Carers will be identified through the assessment process and specific information relevant to their own circumstances will be made available and accessible to them as appropriate.

  - Carers will be advised of NHS and Council complaints procedures.

  - Staff will understand the needs of carers and having the knowledge to meet carers' needs for appropriate information and advice.

- **All carers will be treated equally and will be able to access services to meet their needs irrespective of their race, religion/faith, sexual orientation, age, disability or gender.**

- **Carers from black and minority ethnic groups will be recognised and supported in accordance with the requirement of the Race Relations (Amendment) Act 2000 and NHS responsibilities under "Fair for All".**

  This means that:

  - Staff in NHS and the Council will recognise the effects of discriminatory behaviour and eliminate discriminatory practices affecting carers.

  - Staff will value diversity and demonstrate this through appropriate communication styles, attitudes and behaviour.

- **Carers of people with a mental disorder as defined by the Mental Health (Care & Treatment) (Scotland) Act 2003 will be recognised and supported in ways appropriate to their specific needs.**

  This means that:

  - Carers will be given information that is appropriate to their caring role with the cared-for person. This may include information about the types of disorder, medical condition, medication, treatment and practical issues relevant to their circumstances.

  - Where service users are unable to consent through incapacity and there is no formal arrangements already in place to support them, NHS and Council staff will work together with the nearest relatives and consider what action may need to be taken under the Adults with Incapacity (Scotland) Act 2000.

- **Staff at all levels of NHS Shetland and in the Council will work in partnership with a wide range of stakeholders to promote the needs of carers.**

  This means:

  - Working in partnership with carers themselves in line with "Partnership for Care"

  - Working with other agencies through the Community Planning Board and the Community Health Partnership on planning for the future.

  - Working jointly with carers and others on health improvement and well-being.

Roles and Responsibilities

Lead Officer
The Lead Officer for NHS Shetland with responsibility for the effective development and implementation of the Carer Information Strategy is the Director of Clinical Services (DCS). The DCS reports directly to the Chief Executive and sits on the Senior Management Team.

Patient Focus and Public Involvement Initiative
The Lead Officer for the Patient Focus and Public Involvement Initiative locally is the Director of Service Improvement (DSI). The DSI reports directly to the Chief Executive and sits on the Senior Management Team.

Through the PFPI and Carers' Link Group, carers will be invited to take part in focus group activities on a range of topics and contribute to reviews of policies and procedures including:

- Discharge Protocol
- Complaints procedures
- Information availability / accessibility
- Sign posting
- Key workers / named nurse role in providing information and advice

Carer Identification Officers
The post holders identified below will be responsible within their area of work for the promotion of information to carers and for carer identification.

GP practices	CHP Manager
Community Nursing Teams	Assistant Director of Nursing (Community)
Gilbert Bain Hospital	Hospital Manager
Montfield Hospital	Hospital Manager
Hospital and Community Pharmacy	Chief Pharmacist
Community Mental Health Team	Senior CPN (Community Psychiatric Nurse)
Children & Young Peoples Mental Health Team	Children's & Young People's CPN
Therapy Services	Hospital Manager
Community Care & Joint Future Services	Head of Community Care
Dental Services	Health Promotion Specialist with responsibility for Oral Care for Older People and Carers

Human Resources Managers
The Director of Human Resources for NHS Shetland and the Personnel Manager for the Council will be responsible for the development and promotion of carer-friendly employment policies. These will be in addition to and complement existing family friendly policies.

Training Managers
Induction programmes will be reviewed regularly as part of the implementation of the Carer Information Strategy to ensure all staff are aware of the need to identify carers at an early stage. Carers' issues will be key topics in training on Single Shared Assessment and the Integrated Assessment Framework for Children.

Line Managers/Supervisors
All staff with supervisory responsibilities will be aware of and responsive to the needs of employees who are carers. Employees should have the opportunity to discuss any issues they have in their roles as carers confidentially in supervision or with the staff welfare officer/personnel section. The Council and NHS operate flexible carer and family friendly employment policies.

All Staff
Every member of staff through induction programmes will be made aware of carers' issues and be able to provide information/signposting to services.

Carer Identification & Assessment Process

Information Sharing

There is an Information Sharing Protocol jointly agreed by the Council and NHS Shetland. The protocol underpins the Single Shared Assessment, the Integrated Assessment Framework for Children and all joint working across agencies.

Information is shared on a case-by-case basis subject to the agreement of the service user that information about them can be shared. Shetland's data Sharing Partnership is working to ensure that we have robust systems in place for sharing and not sharing where consent is withheld.

Aggregated Information is also shared and published by the Council and NHS Shetland to inform planning processes.

There is a procedure and forms in place to collect carers contact details through primary care and social care services. The information is used to create a mailing list held by the Community Health Partnership.

Hospital Admission

Information on carers issues is included in the booklets given to patients, relatives and carers when someone is admitted to hospital. Carers are routinely identified on admission so that they can be involved in discussions regarding the care and treatment of the cared for person and also advised of their rights as carers. Carers are an integral part of the care planning process and work with staff to facilitate early discharge from hospital.

Hospital Discharge

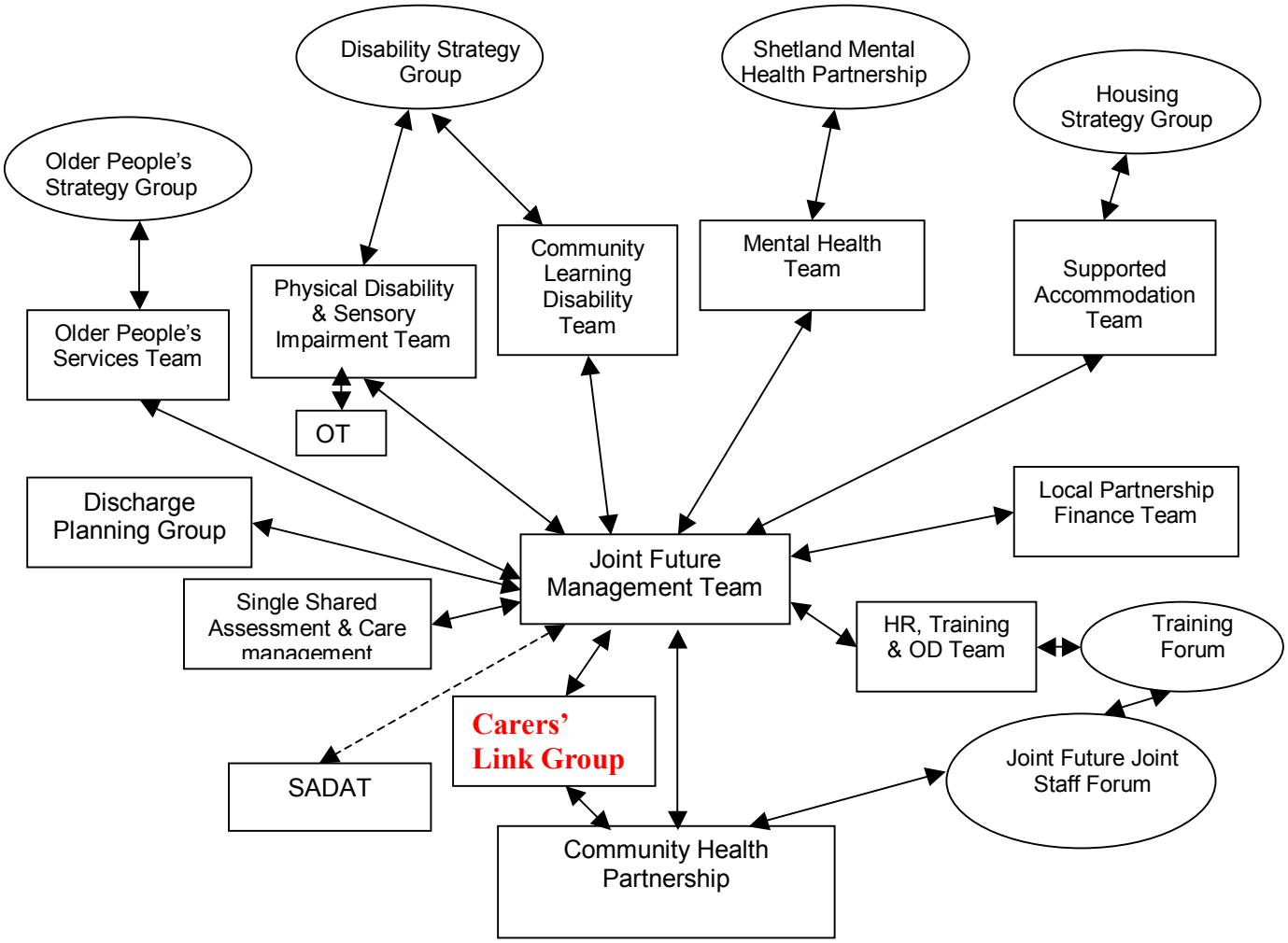
The Discharge Liaison Nurse and Health Service Liaison Social Worker each have a key role in ensuring effective carer identification and carers assessment where appropriate prior to discharge.

Both post holders work together to ensure carers' issues are taken into account fully during discharge planning. They ensure that specific information is made available to carers in a format that is accessible to them and relevant to their particular circumstances, including signposting other resources which may be useful.

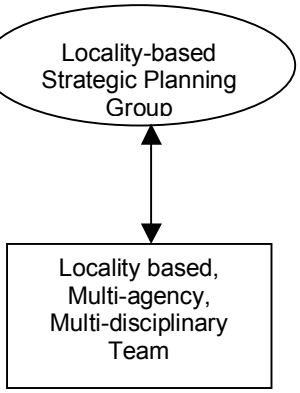
Partnership Working

Community Health Partnership (CHP) and Joint Future
The Scheme of Establishment of the CHP locally incorporates Joint Future planning and management arrangements. These are shown in the diagrams below:

Specialist Services



Generic Services



There are 7 localities:

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

Service users and carers are represented on the strategic planning groups and on the Public Participation Forum (PPF). The PPF for Shetland is being developed as a network closely linked at locality level with the seven Local Service Delivery Groups.

One of the main roles of the PPF is "to engage local service users, carers and the public in discussions about how to improve services to enable the CHP to respond to the needs, concerns and experiences of patients, carers and families".

Carers service developments are promoted by the Joint Future Management Team which brings together lead officers from all specialist care groups, human resources and finance specialists in a functional management relationship across the NHS and Council.

Carers' Link Group

This group is carer led and brings together representatives from the Council, NHS Shetland and the voluntary sector. The group monitors progress against the objectives of the Carer Information Strategy and Joint Carers Strategy advising the NHS Board via the CHP.

Children's Services Planning Group (CSPG)

The CSPG draws together a wide range of professionals from the statutory and voluntary sector. A dedicated sub-group has developed a Young Carers' Strategy and promotes the identification of and provision of information and resources to support young carer's through all staff who come into contact with children and young people including health professionals, teachers, youth workers, social workers.

The CSPG links into the CHP. The Children's Service Plan draws together all aspects of planning for children's services including the needs of young carers.

Voluntary Sector

Shetland Council of Social Service has established and continues to support a local carers group, which meets regularly to discuss issues affecting carers. Staff from the Council and NHS Shetland attend these meetings to provide information and advice and to listen to the concerns of carers.

Information and Advice Services

Current Service Provision

The Council and NHS Shetland routinely produce a wide range of information on the services available from the statutory agencies and voluntary sector organisations. Information is made available in different formats on request e.g. different languages, easy read, large print. Local interpreters are available for most European languages.

- **Signposting** – All staff are increasingly encouraged to operate as individual one-stop-shops, signposting people to the services they need and supporting them to access services. This approach is being promoted through the work of the Local Service Delivery Groups and the evolving PPF network.

- **Booklets / Fact sheets** – NHS Shetland provide booklets / fact sheets on specific conditions, illnesses and treatments. These include advice to all patients and their carers on discharge from hospital.

- **Leaflets** – are available on all community care service provision in different languages and Braille or audio on request, including leaflets for carers or young carers giving information on the right to an assessment and a range of useful contacts.

- **Websites** – the Council and NHS Shetland websites (as below) provide up to date information on all services and contact information. Further work is needed to develop interactive sessions and use the internet to consult carers and the public on needs.
  SIC: www.shetland.gov.uk
  NHS: www.shetlandhealthboard.org

- **Local Area Co-ordinator (LAC)** – The Council employs a full time Local Area Co-ordinator. The LAC provides information and advice to people of any age who have a learning disability, their family and carers. The LAC acts as a link worker across agencies to help sign post resources and support services available.

- **Single Shared Assessment (SSA)** – Carers are identified as part of every SSA and on referral for an assessment. Referral forms and the SSA prompt for identification of carers and whether or not a carer's assessment is required/requested.

- **Carers Assessment** – Carers who provide a "substantial amount of care on a regular basis" are entitled to an assessment of their needs as a carer in their own right. There is a separate section in the SSA process that focuses on the needs of carers. Training on carers assessment is an integral part of multi disciplinary training on the SSA which is available to a wide range of professionals in the NHS, the Council and voluntary sector. CareNap D is used to provide additional information for people with dementia and their carers.

- **Voluntary Sector Organisations** – the Council and NHS Shetland work in partnership with a number of organisations in the voluntary sector providing information on the services they provide and who to contact. These include:

Advocacy Shetland	Epilepsy Shetland	Shetland Crossroads Care Attendant Scheme
Age Concern	Firth & Mossbank Family Centre	Shetland Hospitals and Community Friends
Arthritis Care	MS Society (Shetland Branch)	Shetland Link-up
Association of Shetland Community Councils	Moving On	Shetland Pre-School Play Ltd
Befriending Scheme	Red Cross	Shetland Stroke Support Group
Breast Cancer Support Group	Scottish Pensioners Association	Shetland Womens Aid
British Heart Foundation	Shetland Alcohol Support Services	Shetland Youth Information Service
Cancer Care	Shetland Autism Support	Shoard
Care for Unst	Shetland Childcare Partnership	Special Needs Action Group (SNAG)
C.O.P.E Ltd	Shetland Citizens Advice Bureau (CAB)	Stepping Stones Club
Relate Shetland	Shetland Club for the Deaf and Hard of Hearing	The Samaritans
Diabetes UK	Shetland Community Drugs Team	Voluntary Centre Shetland
Disability Shetland	Shetland Council of Social Services (SCSS)	WRVS
Shetland Bereavement Support Service		

- **Shetland Citizens Advice Bureau** offers free, confidential advice to any member of the public. They also operate a **Welfare Rights Service** with funding from Shetland Charitable Trust and a **Direct Payments Support Service** commissioned by the Council.

- **Volunteer Resource Centre** - Many other local voluntary organisations provide information, advice and support to carers. In June 2005, SCSS opened a new Volunteer Resource Centre in Lerwick bringing together many local voluntary organisations under one roof. NHS Shetland and the Council work closely with SCSS to ensure that a comprehensive range of materials is available to service users and carers at the new centre.

- **Independent Advocacy Services** - NHS Shetland and the Council jointly commission a range of independent advocacy services. These include:

  - Generic advocacy service for all users of health and social services
  - Carers' advocacy specifically for unpaid/family carers.

- Specialist mental health advocacy services to meet the needs for advocacy of people with a mental health disorder as defined by the Mental Health (Care & Treatment (Scotland) Act 2003.

- **Counselling Services**

  Counselling services are available through each of the 10 Health Centres across Shetland. Some voluntary sector organisations also provide counselling from COSCA trained counsellors. These include:

  - Shetland Alcohol Support Services
  - Shetland Community Drugs Team
  - Women's Aid
  - Shetland Link Up
  - Shetland Youth Information Service (SYIS)
  - Shetland Bereavement Support Service

Future Developments

Ideas for additional information resources include:

- Using audio-visual formats e.g. videos, audio tapes. Recently a training DVD was produced with the help of a service user with multiple sclerosis.

- "Quick guides" to services

- Laminated cards with key contact details

- Information packs including
  - Discharge pack
  - Care at home pack
  - Residential care pack

  These would complement the "Helping Hands" pack prepared by Disability Shetland for families with a child or young person with disabilities.

- Displays in public places

Training

For Carers

Shetland's Joint Future Joint OD and Training Plan includes courses developed specifically for carers covering the following topics:

- Moving and assisting
- Benefits advice
- Stress management
- Administering medication
- Dementia
- Challenging behaviour

Carers can also access funding via the Social Care service to cover reasonable travel and accommodation costs and course fees for specialist training courses in mainland Scotland on care for specific conditions. This contributes to the development of the role of "expert carers" in the community. Funding is subject to an individual assessment and identification of potential experts who are prepared to share their knowledge with other carers and staff.

For Staff

Carers issues are included in induction programmes for all frontline staff / practitioners and will cover carers potential entitlement to an assessment, identification of carers and diversity /equality issues. Diversity training is a key priority for all NHS staff. Carer awareness and disability awareness is being looked at together in some training programmes for NHS staff.

Multi-agency training in Single Shared Assessment Procedures covers the carer's assessment. There is a separate session in the SSA training on carers with particular emphasis on the needs of young carers and of minority groups in the community. The IAF also promotes the needs of young carers. Both training programmes are available to a wide range of professionals including community and hospital nursing staff, GPs, social workers, occupational therapists and physiotherapists.

Carers' issues are considered routinely as part of the on-going revision of training programmes.

For Voluntary Sector Staff and Volunteers

Training opportunities will be made available to staff in the voluntary sector and to volunteers to support them in their work with cares.

Child Protection Training
Multi-agency procedures and training programmes are well established across Shetland and include issues relating to the needs of young carers.

Funding

Many of the costs of providing information and advice services are included in other service budgets. The main sources of funding for services that include a focus on information and advice for carers that can be identified separately are indicated below.

The figures shown are for 2007/08 and are expected to be annually recurring unless otherwise stated.

NHS Shetland

TBA[5] includes grant funding from the Queen's Nursing Institute	
North and West mainland carers' groups	£18,000

Shetland Islands Council

Public Information e.g. leaflets.	£8,050
Training for carers	£2,500*
Local Area Co-ordinator	£29,940
Direct Payments Support Service	£12,480
Independent Advocacy	£15,000

* Training opportunities are available for carers organised by the Council and NHS Shetland for which the funding is not identified here. A Joint Training and OD Plan is available separately

Shetland Charitable Trust

Welfare Rights Service	£ 34,000

[5] To Be Advised

Action Plan

Task	Timescale	Lead Officer / Agency
Review public information with carers in mind. **Reviewed in 2005/06 and new information made available**	On-going	Snr Planning & Information Officer, SIC/NHS
Increase amount of information available on websites. **Done**	On-going	Director of Service Improvement/ Clinical Governance Support Team
Develop interactive website for carers	2007/08	Snr Planning & Information Officer, SIC/NHS
Develop on-line carers support network	2006/07/08	TBA
Review and formalise distribution processes for information on services to ensure up-to-date versions are available in all locations e.g. GP surgeries, hospital wards, Council offices, websites, voluntary sector organisations, social care settings.	Sept 07	Snr Planning & Information Officer, SIC/NHS
Revise Discharge Protocols to include explicit reference to the identification of carers and their right to an assessment of need.	Reviewed annually	Snr Planning & Information Officer, SIC/NHS
Publicise training plans for carers and include training for staff on carers issues in Joint OD and Training Plans.	Reviewed Annually	Training Manager, SIC Social Care Service
Develop training programmes for carers including moving & handling, benefits advice, stress management, administering medication and challenging behaviour.	Completed and reviewed annually	Training Manager, SIC Social Care Service
Review training programmes for carers and identify priorities	October 2007	Carers' Link Group
Develop training programmes for staff including specific training courses on carer identification and focus on carers in other training e.g. SSA, IAF, staff handbook, junior doctors' induction, monthly induction for all new staff, mandatory refresher training which has a session which is carer led. Develop additional/refresher training for hospital staff on carer identification.	Completed and reviewed annually October 2007	Training Manager, SIC Social Care Service, Training Manager, NHS Shetland

Promote carers issues via Health Centres and Primary Care staff ➢ Include carers issues in training for all staff including receptionists - **done** ➢ Provide literature for patients and their carers e.g. leaflets, fact sheets - **done** ➢ Develop health promotion libraries at health centres for patients and their carers - **done** ➢ Publicise contact details for carers services, information and advice – **done** ➢ Ensure monitoring mechanisms for new GMS contract. Organisational Quality Indicator 9 – **in place** ➢ Develop the role of community and GP practice nurses in identifying and supporting carers – **on-going. Directed and Enhanced service being implemented in 7 practices, 3 others doing via community nursing. Community Nurse Bixter & Walls, as part of degree course, is doing a piece of work on the improvement of health care for carers.**	2006/07 **2006/07**	CHP Manager
Promote carers issues via community pharmacists ➢ Ensure community pharmacists have a range of up-to-date information available for carers e.g. sign posting. **Post Cards in dispensed medicines bag in 2005.** ➢ Develop community pharmacists role in identifying and supporting carers. **Meetings held with community pharmacists and Strategy promoted.**	Completed Arrangements reviewed annually	Chief Pharmacist
Promote carers' issues for black and minority ethnic groups	Workplan to be developed in 2007	PFPI Steering Group
Promote carers issues across localities via local carers groups in North, West and Central and through the Local Service Delivery Groups and PPF network	Review report June 2008	Carers' Link Group

Publicise carers' issues through events in annual national Carers Week and Carers Rights Days. **Events organised in collaboration with Shetland Council of Social Services in 2006 and 2007.**	On-going	CHP Manager

Progress against the action plan will be monitored regularly by the Joint Future Management Team and reported to the CHP Committee and the Council's Services Committee.

Summary of Progress 2005 – 2007

Shetland's CHP

The Primary Care Facilitator within the CHP has taken forward a range of tasks from the 2005 Carer Information Strategy. These include:

- Development of a carers' database / mailing list.
- Production of a range of information materials including:
  - postcards and pre-paid letters
  - posters
  - leaflet on support available for carers
  - booklet on current support services and future plans.
- Carer awareness training for GP practices.
- Representation at conferences on carers' issues, including:
  - Highland Carers Forum annual conference and launch of Care 21 report September 2005;
  - Carers Scotland "Carers into Employment Workshop" in February 2006.
- Support for GP practices on carers' issues:
  - promoting Directed and Enhanced Services for carers;
  - reviewing performance against quality indicator 9 at Quality Outcomes Framework Review visits;
  - encouraging GP practices to maintain their libraries of health promotion literature as part of the GMS contract;
  - developing the roles of community nurses and GP practice nurses in identifying carers.
- Carers Week Activities 2006 and 2007:
  - arranging information stands in health centres and care centres;
  - registering for Carers Week and Carers Rights Days;
  - arranging programmes for events to be held on Carers Rights Day in 2005 and 2006.
- Representation at local groups:
  - attending Carers Link Group;
  - attending Social Forum in Carers Week;
  - attending PFPI meetings.
- Obtaining external funding to establish carer support groups in North and West Mainland Shetland.
- Provide training on carers' issues and particularly young carers as part fo the SSA and care management training programme

Shetland Council of Social Service and Carers Link Group

The Development Worker with Shetland Council of Social Service (SCSS) has taken the lead in setting up a Carers Link Group to support Carers in Shetland. The Link Group includes representatives from SCSS, SIC Social Care and CHP and is carer-led.

Through 2005-2007 the Link Group has met regularly to discuss carers issues and support a local carers' group. Work has included:

- Hosting and facilitating the local carers' group. The group meets once a month to:
  - share experiences / peer support
  - receive information e.g. benefits advice;
  - social activities.

  Attendance varies between 5 and 10 carers per session. A report on the Carers' Group is available separately.
- Adopt a simple constitution;
- Planning and co-ordinating activities for National Carers Week 2006. An evaluation report of Carers Week activities is available separately
- Publicising carers issues e.g. through press releases; poster and leaflet campaigns.

Future Plans are to:

- support and encourage the Carers' Group to become autonomous; to self-organise and develop the Group;
- support the Group in making applications for funding;
- encourage individuals in the Group to train to be "expert carers"[6] to:
  - take part in Carer Awareness Programmes for front-line staff;
  - develop peer support networks through meetings, internet and telephone contact;
  - be the voice of carers in a range of forums e.g. on Carers Link Group; on strategic planning groups and service redesign project teams;
- be a sounding board for service providers in all sectors;
- organise carers-led events in National Carers Week and for Carers Rights Day.

[6] Ref: Scottish Executive NHS Carer Information Strategies, NHS Circular HDL (2006)22, July 2006

Quality Framework and Monitoring Mechanisms

Specific targets and monitoring mechanisms for key deliverables are identified in the table below.

Information materials

Review by PFPI group taking into account the following attributes:

- Status (formal, informal, generic, specialist etc.)
- Accessibility / availability
- Relevance
- Accuracy
- Timeliness (of availability to users / carers)
- Clarity (language, style, format) including arrangements for minority ethnic groups.
- Diversity (culturally sensitive, available in other languages)

Training

- Feedback from participants ("happy" sheets)
- Numbers accessing training opportunities
- Numbers of carers from minority ethnic groups accessing training

Carers Identification & Assessment

- Local Improvement Targets (LITs) for the Joint Future Agenda include targets for numbers of carers assessments completed and times for assessments from referral to completion and service provision. The LITs are reported to the Scottish Executive and published.
- Targets include 21 days for completion of complex assessment and service delivery; 2% increase in short break opportunities year on year; increase by 40% over the next 5 years the opportunities for supported employment for adults with disabilities and/or mental health problems including learning disabilities. This is a key priority for carers in Shetland
- Numbers of carers identified will be published locally by age and ethnic group.

Carers Complaints

- Issues arising from carers' complaints will be reported to the Joint Future Management Group and acted upon.
- All information will be made available to DSI as lead for the strategy. Information will be published with details of any action taken as a result.
- The individual carer's right to confidentiality will be respected at all times.

NHS Shetland Corporate Action Plan (CAP)

The Board's Corporate Services Manager collates information to monitor progress against the CAP. This information is reported regularly to Board members and published in the Board's annual report. The CAP includes sections on the work of the CHP on the carers' strategies locally and links to more detailed workplans that are reported quarterly to the CHP Committee.

Carers Involvement

The Carers Link Group has a key role in monitoring the performance of Shetland's CHP partners on implementing the carers' strategies. Reports and concerns from the Link Group are addressed via the CHP.

Bibliography

Social Work (Scotland) Act 1968
NHS & Community Care Act 1990
Children (Scotland) Act 1995

Carers (Recognition and Services) Act 1995

"Caring about Carers" A National Strategy for Carers 1999

"Strategy for Carers in Scotland" November 1999

Adults with Incapacity (Scotland) Act 2000
Community Care and Health (Scotland) Act 2002

Race Relations Amendment Act 2002
New Statutory Rights for Carers: Scottish Executive Circular No. CCD2/2003

"Fair For All" (Scottish Executive 2002)

Scotland's Health White Paper "Partnership for Care" 2003
Mental Health (Care & Treatment) (Scotland) Act 2003
Introduction of NHS Carer Information Strategies: Draft Guidance – August 2004

"Partnership for Care" Scotland's Health White Paper – February 2003

Shetland's Single Shared Assessment, 2004

Shared Care Scotland News, January 2005
Delivering for Health 2005
Getting it Right for Scotland's Children 2005

Scottish Executive NHS Carer Information Strategies, NHS Circular HDL (2006) 22, July 2006

Changing Lives 2006
Delivering for Mental Health 2006

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Shetland Childcare Partnership Review – Membership and Terms of Reference

1. Introduction

1.1 This Report asks Members to agree to the Terms of Reference for the Review to be carried out with the Childcare Partnership and asks for nominations for Members to participate in the review.

2. Links to Corporate Priorities

2.1 This report will contribute to the Corporate aim of developing Member engagement in systematic performance reporting, review and scrutiny.

2.2 Further, the Report supports the (developing) Corporate Objective that,

> "The Shetland Childcare Partnership, properly resourced, is well placed to co-ordinate the essential redesign early years services to develop affordable models of childcare throughout Shetland."

3. Background

3.1 In August 2007, Services Committee agreed that the Council should invite Shetland Childcare Partnership to participate in a short life working group. It is intended that this group will review the current governance arrangements, including the position of the Chairperson which is vacant, and also consider in detail the Council's role and remit with regard to the delivery and support for Childcare services in the future.

3.2 Shetland Childcare Partnership has indicated their willingness to participate in a review.

3.3 Members may wish to note that Councillors' Manson and Robinson were appointed to the Partnership.

4. Proposal

4.1 The Draft Terms of Reference for the review of the Childcare Partnership is included at Appendix 1, for approval.

4.2 I invite Services Committee to nominate a small number of Members to participate, with members of staff and partners of the Childcare Partnership, in this review.

5. Financial Implications

5.1 There are no significant financial implications arising from this Report. Any expenses incurred by Members in attending meetings of the review group will be classed as an approved duty and met from the Members' Expenses budget head.

6. Policy and Delegated Authority

6.1 In accordance with Section 13 of the Council's Scheme of Delegations, the Services Committee has delegated authority to make decisions on the matters within approved policy and for which there is a budget.

7. Conclusions

7.1 This Report establishes the framework for carrying out a review of the Council's relationship with the Childcare Partnership.

8. Recommendations

8.1 I recommend that Services Committee: -

(a) agree the Terms of Reference, at Appendix 1, to be the basis of the review of the Council's relationship with the Childcare Partnership, the detail of which can be worked up with the review group; and

(b) appoint a number of Members to participate in the Shetland Childcare Partnership review.

Ref: HAS/sa Report no: ESCD-17-F

Childcare Partnership – Governance and Service Review

Draft Terms of Reference for Approval

Partners

Shetland Childcare Partnership
Shetland Islands Council

Purpose

To review the governance arrangements and ongoing delivery and support for Childcare services by Shetland Islands Council.

To review the governance arrangements in terms of:

- Links to strategic direction and relevant plans
- Legal nature of partnership and relationship with SIC decision making structures, scheme of delegation and employed staff
- Role and Remit of Chairperson
- Service reporting arrangements
- Staff reporting arrangements (particularly difference between Board and line management)
- Service performance
- Resource allocation, finances and budgets

To review the ongoing delivery and support for childcare services by Shetland Islands Council in terms of:

- Role of Children's Services
- Role of Schools Service
- Commissioning Strategy – public / private / voluntary sector – for the following service areas:

    - Out of School Care
    - Breakfast Clubs

Tasks

- Identify legislative requirements
- Describe current arrangements
- Identify governance and service issues and gaps that need resolution
- Identify best practice from elsewhere

Project objectives

- To identify appropriate governance and reporting arrangements which protects the integrity of the partnership as an independent entity but also ensures that the Council's reporting requirements are met
- To provide clarity (where required) to SIC staff who support and advise the partnership as to their responsibilities to the Partnership and to their employer

- To agree an appropriate commissioning policy for the services currently provided by the SIC, where there are options for those services to be delivered in an alternative way

Project Team

To be determined.

Project Board

To be determined.

Timescale

To be determined.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Mareel Project – Roles and Responsibilities

1. Introduction and Key Decisions

1.1 This Report asks Members to agree the three-way partnership between the SIC, Shetland Charitable Trust and Shetland Arts with regard to the delivery of the Mareel project, (the cinema and music venue).

2. Links to Corporate Priorities

2.1 This project is approved for funding through the Council's Capital Programme. Clarification of the roles and responsibilities supports the Council's commitment to effective project and risk management.

3. Background

3.1 Shetland Islands Council has approved a capital contribution for the Mareel project of £5.1M.

3.2 The Council has supported Shetland Arts to work up the application for external funding from the Scottish Arts Council, by way of service and technical advice and information. The Council has strategic responsibility to support cultural and leisure activities in Shetland, as expressed in the multi-agency Cultural Strategy.

3.3 Shetland Charitable Trust has agreed in principle to meet any running costs deficit of up to £100,000 per annum (subject to its financial commitments at that time).

3.4 The Mareel multi agency Project Team following careful consideration of the options for operation of the new venue formally invited Shetland Arts Development Agency to undertake that role. Shetland Arts Board of Trustees subsequently agreed to be operator of the venue.

3.5 It is appropriate to formalise the three-way partnership agreement in order to help clarify the financial, technical and service risks associated with this significant capital investment.

4. Proposal

4.1 The framework three-way partnership is enclosed as Appendix 1. This sets out the selective roles and responsibilities of each of the key partners. I would propose to seek the formal agreement of Shetland Charitable Trust and Shetland Arts to this framework agreement, should Services Committee accept the framework.

5. Financial Implications

5.1 There are no direct financial implications arising from this Report.

6. Policy and Delegated Authority

6.1 In accordance with Section 13 of the Council's Scheme of Delegations, the Services Committee has delegated authority to make decisions on the matters within approved policy and for which there is a budget. However, the recommendation in this report seeks to formalise a partnership agreement for which no delegated authority has been given. Therefore a decision of the Council is required.

7. Recommendations

7.1 I recommend that Services Committee recommends that the Council: -

(a) approve the framework agreement for the Mareel Project, set out in Appendix 1; and

(b) delegate to the Executive Director of Education and Social Care the authority to conclude the detail of the agreement with Shetland Charitable Trust and Shetland Arts.

Ref: HAS/sa Report no: ESCD-19-F

ROLE **APPENDIX 1**

Shetland Islands Council

- The creator of Shetland Arts
- Responsible for the delivery of the Cultural Strategy
- To provide funding of up to £5.1m for the Mareel Project (the Cinema and Music Venue) from the General Fund Capital Programme by way of grant aid to Shetland Arts
- Provider of strategic direction on cultural service needs
- Provider of technical advice and support on the management of the capital project, by way of a service level agreement or similar with Shetland Arts
- To put in place contractual arrangements with Shetland Arts for the overall development and management of the capital project, including finances (by way of grant offer letters, service level agreements or similar).

Shetland Arts

- To deliver arts services in line with the Cultural Strategy
- To enter into a contractual / partnership agreement with Shetland Islands Council to ensure that the project is delivered on time and on budget
- To work up the detailed Stage 2 application for funding from the Scottish Arts Council
- To explore and secure alternative external funding to make up the difference between the cost of the project and the SIC / Arts Lottery contributions
- To consult and communicate with service users
- To develop appropriate policies, procedures, systems and staffing arrangements for the operation of the new facility
- To develop appropriate arts based programmes and training activities to maximise the use of the new facility.

Shetland Charitable Trust

- To fund current service arrangements (revenue costs) by way of grant aid to Shetland Arts
- To fund the any deficit on the running costs of the facility up to £100,000 per annum (subject to the Trust's financial strategy at that time) by way of grant aid to Shetland Arts.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Social Work Inspection Agency Performance Agency (SWIA) Inspection Reports – Action Plan for Social Work

1. Introduction and Key Decisions

1.1 This Report asks Members to agree the Action Plan to address the recommendations for service improvement which were identified by the recent Social Work inspection.

2. Links to Council Priorities

2.1 Effective and efficient Social Work services are key to delivering the Council's priorities of social justice and community safety. Child protection is the Services Committee's principal priority and there is a desire to maintain a modern and affordable range of community care services.

3. Background

3.1 The Social Work Inspection Agency (known as SWIA) undertook a review of Social Work services during 2007. Their Report with recommendations was published and reported to Members at a Special meeting of Services Committee on 6 August 2007. There is a requirement on the Council to agree an Action Plan with SWIA by 29 October 2007, to address the recommendations made.

3.2 The inspection process identified nineteen recommendations for service improvement. Staff have identified a further two service improvements, which they would wish to progress.

4. Proposals

4.1 An Action Plan is being developed with input from staff, service users and our Link Inspector. The Action Plan is contained in Appendix 1 and sets out the recommendations which we need to address alongside planned actions and service outcomes. It is clear that there is an underlying philosophy that if our systems are systematic and comprehensive, our services will become better. In all that we do, we must not lose sight of the fact that the whole purpose of delivering on the recommendations is to improve the services we

provide for this community. In some cases, we hope to improve actual service delivery through better consultation with service users, clearer information and better planning. In most cases, the improvements relate to the way in which we do our business and include topics such as financial and service planning, training and workforce development, risk management, procurement and management reporting.

4.2 In most cases, the responsibility for delivering on the recommendations rests with members of staff within the Education and Social Care Department. Some actions require the Council to change some of the corporate business systems, for example to better link up service planning and financial planning and to review our approach to risk management. These actions require to be addressed by the Council's Executive Services Department.

4.3 One key action which will require input from Members is Recommendation fifteen, "The Council should work towards reconciling the level of service provision with the sustainable funding available to support that level in the medium to longer term".

5. Financial Implications

5.1 There are no direct financial implications arising from this report.

6. Policy and Delegated Authority

6.1 All social work matters stand referred to the Services Committee. The Committee has delegated authority to make decisions on matters within its remit and for which the overall objectives have been approved by the Council, in addition to appropriate budget provision, in accordance with Section 13 of the Council's Scheme of Delegations.

7. Recommendations

7.1 I recommend that Services Committee:

(a) approve the framework Action Plan at Appendix 1; and

(b) note that the Plan will continue to be developed with staff, stakeholders and our Link Inspector until its final submission at the end of October; and

(c) therefore delegate to the Executive Director of Education and Social Care the final format and content of the Action Plan, in line with SWIA guidelines.

Our Ref: HAS/sa Report No: ESCD-22-F

Section Heading	Reccommendations: Social Work Services should:	Quantfiable Outcomes	Steps to Achieve Outcomes	Lead Officer	Actions	Consultation with Stakeholders	Progress	Financial Impact	Evidence and Monitoring Arrangements	Completed
APPENDIX 1										
Outcomes for people who use social work services	Shetland Islands Council Social Care services should systematically gather information on outcomes for people who use services.	A systematic consultation mechanism, which feeds into needs assessments and service design/delivery.		Dougie Shearer	Service Managers to ensure all staff input assessment and service details onto SWIFT.		Ongoing.	None, WER.	Monthly management reports and yearly Scottish Government returns.	
Impact on staff	Social Care services should review its administrative structure and should ensure that administrative staff are included in the employee review and development programme.	Review of administrative structure, to ensure services are appropriately supported at the front line		Christine Ferguson	Administrative staff to be placed in care centres.		Complete, Summer 2007.	None, WER.	Physical location.	Yes.
				Christine Ferguson	Front line staff to be included in the Employee Review and Development programme, by Unit Managers		Ongoing.	None, WER.	Employee Review and Development Records.	
				Christine Ferguson	Career grade structure to be implemented for front line administrative staff.		Awaiting confirmation of grade from Single Status Project Manager (due by end Sept 2007)	£X, per annum, reflecting a slight increase in grade for (how many?) postholders.	Personnel and Payroll Records (CHRIS system).	
		Review of administrative structure, to ensure services are appropriately supported in the central office function		Hazel Sutherland	Proposals for additional administrative staff were presented to the Chief Executive in August 2007.		Unsuccessful.			

O: Planning/Inspection/Action Plan

Notes:
WER = Within Existing Resources

				Graham Johnston, Hazel Sutherland and Shona Thompson	Reviews of financial / personnel / administration systems and processes at corporate / departmental and front line level will be undertaken during 2007, with a view to simplifying our business practices to the extent that additional administrative time can be released for new tasks. This will also be a consideration for the service re-design part of our Single Status project, which looks to modernise our business practices for the future.		Working Group membership and Terms of Reference being established.	Not quantified financially but expectation of time efficiency savings.	Project Initiation Document.	
		Ensure administrative staff are included in employee review and development programme		Shona Thompson	Office based administrative staff to be included in the Employee Review and Development programme.		In place for all administrative staff except 4 in Children's Services, due to be completed by November 2007.	None, WER.	Employee Review and Development Records.	
Impact on the community	Social Care services should review the method and format of information made to the general public and ensure maximum accessibility.	A range of appropriate materials, to give the right information, to the right people, at the right time and in the right format.		Dougie Shearer	A central database for storing procedures and public information ensuring details can be updated, maintained and distributed regularly.		Meetings booked to identify responsibility and work involved. Should be in place by Jan 08.	None, WER.	Database(s) storing relevant inforamtion.	

Notes:
WER = Within Existing Resources

Delivery of key processes	Social Care services should put in place a more detailed eligibility and priority framework.		A transparent prioirty framework liked to outcomes, across Community Care Services . Published detailed eligibility criteria for specialist services.	Marilyn Harris	Develop priority framework by Dec 07. Develop criteria for OT services by Dec 07. Develop draft criteria for Care at Home Domestic services by end March 08. Develop allocations and referral procedure for Erik Gray Resource centre. Review eligibility criteria for Mental Health Community Support Service (Annsbrae). MPH to check with Service Managers if other eligibility criteria/procedures required			MPH to prepare draft prioity framework by end October 07. OT criteria in draft for SCMT approval Oct 08.		
	Social Care services should ensure that carer's assessments are offered on a consistent basis.	A systematic mechanism for offering assessments, through the Single Shared Assessment process (SSA) and Integrated Assessment Framework (IAF).		Ann Williamson	The SSA now includes an expanded section of assessing carer's needs.		Complete.	None, WER.	SSA	Yes
				Ann Williamson	The IAF will need to include a similar section on assessing carer's needs.			None, WER.	IAF	
		That the SSA and IAF appropriately assesses Carer's needs, where requested.		Ann Williamson	Include in training programme for SSA and IAF.			None, WER.	Management Reports (SWIFT)	
		Robust recording mechanisms are established, for management reporting purposes.		Dougie Shearer	Ensure that recording systems include the no. of assessments which are not required as well as those who require a service.			None, WER.	Management Reports (SWIFT)	

Notes:
WER = Within Existing Resources

	Social Care services should, with a degree of urgency work in partnership with others to agree, finalise and implement the adult protection procedures. This should include a standard format for risk assessment	There will be in place a framework of policies and procedures that will allow workers to interpret risk to vulnerable adults and allow them to take appropriate action, by December 2007.		Ann Williamson	Procedures are currently in place including risk assessments and how they should be implemented. However, existing draft procedures require updating. This will be undertaken through the Multi Agency Work Group (MAWG) that has been established. Best practice examples of other agencies procedures are being gathered and we are consulting with agencies across the Highlands and Islands to establish consistency acorss the Northern Constabulary area. There will be significant training requirements across the whole department.		Working Group established and meeting regularly.	Training Programme £x cost.	New Policy and Procedures Report approved by Services Committee, by December 2007.	
		Appropriate governance arrangements will be established to meet the requirements of the new legislation.			Interpret new legislation, establish Board with Membership from relevant stakeholders and appropriate delegation/reporting arrangements.		Awaiting requirements of new legislation?			
Policy and service development, planning and performance management	Social Care services should ensure the function of policy review and development is given sufficient priority within the remits of the operational managers	Service management capacity adequate for all strategy, policy and service redesign needs, as well as day to day operational responsibility.		Stephen Morgan	Recruit to vacant Resources Manager post within the Children's Services Team, by January 2008.		Recruitment process underway	None, WER.	Personnel Records (CHRIS).	
		Service management capacity adequate for all strategy, policy and service redesign needs, as well as day to day operational responsibility.		Hazel Sutherland	Report to seek approval in principle for additional management capacity within the community care team.		Approved, August 2007	Additional revenue cost of £145,000 per annum.	Report to Services Committee and Minutes of Meeting.	Yes
				Christine Ferguson	Detailed Report on allocations of additional management time agreed in principle, by December 2007.		Gap analysis progressing, in detail.	Additional revenue cost of £145,000 per annum.	Report to Services Committee and Minutes of Meeting.	

O: Planning/Inspection/Action Plan

Notes:
WER = Within Existing Resources

				Christine Ferguson	Review of the Governance and Management Arrangements for the Community Health Partnership, to avoid duplication of reporting/activity and investigate further joint posts.		Community Health Partnership Development Day on 20 September 2007 identified some key actions.	None, WER, but options for securing time efficiency savings, which can be released for service redesign projects.	Development Day Notes	Yes
				Christine Ferguson	Report on outcome of Community Health Partnership Development Day, with regard to simplifying the current arrangements, by December 2007.			None.	Report to Community Health Partnership.	
				Christine Ferguson	New post to manage Mental Health Services approved at EMT on 18 September 2007, to be recruited to as soon as possible.		Post approved, awaiting recruitment.	None, met from JLIP funding.	Minutes of EMT.	
	Social Care services should more actively seek the involvement of people who use services and their carers at an individual and collective level.	At an individual level, to ensure that the system of person centred planning is embedded at all levels.		Wolfgang Weis	?					
		At an individual level, better recording systems of people's choices and decisions.			Better recording systems					
		At an individual level, to actively listen to individual's experiences of services to try to improve their care packages.			User and Carer Groups in all settings.					
					Formal involement in strategic service planning and redesign groups.					
					Topical Focus groups established.					
					Intensive user involvement into care planning through SSA.					

O: Planning/Inspection/Action Plan

Notes:
WER = Within Existing Resources

		At a collective level, to pursue the Public Participation Forum concept through the Community Health Partnership.		Christine Ferguson	Regular reports to community based groups, like community councils.					
		At a collective level, to pursue the Local Service Delivery Group concept through the Community Planning Partnership.		Community Planning Board	A LSDG to be established in all 7 electoral wards, with links into CHP management team.					
	Social Care services should review their transition arrangements for young people moving on to adulthood and ensure they have robust planning systems in place.			Hughina Leslie	Transitions Group has been established on the back of reviewing Children & Families procedures. Martha is leading that group.					
Management and support of staff	Social care services should prepare a comprehensive workforce planning strategy to cover short, medium and long term requirements. This should include the consideration of having the right staff in the right place.	Workforce Strategy approved by Services Committee and communicated to all staff		Hazel Sutherland	Report to agree framework to Services Committee by August 2007		Report approved.	None, WER.	Report to Services Committee and Minutes of Meeting.	Yes
		Working Group established to develop the strategy by end of September 2007			Invitation circulated.		Awaiting responses.	None, WER.	Working Group Membership and Terms of Reference	
		Tasks and Timescales by end October 2007						None, WER	Tasks and Timescales	
		Draft Strategy by end December 2007, for consultation							Report to Services Committee and Minutes of Meeting.	
		Strategy Approved by February 2008							Report to Services Committee and Minutes of Meeting.	
	Social Care services should take urgent action to address the safer recruitment issues identified in the internal audit report.	Database established		Shona Thompson	In place.		Complete.	None, WER.	Database.	Yes.
		Certificates held in safekeeping			In place.		Complete.	None, WER.	Records Management System.	Yes.
		SSSC Registration			Ongoing.		Ongoing.	None, WER.	New Procedures.	

O: Planning/Inspection/Action Plan

Notes:
WER = Within Existing Resources

	Social Care services should develop a comprehensive training strategy and in doing so, should give consideration to getting best value from its training budget.	Ensure that the Training Strategy is built on the Workforce Development Strategy, the Extended Local Partnership Agreement and Joint Community Care Plans and the Children's Services Plan.		Hazel Sutherland	Establish robust links between all strategies.			None, WER.	Training Strategy, Workforce Development Strategy, ELPA and Children's Services Plan.	
		Full option appraisal through a Best Value Review of the most appropriate arrangements for delivering the range of training needs.		Graham Spall (Executive Director of Infrastructure and Lead Officer for Training Review).	Best Value Option Appraisal on Training Providers for Training Needs Analysis (across the Council), by (when?)		Working Group established and Management Reporting requirements determined.	None, WER.	Working Group Membership and Terms of Reference. Management Information Needs Analysis.	
		Simplified systems for identifying and recording training needs, clearly linked to Employee Review and Development Records and service training plans.		Gail Bray	Standardised training plans and recording systems, avoiding duplication in identifying and recording needs.		Meetings with Service Managers Unit Managers and Others have commenced.	WER	Planned Meetings, Training Needs Analysis, Training Strategy	
	The service should review how it monitors and reports on sickness absence.	Robust recording mechanisms are established, for management reporting purposes.		Dougie Shearer	Establish Management Reporting Requirements and design management reports.		Complete.	None, WER.	Management Information Needs Analysis	Yes.
				Dougie Shearer	Preparation and Production of Reports on a regular basis.		ICT finalising the reporting arrangements , first reports due by (when?)	None, WER.	Management Reports (CHRIS)	

O: Planning/Inspection/Action Plan

Notes:
WER = Within Existing Resources

Resources and capacity building	The Council should ensure that service plans are clearly linked to available resources as identified in detailed financial plans. Furthermore Social Care services should ensure that it provides full service planning information including longer term trends) to corporate finance to enable corporate finance to provide the necessary financial management and planning support required.	Redesign corporate and departmental systems to link discrete processes together, avoiding duplication and ensuring that revenue and capital estimates processes are built on service planning data.		Executive Management Team	Ensure links between the key business processes of budgeting and service planning, for 2008/09 financial year. [Graham Johnston and John R Smith]				Service Plans Revenue Estimates and Capital Programme	
		Service Planning data and costing to feed into Long Term Financial Planning process.		Graham Johnston	Finance Services requested data on significant changes to budget for 2008/09 Budget Strategy Report, which was provided.		Complete for 2008/09.	More robust financial planning process.	Long Term Financial Plans.	Yes.
	The Council should work towards reconciling the level of service provision with the sustainable funding available to support that level in the medium to longer term.	Prioritised and affordable Capital Programme, which meets the Council's Financial Strategies on use of reserves		Executive Management Team, Executive Committee and Council	Full costed capital projects to support the Joint Community Care Plans for 2007 - 2010 and the (soon to be updated) Children's Services Plan.			Sustainable use of Reserves.	Capital Programme Report to Council and Minutes of Meeting.	
		Prioritised and affordable Revenue Budget, which meets the Council's Financial Strategies with regard to use of reserves.		Hazel Sutherland	Discussion Paper on Prioritisation of Services, targeted at those in greatest need by December 2007.				Discussion Paper and Report to Services Committee and Council by December 2007.	
				Graham Johnston	Approved Revenue Budget by February 2008.				Revenue Estimates and Council Tax Setting Report to Council and Minutes of Meeting.	
				Hazel Sutherland	Thereafter, ongoing dialogue with Members.					

Notes:
WER = Within Existing Resources

	The quality of financial reporting to members should be improved through enhanced level of analysis and explanation of budget performance. Furthermore, the financial training programme for BROs should be completed as soon as possible to enable them to manage their budgets more effectively.	Revised Management Reporting arrangements to Services Committee.		Graham Johnston	Complete - presented August 2007.		Complete.	None.	Report to Services Committee and Minutes of Meeting.	Yes.
		Financial Training Programme Complete		Hazel Tait	Three outstanding Budget Responsible Officers to be trained.		Ongoing.	None.	Training Records.	
	The Social Care risk register should be reviewed to ensure all risks relevant to the service are identified and recorded. It should be monitored regularly to ensure risks are being managed appropriately and are in line with the Council's risk management policy which should also be reviewed.	A revised framework of risk management arrangements, which embeds the principle of risk management into everyday working practices, strategies and plans.		Stephen Morgan	Establish a worknig group, identify best practice from elsewhere, carry out a gap analysis of current and future needs and establish new risk management procedures and practices, to ensure that all risks are managed appropriately.			None.	Working Group Membership and Terms of Reference.	
		Ongoing review and updated annually		Stephen Morgan						
		Level 1: Unit / Team / Activity Risk Register		Stephen Morgan	Establish detailed operational risks, by March 2008					
		Level 2: Service Risk Register		Stephen Morgan	Operational Risks and Service wide risks, by May 2008.					
		Level 3: Departmental Risk Register		Stephen Morgan	Operational, Service and departmental wide risks, by June 2008.					
		A revised SIC Risk Management Policy	Ongoing management through Health and Safety Framework Annual Review	Sandra Pearson	Work on this commenced in July 2007. Progress to be reported to RM Board in Nov 2007 for Council wide consultation. Final approval from Council meeting target date by end March 2008.		Report to Risk Management Board in December 07 (date = TBA)			

O: Planning/Inspection/Action Plan

Notes:
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	Social Care services should develop a commissioning strategy.	A Commissioning Strategy, which recognises the limited market opportunities for out-sourcing services in the Shetland context.		Christine Ferguson	Prepare a Draft Commissioning Strategy for consultation and approval by December 2007.			None.	Draft Strategy, Report to Community Health Partnership and Minutes of Meetings	
Leadership and direction	Social Care services should develop and disseminate a vision for future social work services with clear values and aims setting out how this fits with the council's corporate vision, wider service plans and specific social work objectives.	Established Vision for Social Work Services		Hazel Sutherland	Establish political direction for Social Care Services, with the new Council.		Complete.	None.	Services Committee 4 Year Plan (part of the Corporate Plan)	Yes.
				Hazel Sutherland	Develop Draft Vision for the Service, in full consultation with our stakeholders by end October 2007.					
				Hazel Sutherland	Approved by Services Committee by December 2007.					
Service Improvement	Sharing Good Practice	To ensure staff have the opportunity to learn from others and share their good practice, across the Council.		All	Embed into Employee Review and Development sessions.					
Service Improvement	Communication	To ensure that all staff have access to all the information which they need to effectively do their job.		All	Establish from staff what information they need and in what format, that they currently are not able to access and find innovative mechanisms for sharing that information.					

Notes:
WER = Within Existing Resources

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Shetland's Cultural Strategy: Progress and Way Ahead

1. Introduction

1.1 This reports asks Services Committee to nominate a number of Members to participate in the Cultural Strategy Partnership, to refresh Shetland's Cultural Strategy and Action Plan.

2. Links to Corporate Priorities

2.1 Culture is embedded in the Community Planning Board's aim to, "create a secure livelihood, look after our stunning environment and care well for our people and our culture". The Cultural Strategy contributes to the key priorities of respecting Shetland's cultural identity; by promoting, celebrating, contributing and supporting its diverse cultural traditions, heritage creativity and activity. The Cultural Strategy also contributes to active citizenship, skills development, regeneration, improving health, strengthening rural communities and inclusion.

3. Background

3.1 The Shetland Cultural Strategy was approved by the Council in February 2004 and has been considered by a number of partners/boards/ management structures. The Strategy was formally launched in June 2005 and copies have been widely distributed both within Shetland and outwith to national agencies and local authorities.

3.2 The Cultural Strategy Partnership's outcomes are: -

> <u>Access, participation and potential</u>
> Encourage active and participative lifestyles, equality of opportunity, personal and community development through increasing access to and participation in the broadest range of cultural activities throughout Shetland, particularly for people who may be excluded or marginalised at present.

Creativity and heritage

Celebrate, promote and invest in the islands' distinctive creativity, diverse culture, heritage and environment, and develop and promote them within Shetland and to the wider world.

Learning, economy and regeneration

Contribute to the regeneration of Shetland's quality of life, image and economy through the strategic development of human, physical, geographic and financial resources.

3.3 It is considered an appropriate time to refresh the Cultural Strategy and Action Plan, following a period of organisational, member and staff changes. The Spokesperson for Culture and Recreation has recently been appointed and this work will help to frame his terms of reference.

3.4 It is acknowledged that there is a considerable amount of cultural activity and projects already taking place. The proposal to update the Strategy seeks to provide focus and clarity on the objectives which we are seeking to achieve, around leisure, learning and economic opportunities.

4. Proposal

4.1 I would further propose that Services Committee invite a number of Members to participate in a short life working group to review the Cultural Strategy and update the Action Plan. The terms of reference for the Partnership is set out at Appendix 1 and it would be appropriate to use the current partnership, together with a number of Members, to update this work.

5. Financial Implications

5.1 There are no significant financial implications arising from this Report. Any expenses incurred by Members in attending meetings of the review group will be classed as an approved duty and met from the Members' Expenses budget head.

6. Policy and Delegated Authority

6.1 In accordance with Section 13 of the Council's Scheme of Delegation, the Services Committee has delegated authority to make decisions on the matters within approved policy and for which there is a budget.

7. Recommendations

7.1 I recommend that Services Committee:

(a) appoint a number of members to join the Culture Strategy Group to refresh the Strategy and Update the Action Plan, the details of which are shown in Appendix 1.

Appendix 1

CULTURAL STRATEGY PARTNERSHIP

1. REMIT

To work together to support and develop cultural services, projects and activities. which meet the needs individuals, families, groups and communities in Shetland.

The purpose of the partnership is to:

- bring together a wide range of ideas and opinions about the cultural spirit of Shetland and the way its citizens would like life in the islands to be.
- establish a shared vision and diverse range of objectives for developing cultural facilities, services and activities for the benefit of the Shetland community in general.
- Ensures links into many other Council and organisation strategies and plans, such as the Community Plan, Shetland Islands Council's Corporate Plan, and individual Trust Plans
- provides encouragement to create and nurture links across different areas
- finds areas where a broad and inclusive attitude to culture can lead to individual and community benefits and economic regeneration.
- celebrates success and the many aspects of Shetland life
- addresses challenges and points to improvements and cultural changes which are sought by the community.

2. MEMBERSHIP

Membership is open to any organisation that is involved in culture in Shetland. The current members include representatives from:

Shetland Islands Council –
- Spokesperson for Culture and Recreation
- Education and Social Care
- Shetland College
- Community Development
- Schools
- Economic Development
- Planning

Visit Shetland
Shetland Amenity Trust
Shetland Arts
Shetland Council of Social Services
HIE Shetland
NHS Shetland

3. AUTHORITY AND REPORTING

The Partnership is purely advisory and has no executive powers. With regard to any business concerning the Council, any proposals arising from the work of the

group must be referred by report from the Executive Director of Education and Social Care to the Services Committee for decision.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Shetland Alcohol and Drugs Action Team (SADAT): Action Plan

1. Introduction

1.1 This Report asks Members to note the management arrangements and Action Plan for the Shetland Alcohol and Drugs Action Team, known as SADAT.

1.2 The Report also invites Members to nominate up to two Members to participate in the work of the Partnership.

1.3 Further, I ask Members to agree in principle to change the funding arrangements for the Shetland Community Drugs Team and the Shetland Alcohol Advice Service (soon to be merged into one new organisation).

2. Links to Corporate Priorities

2.1 This report will contribute to the Corporate aim of developing Member engagement in systematic performance reporting, review and scrutiny.

2.2 Further, the Report supports the (developing) Corporate Objective of,

> "Delivering a modern, affordable community care service across Shetland..."

3. Background

3.1 SADAT has no formal constitution. The Terms of Reference for the Partnership is currently being reviewed and is included at Appendix 1. The structure was originally established in response to specific funding from the Scottish Executive to promote health lifestyles and address the complex issues associated with substance misuse, particularly drugs and alcohol. The drive, at that time as it is now, was to adopt a multi-agency, community based response to the problems of substance misuse.

3.2 The aim of the Partnership is, to plan, coordinate and stimulate local action on drugs and alcohol misuse.

3.4 Membership of the Partnership is open to statutory, private sector and voluntary sector organisations. A list of the current Membership is included at Appendix 1.

3.5 At the moment, I am the Chairperson of the Partnership. The position of Chair rotates, usually between NHS Shetland and the SIC.

3.6 The funding for the Partnership is awarded through a variety of sources, including Shetland Charitable Trust, NHS Shetland, the SIC General Fund and specific grants from the Scottish Government, which usually target specific issues or projects.

3.7 The staff who support the Partnership are employees of NHS Shetland, with line management responsibility through the Director of Public Health, Ms Sarah Taylor. SADAT is not a corporate body with a legal personality distinct from its members.

3.8 The work of the Partnership mainly supports national targets in relation to maintaining a healthy lifestyle. More detail on the Action Plan is included at Appendix 2 and the targets are:

- Reduce binge drinking
- Reduce drug and alcohol related crime and reassure communities that effective action is being taken.
- Reduce hazardous or at risk drinking by children and young people because of the particular health and social risks.
- Reduce the proportion of young people reporting use of illegal drugs
- Reduce harm to children affected by substance misusing parents/carers through improved multi-agency support to parents and children.
- Reduce waiting times for drug treatment and rehabilitation services
- Increase the number of drug misusers in contact with treatment and care services.
- Increase the number of drug misusers successfully completing treatment.
- Increase the number of people recovering from drug and alcohol problems entering training, education and employment.
- Reduce the number of drug related deaths.
- Reduce the proportion of under 25's offered illegal drugs.

3.9 One of SADAT key objectives over the next few years is to attempt to influence the drinking culture in Shetland. This campaign runs under the heading of "Drink Better". The philosophy is based on a project which has run in Quebec since 1989, called Educ'alcool. It is based on the belief that people's relationship with alcohol is influenced by culture and that this relationship can be healthy or unhealthy. It focuses on moving away from a culture of drinking to get drunk to a culture of drinking because you enjoy the taste. The underlying principles include:

- There is a safe level of alcohol consumption
- Alcohol is accepted in society and is part of our lives
- People are responsible for their own choices. They deserve to be treated as adults and responsible persons.

4. Proposal

4.1 The Action Plan (at Appendix 2) is for noting.

4.2 I invite Services Committee to nominate two Members to participate in the SADAT Partnership, the (Draft) Terms of Reference for which is included at Appendix 1. This has been custom and practice for a number of years and is considered appropriate in light of the strategic nature of the work and the significant focus on a community approach, which Members are ideally placed to direct. However, I should point out that these appointment will be subject to detailed review by the Member / Officer Working Group's study on appointments to external bodies.

4.3 At the moment, Shetland Charitable Trust provides grant assistance to Shetland Community Drugs Team and Shetland Alcohol Advice Services. In my view, it would be more appropriate to fund these services from the General Fund as I consider them to be a core community care service targeted at individuals and families with high service need. If agreement is reached in principle, I will ask Shetland Charitable Trust if they agree and identify an appropriate alternative service of the same value to transfer to Shetland Charitable Trust in order that there is no change to the bottom line.

5. Financial Implications

5.1 There are no significant financial implications arising from this Report. Any expenses incurred by Members in attending meetings of the review group will be classed as an approved duty and met from the Members' Expenses budget head. If agreement in principle is accepted to fund SADAT services through the General Fund, a compensating transfer will be suggested for funding through Shetland Charitable Trust so that there is no overall financial change.

6. Policy and Delegated Authority

6.1 In accordance with Section 13 of the Council's Scheme of Delegations, the Services Committee has delegated authority to make decisions on the matters within approved policy and for which there is a budget.

7. Conclusions

7.1 This Report provides information on the Action Plan for the work of the SADAT partnership and invites two Members to participate in the group, in line with previous practice. In light of the support for these service users being at the higher end of targeted needs, I am proposing that the funding be transferred to the General Fund and from Shetland Charitable Trust.

8. Recommendations

8.1 I recommend that Services Committee:

(a) Note the SADAT Action Plan; and

(b) appoint two Members to participate in the SADAT partnership; and

(c) agree in principle to transfer the core funding for the Shetland Community Drugs Team and the Shetland Alcohol Advice Service to the General Fund, subject to the agreement of Shetland Charitable Trust and subject to a compensating transfer of service being identified of the same amount.

Ref: HAS/sa Report no: ESCD-25-F

Appendix 1

SADAT Terms of Reference (Draft)

- To plan, coordinate and stimulate local action on drug and alcohol misuse.

- To assess the level of drugs and alcohol misuse within Shetland Islands based on established data collection methods and, from time to time, specific commissioned research.

- To determine the social and economic consequences upon individuals, families and communities and make arrangements for appropriate, innovative, flexible and challenging services to meet those needs.

- To ensure effective consultation, specifically through the Drugs and Alcohol Forum, and that the views of interested parties are taken into account in the design of service delivery models.

- To ensure consultation and cooperation between partner organisations.

- To draw up appropriate strategies to tackle the social and economic consequences of substance misuse, drawing on best practice from national and international sources, and set that out in an annual Corporate Action Plan.

- To allocate financial and other resources to meet the priority needs, as described in the Corporate Action Plan.

- To monitor the impact and effectiveness of the various service delivery models and consequences, through the performance management arrangements. This might involve challenging individual agencies and taking risks on new and innovative practice.

- To oversee communication messages on safe practices, harm reduction and harm minimisation.

- To oversee training programmes, methods and coverage to ensure individuals, families, communities, organisations and professional groups have access to all the information they need.

- To challenge local perceptions and support a community led approach to tackling drug and alcohol misuse.

Links to Key Strategies

- Community Safety
- Joint Future/Community Care – Extended Local Partnership Agreement
- Community Justice Authority Corporate Plan
- Health Action Team
- Housing Strategy and Homelessness
- Integrated Children and Young People Service Plan

- Child Protection

Membership – Current

Two Councillors/Elected Members, Shetland Islands Council (vacant)
Hazel Sutherland (Chair) – Education and Social Care, Shetland Islands Council
Brian Gregson (Vice Chair) – Chair or Shetland Community Drugs Team
Dr Sarah Taylor, Director of Public Heath – NHS Shetland
Chief Inspector Malcolm Bell, Area Commander – Northern Constabulary
Dr Helen Ward, Vice Chair of Shetland Alcohol and Drug Forum
Amanda Pearson, Chair of Shetland Alcohol and Drug Forum
Mark Loynd, Assistant District Officer – Highland and Islands Fire and Rescue Service
Jim Reyner, Quality Improvement Manager – Shetland Islands Council
Stephen Morgan, Head of Children's Services – Shetland Islands Council
Chris Medley, Head of Housing and Capital Projects – Shetland Islands Council
Gill Hessian, Manager – Shetland Community Drugs Team and Alcohol Resource Centre
Ann Williamson, Chief Social Work Officer – Shetland Islands Council

Observer Status

Graeme Napier, Sheriff – Scottish Courts
Duncan Mackenzie, Procurator Fiscal

SHETLAND ALCOHOL AND DRUG ACTION TEAM [SADAT]

CORPORATE ACTION PLAN 2007-8
Extract of Actions Only

Culture Change and Communities

National Priority: Reduce binge drinking
Target: Reduce the incidence of adults exceeding weekly sensible drinking levels from: • 33% to 31% for men between 1995 and 2005, and to 29% by 2010 • 13% to 12% for women between 1995 and 2005, and to 11% by 2010

- To run educ'alcool alongside at least one community event
- Continued promotion of the Alcohol Fire Death Prevention Project
- Promotion of late license bus schemes to reduce alcohol related Road Traffic Collisions [RTCs].
- Continued programme of Home Fire Safety Checks predominantly targeted at high risk households.

National Priority: Reduce drug and alcohol related crime and reassure communities that effective action is being taken.

- Continue development of CCTV in Lerwick town centre
- Evaluate the impact of it's your life it's your choice DVD
- Monitor impact of alcohol byelaw
- Investigate the feasibility of an Arrest Referral Scheme/Crisis centre
- Develop and/or add to established tool for collection of local information in order to create baseline figures and thereafter assess the extent to which national targets have been met.

Prevention, Education and Young People

National Priority: Reduce hazardous or at risk drinking by children and young people because of the particular health and social risks.
Target: Reduce frequency and level of drinking from 20% of 12 – 15 year olds to 18% between 1995 and 2006, and to 16% by 2010.

- Successfully bid to Lloyds TSB for Young peoples drug and alcohol interventions worker
- Develop (and or add to existing) tool for collection of local information in order to create baseline figures and thereafter assess the extent to which national targets have been met.
- Develop and roll out alcohol and drugs education programme to all schools in Shetland.
- Provide Advice/Info/Support to young people on alcohol and drug issues at outreach venues.
- SYIS – 100 sessions
- Aith School – 18 sessions
- Sandwick School – 18 sessions
- Develop weekly Young People's alcohol/drugs surgery with Advice/Info and support combined with activities for vulnerable young people at SASS.

National Priority: Reduce the proportion of young people reporting use of illegal drugs.
Target: Reduce proportion of under 25's reporting use of illegal drugs in the last month and previous year substantially, and heroin use by 25% by 2006.

- Design and deliver young people's services in line with local needs assessment
- Review and re-establish FDAT to ensure coordination of training delivered.
- Develop and roll out alcohol and drugs education programme to all schools in Shetland.
- Provide Advice/Info/Support to young people on alcohol and drug issues at outreach venues.
- SYIS – 100 sessions
- Aith School – 18 sessions
- Sandwick School – 18 sessions
- Develop weekly Young People's alcohol/drugs surgery with Advice/Info and support combined with activities for vulnerable young people at SASS.

National Priority: Reduce harm to children affected by substance misusing parents/carers through improved multi-agency support to parents and children.

- Complete and implement Protecting Children and Young People living in families with problem substance use
- Fully establish Family Support/Therapy Service in relation to problem substance use linking existing adult and young people services.
- SASS staff to meet monthly with Consultant Family therapist and CPN for young people in family therapy supervision group.
- Provide specialist placement for child psychology student in relation to problem substance use and systemic practice.

Provision of Support and Treatment Services

National Priority: Reduce waiting times for drug treatment and rehabilitation services

- Part-time aftercare and resettlement worker will be made full-time
- Activities worker will be made full time

National Priority: Increase the number of drug misusers in contact with treatment and care services.
Target: Increase the number of drug misusers in treatment and care services by 10% by 2008.

- Activities worker post Full-time
- SMART (outreach) to deliver weekly satellite service to local homeless hostel
- Funding for second Full-Time drugs worker to be identified as a priority to cope with the influx of new clients
- Second Aftercare and Resettlement post to become Full-Time to address education and training needs of client groups

- Ensure 6 monthly reports on progress are submitted by Papa Stour Project to SADAT
- Monitor amalgamation of SCDT and SASS

National Priority: Increase the number of drug misusers successfully completing treatment.

- Monitor uptake of SCDT services
- Full-time Aftercare and Resettlement worker will continue to develop links with training and employment providers (support training, Turning Point Craft Initiative, Shetland Community Bike Project, job centre plus)
- Weekly drug and alcohol support sessions to take place at Ladies Drive Hostel from May 2007

National Priority: Increase the number of people recovering from drug and alcohol problems entering training, education and employment.

- Develop tool for collection of local information in order to create baseline figures and thereafter assess the extent to which national targets have been met.
- Continue to develop links with training and employment providers (support training, TPCI, SCBP, job centre plus)
- Continue to support SCBP and TPCI via SADAT Support Staff. The latter will keep in regular contact with the projects. ADDA to step-down as secretary for SCBP but to remain on group in advisory capacity.

National Priority: Reduce the number of drug related deaths.

Target: Reverse the upward trend in drug-related deaths and reduce the total number, by at least 25% by 2006.

- A trainer has been identified and is going to undertake their training for trainers in April/May 07. It is therefore planned to deliver a minimum of 3 Applied Suicide Intervention Skills Training (ASSIST) sessions.
- Monitor and evaluate safer Shetland action line in line with National Standards
- Continue to distribute health alerts from the Scottish Crime and Drug Enforcement Agency (SCDEA)
- Monitor impact of new ADDO combining ADDO post and Choose Life coordinator role.

Protection, Controls and Availability

National Priority: Reduce the proportion of under 25's offered illegal drugs.

Targets:

- Reduce the proportion of under 25's who are offered illegal drugs significantly, and heroin by 25%, by 2006.
- Continuous improvement in the weight of Category A drug seized.
- Continuous improvement in the detection of offences for supply or intent to supply Category A drugs.

- To continue to implement and develop the Drugs Education choice for Young People within Shetland Schools through our Drugs Education Programme in partnership with FDAT.
- Review and re-establish FDAT to ensure coordination of training delivered.

- Monitor and evaluate safer Shetland action line in line with National Standards.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Developing a Skills Strategy

1. Introduction

1.1 This Report asks Members to note the findings of a Scottish Government Report called Skills for Scotland, a Lifelong Skills Strategy[1]. I have set out a proposal to develop an integrated response to the findings of this Report.

2. Links to Corporate Priorities

2.1 This report will contribute to the Corporate aims of delivering a quality education service, life long learning opportunities, appropriate further and higher education activities, early intervention, targeting resources at individuals with particular needs, workforce development, helping to address deprivation and social exclusion as well as growing a healthy economy.

3. Background

3.1 In September 2007, the Cabinet Secretary for Education and Lifelong Learning published a Report called Skills for Scotland, a Lifelong Skills Strategy. In this Report, the Scottish Government sets out their vision for a "smarter Scotland" and calls upon all their partners to work together to work towards that Vision. The Vision is set out below:

> "Our vision is for a smarter Scotland with a globally competitive economy based on high value jobs, with progressive and innovative business leadership:
>
> - Where people can work in teams, are creative and enterprising and hungry to continually learn new skills. They expect to realise their aspirations and are equipped to achieve their potential in a constantly changing world. People are motivated to contribute to Scotland's future and are confident that they can do so.
> - Where people are entrepreneurial and innovative; small businesses are encouraged to grow and there is strong, coherent support for businesses of all sizes. Migrant workers and overseas

students play a valuable role in an expanded workforce and economy.

- Where employers improve productivity by investing in their own staff and are able to access a skilled workforce that is increasingly literate and numerate with good ICT and problem solving skills.
- Where learning and training providers work as one system and thanks to wider use of technology and e-learning, barriers of geography and rurality have been reduced."

3.2 In order to achieve this, the Scottish Government has recognised the need to focus on a number of linked activities and organisations. The report states,

"To achieve this, we need to focus on the following:

Individual Development

1. Developing a distinctively Scottish approach to skills acquisition, balancing the needs of employers and individuals, aligning employment and skills and placing the individual at the centre of learning and skills development.

2. Developing a coherent funding support system for individuals of all ages and in all forms of education and training that encourages participation in learning and work. This will include support for individuals to increase control and choice over their learning and skills development.

3. Ensuring that this Strategy will promote equal access to and participation in, skills and learning for everyone. This Strategy aims to promote equality of opportunity to those trapped by persistent disadvantage and to improve numbers of people economically active including those from groups such as race, disability, gender, sexual orientation, age and religion/faith and educational starting points.

Economic Pull

4. Stimulating increased demand for skills from employers, both public and private.

5. Improving the utilisation of skills in the workplace.

6. Understanding current and projected demands for skills to help prepare for future skills needs.

7. Challenging employers, learning providers, awarding bodies and others to use the Scottish Credit and Qualifications Framework (SCQF) as a tool to support learning, specifically to facilitate the recognition of learning and for enabling individuals to move smoothly through learning environments, getting credit for learning they have already achieved.

Cohesive Structures

8. Simplifying structures to make it easier for people to access the learning, training and development they need, including formal and informal learning by merging a number of bodies into one, focussed on skills.

9. Ensuring that *Curriculum for Excellence* provides vocational learning and the employability skills needed for the world of work and is the foundation for skills development throughout life.

10. Achieving parity of esteem between academic and vocational learning, recognising that vocational learning is a valuable alternative to the academic pathway and important to all.

11. Challenging our funding bodies to use their budgets to help achieve a stepchange in skills development and use.

12. Encouraging providers to see themselves as part of a continuum of provision - links in a chain - which helps individuals to see the relevance of learning to them, progress in their learning and make full and effective use of the skills they have acquired. Judging that system by how well it serves those who need the most support."

3.4 At the moment, the Education and Social Care Department has in place a number of strategies, policies, plans and services which would be relevant to delivering on this over-arching Skills Strategy, including:

- Workforce Development Strategies (being developed) and Training Plans
- Education Service Improvement Plan
- Children and Young People's Service Plan
- Early Education and Childcare Action Plan
- Getting it Right For Every Child
- More Choices, More Chances Action Plan
- Shetland College and Train Shetland Strategic, Operational and Service Plans
- Community Learning and Development Strategy
- Shetland Literacy and Numeracy Strategic Plan
- Cultural Strategy

3.5 There are also key links to the Economic Development strategies and the Deprivation and Social Exclusion research and Action Plan. HIE Shetland lead on the Skills and Learning Unit, as a key aspect is to ensure that employers' experiences and needs are fed into the system in a way in which service providers can react to meet those needs. There is an opportunity to draw all this work together into one over-arching framework document, which could then help to direct the service specific strategies mentioned above.

3.6 The Scottish Executive Report sets out the Council's responsibilities in the context of developing a Skills Strategy, as an employer and a provider of services. I have extracted from the Report the section on "What our Partners need to do" (as the Scottish Government sees it) and set that out as Appendix 1, in terms of the responsibilities of this Committee.

4. Proposal

4.1 In order to pull together all the strands of this work, I am proposing that the Education and Social Care Department work with HIE Shetland, the Economic Development Unit and the Council's Organisational Development Service to develop an over-arching Skills Strategy for Shetland. This will be a high-level framework document to support schools, children's services, community development and Shetland College in providing their services. It will draw on a wide range of existing data, strategies and plans. It is hoped that having one over-arching framework will help to simplify the current planning arrangements.

5. Financial Implications

5.1 There are no financial implications arising from this Report.

6. Policy and Delegated Authority

6.1 In accordance with Section 13 of the Council's Scheme of Delegations, the Services Committee has delegated authority to make decisions on the matters within approved policy and for which there is a budget. Approval of a new Skills Strategy will be reported to Committee for approval, in due course.

7. Recommendations

7.1 I recommend that Services Committee:

(a) note the findings of the Scottish Government on the need to draw together a "Lifelong Skills Strategy"; and

(b) agree that Education and Social Care staff will work with our partners, to draw together an over-arching Skills Framework, to support the direction for skills and learning in Shetland, to be reported for approval in due course.

Ref: HAS/sa Report no: ESCD-26-F

[1] http://www.scotland.gov.uk/Publications/2007/09/06091114/0

What our (Scottish Government) partners need to do

All of our delivery partners need to recognise that different people have different needs, promote equality in ways most suited to individual needs and have due regard to the relevant statutory duties relating to equal opportunities.

EMPLOYERS NEED TO:

- Be ambitious, demanding consumers of skills;
- Make best use of the skills of their workers by investing in their management and leadership and HR practices;
- Understand how training can benefit their performance and their staff and be aware of the range of training and support that is available to them;
- Be prepared to train individuals to develop the employee they want - and be prepared to invest in that training;
- Encourage and facilitate staff to access available learning opportunities;
- Work with learning providers to offer work opportunities and experiences, both at entry level and as integrated parts of higher-level learning, across learning sectors;
- Create a better business environment by working more closely with communities;
- Recognise the importance of their role in engaging with young people, schools and parents and carers;
- Establish links with their relevant Sector Skills Council to ensure that their skills needs are addressed and their voice is heard in the development of qualifications; and
- Work together with Trade Unions, using local learning agreements, to support the development of individuals in the workplace.

LEARNING AND TRAINING PROVIDERS NEED TO:

- Play to their specific strengths:
    - with schools providing a sound basis for future learning and skills development;
    - with Community Learning and Development offering learning opportunities to engage, attract and enthuse those who are least likely to get involved in learning;
    - with colleges delivering core, employability and vocational skills and training to meet national, regional and local needs;
    - with universities competing on a global basis in research, development and teaching, serving as a key driver in Scotland's economic and enterprise agenda;

    - with learndirect scotland learning centres offering a less formal entry-route;
    - with voluntary and private training providers as key elements of responsive provision that meets local needs; and
    - with all providers empowering individuals to demand a quality learning experience that meets their needs.
- Consider themselves as part of one system geared towards helping people develop the skills they need, where articulation, integration and working with other providers are the norm:
    - building on the effective partnership working that already exists;
    - work with awarding bodies and use SCQF to enable all learning to be recognised;
    - ensure that it is easy for individuals to progress from one from of learning to another; and
    - understand and support individuals before and after their learning and into employment.
- Develop strong partnerships and communication links to ensure that information about an individual's support needs, learning styles and achievements are shared:
    - for those school pupils who undertake part of their learning in college, they should be able to relate this learning to the wider curriculum and their achievements and learning in college must be recognised and acknowledged within their school; and
    - address the barriers which prevent young people from undertaking different models of learning, including learning opportunities outside of school.
- Provide high quality, relevant, learning opportunities that have value in the workplace:
    - provide learning at times and places accessible by workers;
    - offer easy access to robust information about learning opportunities and funding to individuals and employers;
    - emphasise and prioritise employability as a key outcome from learning;
    - ensure that learning is geared towards helping individuals to utilise their skills at all levels, from foundation-level to PhD - not just their subject-based knowledge and understanding, but also the practical application skills, generic cognitive skills, communication skills and autonomy, accountability and the ability to work with others - providing individuals with the ability to utilise skills and foster innovation in a changing and demanding labour market; and
    - engage with employers so that people can use the skills gained through learning to access work and progress in the workplace.

- Work with and through their representative bodies - in the case of universities and colleges this means Universities Scotland and the Association of Scottish Colleges - to:
    - ensure that in teaching individuals they provide them with essential skills;
    - ensure positive destinations for individuals where the learning that those individuals have undertaken will be effectively used;
    - work closely with business to develop courses that will lead to individuals having the knowledge and skills that meet both business need and individual aspirations; and
    - work with business in developing relationships that will make best use of the knowledge created in institutions for the benefit of Scotland's economy.
- Make effective use of labour market information and information, advice and guidance in:
    - developing learning, qualifications and work experience opportunities; and
    - responding to demand from individuals and employers and different segments of these markets.
- Work with learndirect Scotland to register all publicly-funded learning courses on the National Learning Opportunities Database, so that the Database can become an effective national resource for all to use.

LOCAL AUTHORITIES NEED TO:

- Take forward robust implementation plans for *Curriculum for Excellence*;
- Develop clear processes for identifying communities, families and children who may have higher needs or who are at higher risk of poor outcomes and tailor services to meet their particular needs, building on the work of local partnerships implementing *More Choices, More Chances* and *Workforce Plus*;
- Enhance their strategic role as both providers and commissioners of early years services;
- Encourage the links that are emerging between employers and schools through *Determined to Succeed* (DtS) and look to expand them into early years;
- Ensure that all partners, including colleges and community based learning providers, are included in the production of Community Learning and Development strategies and that appropriate linkages are made to community planning; and
- Deliver coherence between all functions that support skills development, including Workforce Plus and NEET partnerships.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Social Work Inspection Agency Performance Agency (SWIA) Inspection Reports – Action Plan for Criminal Justice Service

1. Introduction and Key Decisions

1.1 This Report asks Members to agree the Action Plan to address the recommendations for service improvement which were identified by the recent inspection of Criminal Justice Services.

2. Links to Council Priorities

2.1 Effective and efficient Social Work services, which includes Criminal Justice, are key to delivering the Council's priorities of social justice and community safety.

3. Background

3.1 The Social Work Inspection Agency (known as SWIA) undertook a review of Criminal Justice services during 2007. Their Report with recommendations was published and reported to Members at a Special meeting of Services Committee on 6 August 2007. There is a requirement on the Council to agree an Action Plan with SWIA by 29 October 2007, to address the recommendations made.

3.2 Overall, SWIA found that the criminal justice social work service in Shetland was found to be well managed and sought to measure and improve its performance. The service did particularly well in meeting National Standards. The service was performing very well but there were some areas where there was room for improvement. The key findings and areas for improvement are summarised below.

Key findings

- Over half the reports we read achieved a 'good' or 'very good' and nearly one third an 'adequate' overall standard;
- In all cases the service arranged an appointment within five working days and arranged four appointments in the first four weeks;
- All cases had a supervision plan;

- Supervision consistently addressed offending related needs in almost all cases and addressed offending in most cases;
- In the sub-sample of sex offender cases three were of a 'good' and two of a 'very good' overall standard; and
- Community service was well managed and provided a good range of group and individual placements.

Key areas for improvement

- Report writers should ensure that they do more to probe offenders' accounts of their offending behaviour;
- Post release supervision plans should be addressed in all home background reports;
- Case managers should ensure that victim awareness and offending behaviour is addressed, and home visits undertaken according to National Standards in all cases;
- The service should ensure that the standards applied in the management and supervision of serious violent offenders, and the methods of intervention used, match those achieved with sex offenders; and
- The service should provide a dedicated vehicle for community service staff to transport offenders and equipment.

4. Proposals

4.1 An Action Plan has been developed, Appendix 1, and it sets out the recommendations which we need to address alongside planned actions and service outcomes. Members are asked to approve the Action Plan.

5. Financial Implications

5.1 There are no direct financial implications arising from this report.

6. Policy and Delegated Authority

6.1 All social work matters stand referred to the Services Committee. The Committee has delegated authority to make decisions on matters within its remit and for which the overall objectives have been approved by the Council, in addition to appropriate budget provision, in accordance with Section 13 of the Council's Scheme of Delegations. Members will be aware that the authority is formally linked to the North of Scotland Community Justice Authority (CJA) for the purpose of delivering criminal justice social work services.

7. Recommendations

7.1 I recommend that Services Committee approve the Action Plan at Appendix 1, which addresses the recommendations for improvement by SWIA on the Criminal Justice service.

Our Ref: HAS/sa Report No: ESCD-27-F

SHETLAND ISLANDS COUNCIL CRIMINAL JUSTICE SOCIAL WORK ACTION PLAN – OCTOBER 2007

Objective	Method	Lead Person	Timescale	Outcome	Resources
1. Ensure SER writers probe offenders accounts of their offending behaviour	• Practitioners to follow quality assurance checklists for report writing • 1:4 SERs to be Quality assured	Senior Social Worker Service Manager	December 2007 Monthly	• Evidence of improved report writing • Minimum 25% reports to be quality assured annually	• No additional cost
2. Ensure that post release supervision plans are included in Home Background Reports	• Reintroduce the HBR checklist • Practitioners to complete quality assurance checklists at report stage • Annual audit of all HBRs	Senior Social Worker Service Manager	Completed May 2007 June 2008	• All report writers aware of the tool. • All prisoners to have post release supervision plan. • 100% HBRs to be quality assured annually	• No additional cost
3. Ensure that offending behaviour is consistently addressed and that victim awareness is more fully addressed	• All action plans to include relevant intervention that focuses on offending behaviour. • All action plans to include victim awareness work • Training and or programme of work to be provided were necessary • Liase with Restorative Justice Scheme	Service Manager	January 2008 Ongoing Ongoing	• Increase offenders understanding of the effect of their actions on others. • Increase offender's awareness of why they offend and to look at ways of reducing their offending behaviour. • Increase practitioners knowledge base • All intervention plans will be reviewed at the client review	• Any additional cost for training will be met within existing budget

Objective	Method	Lead Person	Timescale	Outcome	Resources
4. Ensure home visits are carried out in line with national standards	• Practitioners to diarise first 3-month appointments. • Min 10% of all new cases to be audited prior to first review.	Service Manager	Immediate	• Home visits take place in line with national standards.	• No additional cost
5. To provide a dedicated vehicle for community service	• Lease vehicle from SIC Infrastructure Service	Service Manager	Completed June 2007	• Dedicated vehicle for community service	• Additional cost to be met out of existing budget
6. To improve the management of and intervention with violent offenders	• MAPPA definition of violent / dangerous offender to be implemented • Discussions with police and MAPPA coordinator to implement joint working arrangements similar to the management of sexual offenders. I.e. formal screening group • MAPPA arrangements to be implemented when they have been finalised by the Scottish Executive • Liase with the Risk Management Authority on appropriate training	Service Manager (Chief Social Work Officer in SMs absence)	November 2007 December 2007 TBA June 2008	• All violent offenders will be identified using a common definition. • All violent offenders will be managed in line with the MAPPA guidance for sex offenders • All violent offenders to undergo a RAF4 risk assessment. • To identify appropriate training and intervention programmes	No additional cost at present.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Head of Schools

Financial Aspects of the Schools Service

1. Introduction

1.1 As part of the review of the Schools Estates Management, the previous Council asked for detailed financial information on the cost of the Schools Service to be presented. That report was presented in June 2007 (Min Ref: SC 29/07).

1.2 A further report was requested by Council for clarity. This report, therefore, presents information to show the cost of delivering an education service in each school setting together with relevant indicators, such as teacher/pupil ratios. The report is for noting.

2. Background

2.1 It was agreed that instead of conducting a planned Task Force Review for the Schools Service, the Interim Head of Education at the time in his role as an external consultant, examine all the documentation available from the Education Best Value Review and produce a report with his conclusions and recommendations (Min Ref: SIC 13/06).

2.2 The report on the Examination of the Council's Education Best Value Review was presented at Services Committee on 15 June 2006 (Min Ref: SC 33/06).

2.3 On 31 August 2006, a subsequent report set out the approach to be adopted by the Schools Service in undertaking this evaluation (Min Ref: SC 53/06).

2.4 The Schools Service is responsible for providing education at a local level which requires it to respond to an ever-changing landscape. The statutory duty is to make adequate and efficient provision of school education across the whole of Shetland. This requires the Schools Service to evaluate the management of the whole school estate, taking into account a range of factors.

3. Links to Council Priorities

3.1 The Corporate Plan 2004-2008 commits the Council to providing the best learning environment for all and to providing a Best Value Service in Education. This report clarifies the allocation of spend which ensures the quality of the learning environment.

3.2 In August 2007, Services Committee agreed an Action Plan for the Education and Social Care Department, as part of the process of developing a Corporate Plan for the new Council. In relation to Schools, the Committee agreed that,

"Shetland schools' population projections anticipate a substantial reduction in pupils within a relatively short time frame. The challenge for the authority is, therefore, to develop a modern "blueprint" for the shape of the education service across Shetland for 10 years time. This model will consider the educational and financial viability levels for schools, their host communities as well as important associated issues such as transport requirements. It will consider links with pre schools services and life long, vocational, further and higher education and training. It will consider the development of centres of excellence, focused on particular sectors of the economy across Shetland building on existing high quality facilities. It is anticipated that significant capital investment will be required to bring some schools and facilities up to a modern standard."

3.3 Furthermore, Members agreed a programme of activity to develop the new framework. The programme is set out below:

Information Sessions - in September / October 2007 for Members on the work and analysis done to date in previous studies, including:

- Legislative Framework
- The Current Model
- Costs and Comparisons
- Quality of Current Arrangements, Service Outcome and Comparisons
- National and Local Priories in Education and a Curriculum for Excellence
- Integrated Community Schools
- A Teaching Profession for the 21st century (The McCrone Agreement)
- What issues were considered for evaluating alternative models (school rolls, class sizes, population trends, planning considerations, geographical distances and transport, quality of school estate buildings, workforce profile and recruitment and retention of teachers and other staff, specialist or generalist teaching, breadth and balance of curriculum available, peer/social support and opportunity for group work for pupils, experience of different teachers and styles, the school role within the wider community).

Terms of Reference for the 'Blueprint' review – by December 2007
Conference – Developing the Blueprint – First Quarter 2008
Analysis / Options / Consultation Process – Second Quarter 2008
Draft Strategic Blueprint – by September 2008
Consultation / Review Period – 6 months
Final Strategic Blueprint – Second Quarter 2009
Implementation – thereafter.

3.4 The financial analysis presented today is an integral part of the programme of work, which seeks to provide detailed information to members on costs and comparisons.

4. Proposal

4.1 This report provides detailed financial information to the new Council following a call for a further report on the financial aspects of the Schools Service to augment what is being recommended on educational grounds for the school estate. The information set out allows Members to compare estimated costs and costs per pupil across all schools in Shetland.

4.2 The information provided in Appendix A demonstrates the costs allocated to schools; direct costs, indirect costs, central costs and non attributable income and expenditure.

4.3 This report provides information at a point in time. There will be factors which will alter these costs as staff move into and out of posts. There will also be changes to costs if the pupil numbers change.

4.4 Appendix A sets out the costs allocated to nursery, primary and secondary sectors within the Schools Service. All budgets within the Schools Service have been reviewed by Budget Responsible Officers. Individual School Budgets have been analysed to ensure that all costs relating to Nursery, Primary and Secondary are charged as appropriate to each section, and any work or support provided to other schools is charged out to the appropriate school. The Head Teachers have been involved throughout this exercise. They have had to meet very tight timescales as the information has been gathered and this has been very much appreciated by all involved in this process.

4.5 Central Budgets have been analysed and allocated out to schools. Where it is not appropriate to allocate central costs to schools, a detailed explanation is given. This exercise, though time-consuming, has been useful in highlighting some issues, such as visiting staff mileage charges, timetabling, preparation and non-contact time, etc which will continue to be reviewed in more detail.

4.6 There has been considerable discussion since June on the allocation of the spend for the Schools Service. One area which has been changed in the way the figures have been presented is under recharges. Many Head Teachers have asked about the detail behind this. It has been agreed at the Schools Service Management Team that the allocation of this budget will now be on pupil numbers. This has altered the figures for schools. It was also felt that the recharges and capital charges should come out from direct school costs and be highlighted in a separate section.

4.7 The Head Teachers at North Roe Primary School and Urafirth Primary School have not been able to agree their budget costs fully. Both Head Teachers feel with regard to visiting staff costs, that they have no way of knowing if the figures are robust with the level of knowledge and training they have. It was agreed that this would be reported within this report.

4.8 Schools have costs allocated to them which relate to evening classes. There has been an agreement which means that evening classes have been delivered in schools for no cost. This will have to be reviewed as the schools have janitors overtime and the loss of let costs which are for evening classes which are not directly for the pupils within the schools.

5. Financial Implications

5.1 The Head of Finance highlighted in a report to the previous Council, General Fund Expenditure Growth 2002/03 to 2006/07 (Report No: F-019), that there had been significant growth well above both inflation and additional monies received, over the past four years particularly in Social Work and the Schools Service (Min Ref: SIC 88/06).

5.2 A detailed analysis of the Schools Service budget spend was recommended to assist in taking forward the proposals for the school estate evaluations. Financial information will be made available as part of that process.

5.3 It should be noted that there are no financial implications arising directly from this report.

6. Policy and Delegated Authority

6.1 All education matters stand referred to the Services Committee. The Committee has delegated authority to make decisions on matters within its remit for which the overall objectives have been approved by the Council, in addition to appropriate budget provision, in accordance with Section 13 of the Council's Scheme of Delegation.

6.2 As this report is for noting only, there are no policy and delegated authority issues to be addressed.

7. Recommendations

7.1 I recommend that the Services Committee

(a) note the content of this report and the information provided in the appendix; and

(b) note that Information Sessions will be arranged as part of developing the 'blueprint' for education, which will include a study of the costs of the School Service (as provided in the Appendix).

October 2007

SCHOOL ESTATES MANAGEMENT REVIEW - ESTIMATED COST PER SCHOOL BASED ON 0708 BU

NURSERY SCHOOLS	Direct School Costs 2007/08 £	Indirect School Costs 2007/08 £	Net Share Central Costs 2007/08 £	Direct School Income 2007/08 £	Total Controllable Costs 2007/08 £	Recharges 2007/08 £	Notional Capital Charges 2007/08 £	Total Non Controllable Costs 2007/08 £
Aith Nursery	54,273	1,407	457	0	**56,137**	5,240	2,453	**7,693**
Baltasound Nursery	50,920	0	409	0	**51,329**	4,636	2,310	**6,946**
Bells Brae Nursery	168,238	0	1,370	(8,502)	**161,106**	25,396	9,174	**34,570**
Brae Nursery	84,642	0	873	0	**85,515**	14,310	4,342	**18,652**
Bressay Nursery	30,443	0	283	0	**30,726**	403	4,368	**4,771**
Cunningsburgh Nursery	69,095	0	738	0	**69,833**	12,698	0	**12,698**
Dunrossness Nursery	65,877	717	866	0	**67,460**	12,698	4,700	**17,398**
Fair Isle Nursery	28,211	0	259	0	**28,470**	1,411	906	**2,317**
Fetlar Nursery	1,074	0	0	0	**1,074**	0	1,618	**1,618**
Foula Nursery	923	0	37	0	**960**	0	877	**877**
Happyhansel Nursery	43,383	5,673	557	0	**49,613**	6,853	3,121	**9,974**
Mid Yell Nursery	97,533	0	570	0	**98,103**	7,256	1,285	**8,541**
Mossbank Nursery	142,590	3,160	1,389	(68,000)	**79,139**	8,465	2,020	**10,485**
Sandwick Nursery	81,351	12,381	494	0	**94,226**	6,248	3,902	**10,150**
Scalloway Nursery	52,692	1,156	502	0	**54,350**	9,564	2,010	**11,574**
Skeld Nursery	45,116	590	390	0	**46,096**	4,636	2,607	**7,243**
Skerries Nursery	11,563	0	203	0	**11,766**	403	2,942	**3,345**
Sound Nursery	126,607	0	1,495	0	**128,102**	31,644	3,249	**34,893**
Urafirth Nursery	43,823	1,204	492	0	**45,519**	4,233	2,116	**6,349**
Whalsay Nursery	84,596	1,227	536	0	**86,359**	6,248	3,254	**9,502**
Whiteness Nursery	89,744	14,213	750	0	**104,707**	13,101	4,785	**17,886**
Nursery Supply	62,412				**62,412**			**0**
Sub-Total for Nurseries	**1,435,106**	**41,728**	**12,670**	**(76,502)**	**1,413,002**	**175,443**	**62,039**	**237,482**

PRIMARY SCHOOLS	Direct School Costs 2007/08 £	Indirect School Costs 2007/08 £	Share of Central Costs 2007/08 £	Direct School Income 2007/08 £	TOTAL £	Recharges 2007/08 £	Notional Capital Charges 2007/08 £	Total Non Controllable Costs 2007/08 £
Aith Primary	424,727	61,680	8,475	(25,175)	**469,707**	42,326	21,987	**64,313**
Baltasound Primary	236,901	14,953	4,451	(5,270)	**251,035**	11,489	26,995	**38,484**
Bells Brae Primary	1,259,056	159,274	19,234	(52,247)	**1,385,317**	186,735	109,445	**296,180**
Brae Primary	497,862	81,260	8,622	(22,302)	**565,442**	58,245	59,839	**118,084**
Bressay Primary	195,429	27,779	4,715	(4,090)	**223,833**	18,610	13,135	**31,745**
Burravoe Primary	102,724	9,064	4,061	(2,233)	**113,616**	12,228	10,279	**22,507**
Cullivoe Primary	81,619	34,604	4,172	(3,181)	**117,214**	10,459	10,905	**21,364**
Cunningsburgh Primary	266,256	36,219	7,148	(11,639)	**297,984**	41,198	16,578	**57,776**
Dunrossness Primary	633,805	85,419	8,982	(22,142)	**706,064**	72,488	48,587	**121,075**
Fair Isle Primary	101,846	3,639	3,521	(2,099)	**106,907**	8,336	3,169	**11,505**
Fetlar Primary	90,676	12,302	3,637	(1,162)	**105,453**	7,421	9,707	**17,128**
Foula Primary	79,503	16,813	1,879	0	**98,195**	3,570	12,063	**15,633**
Hamnavoe Primary	267,490	67,615	7,146	(9,069)	**333,182**	32,257	26,076	**58,333**
Happyhansel Primary	313,589	29,400	5,999	(9,932)	**339,056**	32,016	21,521	**53,537**
Lunnasting Primary	177,431	33,270	4,924	(6,375)	**209,250**	20,058	19,561	**39,619**
Mid Yell Primary	355,470	16,891	5,542	0	**377,903**	23,380	4,662	**28,042**
Mossbank Primary	310,579	40,124	7,024	(7,534)	**350,193**	36,764	51,901	**88,665**
Nesting Primary	161,222	31,721	4,932	(5,681)	**192,194**	18,896	20,091	**38,987**
North Roe Primary	100,945	30,772	4,448	(2,136)	**134,029**	9,502	12,303	**21,805**
Ollaberry Primary	177,138	22,568	5,098	(4,362)	**200,442**	17,284	21,788	**39,072**
Olnafirth Primary	143,375	42,616	5,149	(5,293)	**185,847**	16,251	11,087	**27,338**
Papa Stour Primary*	2,969	0	0	0	**2,969**	1,860	5,133	**6,993**
Sandness Primary	84,853	12,823	3,987	(2,340)	**99,323**	7,309	7,401	**14,710**
Sandwick Primary	382,189	37,930	7,558	(20,789)	**406,888**	56,636	33,450	**90,086**
Scalloway Primary	586,159	58,605	7,035	(19,000)	**632,799**	62,437	41,344	**103,781**
Skeld Primary	131,597	11,307	4,182	(4,751)	**142,335**	18,986	20,594	**39,580**
Skerries Primary	141,545	1,296	2,272	(1,219)	**143,894**	2,217	11,773	**13,990**
Sound Primary	1,211,153	84,183	16,704	(52,271)	**1,259,769**	176,375	49,605	**225,980**
Tingwall Primary	253,743	37,751	5,950	(9,743)	**287,701**	34,050	22,895	**56,945**
Urafirth Primary	149,313	28,489	4,353	(3,980)	**178,175**	15,737	16,324	**32,061**
Uyeasound Primary	100,400	12,604	2,224	(1,730)	**113,498**	8,576	3,850	**12,426**
Whalsay Primary	506,668	36,026	7,650	(10,710)	**539,634**	57,241	49,298	**106,539**
Whiteness Primary	353,795	52,739	8,924	(18,627)	**396,831**	46,672	45,749	**92,421**
Primary Supply	277,624	0	0	0	**277,624**	11,320	0	**11,320**
Sub-Total for Primaries	**10,159,651**	**1,231,736**	**199,998**	**(347,082)**	**11,244,303**	**1,178,929**	**839,095**	**2,018,024**

* Papa Stour Primary School is currently moth-balled.

SECONDARY SCHOOLS	Direct School Costs 2007/08 £	Indirect School Costs 2007/08 £	Net Share Central Costs 2007/08 £	Direct School Income 2007/08 £	Total Controllable Costs 2007/08 £	Recharges 2007/08 £	Notional Capital Charges 2007/08 £	Total Non Controllable Costs 2007/08 £
Aith Secondary	771,306	53,393	19,647	(36,361)	**807,985**	77,842	51,362	**129,204**
Anderson Secondary	4,723,683	141,156	106,233	(199,000)	**4,772,072**	467,637	355,476	**823,113**
Baltasound Secondary	615,277	68,493	16,980	(11,534)	**689,216**	39,109	42,496	**81,605**
Brae Secondary	1,923,471	57,413	53,968	(48,758)	**1,986,094**	159,947	102,572	**262,519**
Mid Yell Secondary	547,259	15,944	17,603	(12,819)	**567,987**	42,400	10,868	**53,268**
Sandwick Secondary	1,307,182	69,106	26,915	(60,526)	**1,342,677**	121,134	110,287	**231,421**
Scalloway Secondary	994,490	36,231	24,036	(38,300)	**1,016,457**	86,876	101,957	**188,833**
Skerries Secondary	69,706	444	3,486	(807)	**72,829**	4,285	2,942	**7,227**
Whalsay Secondary	648,243	17,443	16,190	(22,475)	**659,401**	70,295	48,004	**118,299**
Secondary Supply	199,959	0	0	0	**199,959**	0	0	**0**
Hostel Accommodation	634,416	0	0	(29,773)	**604,643**	3,901	0	**3,901**
Sub-Total for Secondaries	**12,434,992**	**459,623**	**285,058**	**(460,353)**	**12,719,320**	**1,073,426**	**825,964**	**1,899,390**

SPECIAL DEPARTMENTS	Direct School Costs 2007/08 £	Indirect School Costs 2007/08 £	Net Share Central Costs 2007/08 £	Direct School Income 2007/08 £	Total Controllable Costs 2007/08 £	Recharges 2007/08 £	Notional Capital Charges 2007/08 £	Total Non Controllable Costs 2007/08 £
AHS ASN *	771,005	49,888	0	0	**820,893**			**0**
Bell's Brae ASN	758,127	36,612	0	0	**794,739**		7,813	**7,813**
All Schools - ASN Support	2,152,744	0	0	0	**2,152,744**			**0**
Additional Support Base	216,551	0	0	0	**216,551**		36,250	**36,250**
Sub-Total for Special Departments	**1,529,132**	**86,500**	**0**	**0**	**1,615,632**	**0**	**44,063**	**44,063**

* Pupil Numbers for AHS ASN include 6 adults

TOTAL FOR ALL SCHOOLS	**25,558,881**	**1,819,587**	**497,726**	**(883,937)**	**26,992,257**	**2,427,798**	**1,771,161**	**4,198,959**
COSTS NOT ALLOCATED								
Pensions & Central Costs	-	-	614,283	-	**614,283**	-	-	**0**
Grants	-	-	247,507	-	**247,507**	-	-	**0**
Other Non-Attributable Costs (see att	-	-	(165,983)	-	**(165,983)**	-	-	**0**
Sub-Total for Costs not Allocated	**0**	**0**	**695,807**	**0**	**695,807**	**0**	**0**	**0**
TOTAL SCHOOLS SERVICE	**25,558,881**	**1,819,587**	**1,193,533**	**(883,937)**	**27,688,064**	**2,427,798**	**1,771,161**	**4,198,959**

Full Cost (Controllable & Non Controllable) 2007/08 £	Controllable Cost per Pupil £	Full Cost per Pupil £	Sept '07 Pupil Numbers	Teacher FTEs	Pupil/Teacher Ratio	Controllable Cost per Pupil % of Shetland Average £	Full Cost per Pupil % of Shetland Average £
63,830	5,614	6,383	10	0.54	N/A	132%	128%
58,275	5,703	6,475	9	1.85	N/A	134%	130%
195,676	3,356	4,077	48	1.96	N/A	79%	82%
104,167	3,167	3,858	27	0.99	N/A	74%	77%
35,497	30,726	35,497	1	0.6	N/A	720%	712%
82,531	2,910	3,439	24	0.63	N/A	68%	69%
84,858	2,811	3,536	24	1.42	N/A	66%	71%
30,787	9,490	10,262	3	0.32	N/A	222%	206%
2,692	-	-	-	0	N/A	0%	0%
1,837	-	-	-	0	N/A	0%	0%
59,587	3,816	4,584	13	0.7	N/A	89%	92%
106,644	7,007	7,617	14	0.95	N/A	164%	153%
89,624	4,946	5,602	16	1.32	N/A	116%	112%
104,376	7,852	8,698	12	1.53	N/A	184%	174%
65,924	3,623	4,395	15	0.69	N/A	85%	88%
53,339	5,122	5,927	9	0.83	N/A	120%	119%
15,111	11,766	15,111	1	0.09	N/A	276%	303%
162,995	2,135	2,717	60	1.38	N/A	50%	54%
51,868	5,690	6,484	8	0.72	N/A	133%	130%
95,861	7,197	7,988	12	1.18	N/A	169%	160%
122,593	4,188	4,904	25	1.26	N/A	98%	98%
62,412	189	189	-	0.05	N/A	-	-
1,650,484	**4,269**	**4,986**	**331**	**19.01**	**N/A**	**100%**	**100%**

Full Cost (Controllable & Non Controllable) 2007/08 £	Controllable Cost per Pupil £	Full Cost per Pupil £	Pupil Numbers	Teacher FTEs	Pupil/Teacher Ratio	Controllable Cost per Pupil % of Shetland Average £	Full Cost per Pupil % of Shetland Average £
534,020	5,871	6,675	80	8.45	9.5	96%	93%
289,519	11,411	13,160	22	2.23	9.9	187%	183%
1,681,497	4,712	5,719	294	21.29	13.8	77%	79%
683,526	5,140	6,214	110	9.75	11.3	84%	86%
255,578	9,326	10,649	24	3.57	6.7	153%	148%
136,123	8,740	10,471	13	1.26	10.3	143%	146%
138,578	8,372	9,898	14	1.62	8.6	137%	138%
355,760	4,806	5,738	62	5.99	10.4	79%	80%
827,139	6,035	7,070	117	12.36	9.5	99%	98%
118,412	17,818	19,735	6	1.32	4.5	292%	274%
122,581	35,151	40,860	3	1.26	2.4	576%	568%
113,828	49,098	56,914	2	1.24	1.6	805%	791%
391,515	6,664	7,830	50	4.16	12.0	109%	109%
392,593	7,214	8,353	47	4.60	10.2	118%	116%
248,869	8,370	9,955	25	2.60	9.6	137%	138%
405,945	8,589	9,226	44	4.84	9.1	141%	128%
438,858	6,367	7,979	55	3.58	15.4	104%	111%
231,181	6,864	8,256	28	2.47	11.3	113%	115%
155,834	11,169	12,986	12	1.61	7.5	183%	180%
239,514	8,715	10,414	23	2.60	8.8	143%	145%
213,185	7,434	8,527	25	2.73	9.2	122%	119%
9,962	-	-	-	0.00	-	-	-
114,033	14,189	16,290	7	1.21	5.8	233%	226%
496,974	3,803	4,645	107	8.00	13.4	62%	65%
736,580	6,027	7,015	105	9.35	11.2	99%	97%
181,915	6,470	8,269	22	2.14	10.3	106%	115%
157,884	35,974	39,471	4	1.15	3.5	590%	549%
1,485,749	4,598	5,422	274	21.87	12.5	75%	75%
344,646	5,231	6,266	55	3.62	15.2	86%	87%
210,236	9,378	11,065	19	2.44	7.8	154%	154%
125,924	12,611	13,992	9	1.53	5.9	207%	194%
646,173	4,997	5,983	108	10.05	10.7	82%	83%
489,252	5,154	6,354	77	6.59	11.7	84%	88%
288,944	151	157	-	9.00	N/A	-	-
13,262,327	**6,101**	**7,196**	**1843**	**176.48**	**10.4**	**100%**	**100%**

Full Cost (Controllable & Non Controllable) 2007/08 £	Controllable Cost per Pupil £	Full Cost per Pupil £	Pupil Numbers	Teacher FTEs	Pupil/Teacher Ratio	Controllable Cost per Pupil % of Shetland Average £	Full Cost per Pupil % of Shetland Average £
937,189	8,245	9,563	98	14.33	6.8	101%	102%
5,595,185	6,079	7,128	785	69.18	11.3	75%	76%
770,821	19,145	21,412	36	12.72	2.8	235%	229%
2,248,613	8,345	9,448	238	34.56	6.9	103%	101%
621,255	11,360	12,425	50	9.80	5.1	140%	133%
1,574,098	7,761	9,099	173	18.10	9.6	95%	97%
1,205,290	8,332	9,879	122	17.19	7.1	102%	106%
80,056	72,829	80,056	1	1.04	1.0	896%	856%
777,700	10,810	12,749	61	10.46	5.8	133%	136%
199,959	128	128	-	4.19	N/A	-	-
608,544	-	-	-	0.00	-	-	-
14,618,710	**8133**	**9347**	**1564**	**191.57**	**8.2**	**100%**	**100%**

Full Cost (Controllable & Non Controllable) 2007/08 £	Controllable Cost per Pupil £	Full Cost per Pupil £	Pupil Numbers	Teacher FTEs	Pupil/Teacher Ratio	Controllable Cost per Pupil % of Shetland Average £	Full Cost per Pupil % of Shetland Average £
820,893	23,454	23,454	35	8.04	4.4	80%	32%
802,552	39,737	40,128	20	6.91	2.9	135%	55%
2,152,744	-	-	-	26.84	-	-	-
252,801	-	-	-	2.38	-	-	-
4,028,990	**29,375**	**73,254**	**55**	**44.17**	**1**	**100%**	**100%**
33,560,511	**7,116**	**8,848**	**3,793**	**431.23**	**9**		
614,283	-	-					
247,507	-	-					
(165,983)	-	-					
695,807	**183**	**183**					
34,256,318	**7,300**	**9,031**					

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SCHOOL ESTATES MANAGEMENT REVIEW - CONTROLLABLE INCOME AND EXPENDITURE

School	DIRECT SCHOOL COSTS			INDIRECT SCHOOL COSTS							
				Visiting Staff					Staff from Other Schools *	Total	Parent Council Admin
	Employee Costs £	Operating Costs £	Total £	Music £	Art £	PE £	Knitting £	Other £	£	£	£
Aith Nursery	48,939	5,334	**54,273**	0	0	1,407	0	0	0	**1,407**	177
Baltasound Nursery	45,254	5,666	**50,920**	0	0	0	0	0	0	**0**	177
Bells Brae Nursery	146,439	21,799	**168,238**	0	0	0	0	0	0	**0**	354
Brae Nursery	74,755	9,887	**84,642**	0	0	0	0	0	0	**0**	265
Bressay Nursery	26,091	4,352	**30,443**	0	0	0	0	0	0	**0**	177
Cunningsburgh Nursery	58,927	10,168	**69,095**	0	0	0	0	0	0	**0**	242
Dunrossness Nursery	52,970	12,907	**65,877**	0	0	717	0	0	0	**717**	354
Fair Isle Nursery	25,551	2,660	**28,211**	0	0	0	0	0	0	**0**	177
Fetlar Nursery	0	1,074	**1,074**	0	0	0	0	0	0	**0**	0
Foula Nursery	0	923	**923**	0	0	0	0	0	0	**0**	0
Happyhansel Nursery	36,692	6,691	**43,383**	5,083	0	590	0	0	0	**5,673**	242
Mid Yell Nursery	88,935	8,598	**97,533**	0	0	0	0	0	0	**0**	177
Mossbank Nursery	136,338	6,252	**142,590**	1,089	0	2,071	0	0	0	**3,160**	242
Sandwick Nursery	72,516	8,835	**81,351**	0	0	0	0	0	12,381	**12,381**	177
Scalloway Nursery	47,168	5,524	**52,692**	0	0	1,156	0	0	0	**1,156**	177
Skeld Nursery	41,446	3,670	**45,116**	0	0	590	0	0	0	**590**	177
Skerries Nursery	10,338	1,225	**11,563**	0	0	0	0	0	0	**0**	177
Sound Nursery	111,851	14,756	**126,607**	0	0	0	0	0	0	**0**	354
Urafirth Nursery	40,015	3,808	**43,823**	0	0	1,204	0	0	0	**1,204**	260
Whalsay Nursery	77,176	7,420	**84,596**	0	0	1,227	0	0	0	**1,227**	177
Whiteness Nursery	82,884	6,860	**89,744**	846	905	868	0	0	11,594	**14,213**	223
Nursery Supply	61,812	600	**62,412**	0	0	0	0	0	0	**0**	0
Aith Primary	336,976	87,751	**424,727**	19,897	8,502	15,072	4,158	14,051	0	**61,680**	707
Baltasound Primary	167,298	69,603	**236,901**	4,796	0	10,157	0	0	0	**14,953**	530
Bells Brae Primary	864,849	394,207	**1,259,056**	74,527	27,698	44,691	11,797	0	561	**159,274**	1,070
Brae Primary	324,162	173,700	**497,862**	28,950	14,326	31,425	6,559	0	0	**81,260**	796
Bressay Primary	159,817	35,612	**195,429**	12,182	3,253	7,161	3,143	0	2,040	**27,779**	614
Burravoe Primary	77,249	25,475	**102,724**	1,502	0	1,816	1,480	0	4,266	**9,064**	633
Cullivoe Primary	53,732	27,887	**81,619**	1,084	0	1,191	1,350	0	30,979	**34,604**	633
Cunningsburgh Primary	184,269	81,987	**266,256**	17,036	8,515	6,631	4,037	0	0	**36,219**	707
Dunrossness Primary	458,366	175,439	**633,805**	35,193	16,995	22,714	10,517	0	0	**85,419**	753
Fair Isle Primary	79,962	21,884	**101,846**	2,851	0	788	0	0	0	**3,639**	456
Fetlar Primary	73,278	17,398	**90,676**	0	0	2,799	1,410	0	8,093	**12,302**	633
Foula Primary	57,494	22,009	**79,503**	0	0	788	53	0	15,972	**16,813**	633
Hamnavoe Primary	180,700	86,790	**267,490**	31,141	5,430	6,747	5,744	13,982	4,571	**67,615**	949

Happyhansel Primary	245,379	68,210	**313,589**	12,636	5,099	6,671	3,106	0	1,888	**29,400**	707
Lunnasting Primary	125,275	52,156	**177,431**	10,889	5,496	5,185	1,558	10,142	0	**33,270**	790
Mid Yell Primary	298,101	57,369	**355,470**	6,055	0	6,961	3,875	0	0	**16,891**	530
Mossbank Primary	197,378	113,201	**310,579**	18,180	9,050	8,253	4,641	0	0	**40,124**	707
Nesting Primary	108,567	52,655	**161,222**	7,620	3,620	4,714	1,573	9,842	4,352	**31,721**	790
North Roe Primary	71,404	29,541	**100,945**	8,795	4,999	6,524	1,389	9,065	0	**30,772**	633
Ollaberry Primary	136,182	40,956	**177,138**	2,173	4,999	4,982	1,869	8,545	0	**22,568**	790
Olnafirth Primary	105,158	38,217	**143,375**	11,441	2,726	5,193	2,826	0	20,430	**42,616**	790
Papa Stour Primary	0	2,969	**2,969**	0	0	0	0	0	0	**0**	0
Sandness Primary	64,002	20,851	**84,853**	7,712	0	2,384	839	0	1,888	**12,823**	633
Sandwick Primary	265,174	117,015	**382,189**	9,598	6,427	16,571	5,334	0	0	**37,930**	619
Scalloway Primary	401,556	184,603	**586,159**	22,187	12,671	16,593	7,154	0	0	**58,605**	619
Skeld Primary	94,305	37,292	**131,597**	599	3,399	4,181	1,240	0	1,888	**11,307**	614
Skerries Primary	113,094	28,451	**141,545**	89	0	444	763	0	0	**1,296**	279
Sound Primary	914,647	296,506	**1,211,153**	47,638	15,455	2,352	17,500	0	1,238	**84,183**	1,070
Tingwall Primary	187,560	66,183	**253,743**	15,679	5,430	9,684	2,749	0	4,209	**37,751**	949
Urafirth Primary	107,254	42,059	**149,313**	9,490	3,332	5,518	1,464	8,685	0	**28,489**	530
Uyeasound Primary	79,011	21,389	**100,400**	0	0	3,104	0	0	9,500	**12,604**	633
Whalsay Primary	367,800	138,868	**506,668**	7,840	0	28,186	0	0	0	**36,026**	707
Whiteness Primary	246,277	107,518	**353,795**	31,232	8,145	8,707	4,655	0	0	**52,739**	884
Primary Supply	267,804	9,820	**277,624**	0	0	0	0	0	0	**0**	0
Aith Secondary	599,556	171,750	**771,306**	17,475	25,489	9,389	0	0	1,040	**53,393**	380
Anderson Secondary	3,429,683	1,294,000	**4,723,683**	114,155	0	27,001	0	0	0	**141,156**	2,859
Baltasound Secondary	487,301	127,976	**615,277**	36,438	0	31,015	0	0	1,040	**68,493**	400
Brae Secondary	1,508,684	414,787	**1,923,471**	47,896	0	8,475	0	0	1,042	**57,413**	520
Mid Yell Secondary	443,613	103,646	**547,259**	8,031	0	6,873	0	0	1,040	**15,944**	400
Sandwick Secondary	982,888	324,294	**1,307,182**	48,142	0	19,924	0	0	1,040	**69,106**	785
Scalloway Secondary	790,512	203,978	**994,490**	25,207	0	9,984	0	0	1,040	**36,231**	785
Skerries Secondary	64,395	5,311	**69,706**	0	0	444	0	0	0	**444**	177
Whalsay Secondary	515,045	133,198	**648,243**	5,956	0	7,126	0	0	4,361	**17,443**	380
Secondary Supply	189,929	10,030	**199,959**	0	0	0	0	0	0	**0**	0
Hostel Accommodation	439,114	195,302	**634,416**	0	0	0	0	0	0	**0**	0
AHS ASN	684,826	86,179	**771,005**	0	0	0	0	0	49,888	**49,888**	0
Bell's Brae ASN	710,373	47,754	**758,127**	0	0	0	0	0	36,612	**36,612**	0
All Schools - ASN Support	2,002,919	149,825	**2,152,744**	0	0	0	0	0	0	**0**	0
Additional Support Base	199,598	16,953	**216,551**	0	0	0	0	0	0	**0**	0
TOTAL	**19,546,096**	**6,012,785**	**25,558,881**	**769,330**	**201,961**	**428,248**	**112,783**	**74,312**	**232,953**	**1,819,587**	**33,380**

* Please note that the Staff from Other Schools Column includes costs relating to Shared Management at Cullivoe, Fetlar, Foula, Olnafirth, and the ASN depts.

SHARE OF CENTRAL COSTS									DIRECT SCHOOL INCOME			
School Meals Admin £	School Milk £	Work Experience £	Science Tech's £	MIS Costs £	New Creative Links £	In Service £	Resource Base £	Total £	School Meals £	Premises Lets £	Other £	Total £
71	2	0	0	0	126	50	31	**457**	0	0	0	**0**
42	2	0	0	0	114	43	31	**409**	0	0	0	**0**
226	3	0	0	0	607	97	83	**1,370**	0	0	(8,502)	**(8,502)**
184	2	0	0	0	341	50	31	**873**	0	0	0	**0**
28	2	0	0	0	13	32	31	**283**	0	0	0	**0**
127	3	0	0	0	303	32	31	**738**	0	0	0	**0**
127	3	0	0	0	303	48	31	**866**	0	0	0	**0**
0	2	0	0	0	38	27	15	**259**	0	0	0	**0**
0	0	0	0	0	0	0	0	**0**	0	0	0	**0**
0	0	0	0	0	0	22	15	**37**	0	0	0	**0**
85	3	0	0	0	164	32	31	**557**	0	0	0	**0**
85	2	0	0	0	177	65	64	**570**	0	0	0	**0**
837	2	0	0	0	202	75	31	**1,389**	0	0	(68,000)	**(68,000)**
85	2	0	0	0	152	47	31	**494**	0	0	0	**0**
56	2	0	0	0	189	47	31	**502**	0	0	0	**0**
28	2	0	0	0	114	38	31	**390**	0	0	0	**0**
0	2	0	0	0	13	11	0	**203**	0	0	0	**0**
268	2	0	0	0	758	65	48	**1,495**	0	0	0	**0**
71	2	0	0	0	101	27	31	**492**	0	0	0	**0**
127	2	0	0	0	152	47	31	**536**	0	0	0	**0**
124	2	0	0	0	316	54	31	**750**	0	0	0	**0**
0	0	0	0	0	0	0	0	**0**	0	0	0	**0**
4,905	514	0	238	664	1,011	206	230	**8,475**	(24,122)	0	(1,053)	**(25,175)**
1,933	561	0	238	664	278	140	107	**4,451**	(5,270)	0	0	**(5,270)**
11,095	426	0	238	922	3,968	818	697	**19,234**	(52,047)	0	(200)	**(52,247)**
3,877	775	0	585	664	1,390	255	280	**8,622**	(22,302)	0	0	**(22,302)**
2,127	280	0	238	847	303	140	166	**4,715**	(4,090)	0	0	**(4,090)**
1,891	200	0	238	717	164	119	99	**4,061**	(2,233)	0	0	**(2,233)**
1,927	174	0	238	717	177	172	134	**4,172**	(3,181)	0	0	**(3,181)**
3,371	636	0	238	922	783	226	265	**7,148**	(11,639)	0	0	**(11,639)**
4,730	316	0	238	922	1,479	264	280	**8,982**	(22,142)	0	0	**(22,142)**
1,814	40	0	238	717	76	81	99	**3,521**	(1,856)	0	(243)	**(2,099)**
1,773	15	0	238	717	38	108	115	**3,637**	(1,162)	0	0	**(1,162)**
147	0	0	238	717	25	54	65	**1,879**	0	0	0	**0**
3,370	593	0	238	922	632	194	248	**7,146**	(8,619)	(450)	0	**(9,069)**

2,618	480	0	238	922	594	226	214	**5,999**	(9,932)	0	0	**(9,932)**
2,113	182	0	398	847	316	129	149	**4,924**	(6,200)	0	(175)	**(6,375)**
2,739	571	0	239	664	556	119	124	**5,542**	0	0	0	**0**
3,164	757	0	399	922	695	183	197	**7,024**	(7,534)	0	0	**(7,534)**
2,115	255	0	238	847	354	151	182	**4,932**	(5,476)	0	(205)	**(5,681)**
1,894	267	0	399	847	152	119	137	**4,448**	(2,136)	0	0	**(2,136)**
2,064	380	0	398	847	291	162	166	**5,098**	(4,362)	0	0	**(4,362)**
2,069	380	0	399	847	316	151	197	**5,149**	(5,293)	0	0	**(5,293)**
0	0	0	0	0	0	0	0	**0**	0	0	0	**0**
1,814	116	0	238	847	88	119	132	**3,987**	(2,340)	0	0	**(2,340)**
3,877	373	0	239	689	1,352	203	206	**7,558**	(20,789)	0	0	**(20,789)**
3,386	394	0	239	664	1,327	192	214	**7,035**	(19,000)	0	0	**(19,000)**
1,798	105	0	239	847	278	135	166	**4,182**	(4,751)	0	0	**(4,751)**
1,164	76	0	76	454	51	81	91	**2,272**	(1,209)	0	(10)	**(1,219)**
9,057	783	0	238	922	3,462	559	613	**16,704**	(51,663)	(480)	(128)	**(52,271)**
2,535	303	0	239	847	695	183	199	**5,950**	(9,653)	(90)	0	**(9,743)**
1,975	112	0	398	847	240	102	149	**4,353**	(3,980)	0	0	**(3,980)**
263	62	0	239	717	114	97	99	**2,224**	(1,730)	0	0	**(1,730)**
3,658	623	0	238	664	1,365	198	197	**7,650**	(10,710)	0	0	**(10,710)**
4,980	449	0	238	922	974	215	262	**8,924**	(18,627)	0	0	**(18,627)**
0	0	0	0	0		0	0	**0**	0	0	0	**0**
5,237	0	1,228	8,819	2,143	1,238	271	331	**19,647**	(30,917)	0	(5,444)	**(36,361)**
20,259	0	13,573	51,925	4,006	10,489	1,530	1,592	**106,233**	(191,000)	(8,000)	0	**(199,000)**
3,097	0	887	9,609	2,143	455	183	206	**16,980**	(10,034)	(1,500)	0	**(11,534)**
8,015	0	2,865	35,343	3,117	3,007	470	631	**53,968**	(47,013)	0	(1,745)	**(48,758)**
2,902	0	1,228	9,598	2,393	632	194	256	**17,603**	(12,719)	0	(100)	**(12,819)**
6,153	0	3,001	11,887	2,068	2,186	364	471	**26,915**	(35,781)	(18,000)	(6,745)	**(60,526)**
4,502	0	2,592	11,719	2,090	1,542	343	463	**24,036**	(20,000)	(18,200)	(100)	**(38,300)**
819	0	0	1,408	908	13	70	91	**3,486**	(807)	0	0	**(807)**
2,180	0	1,091	9,258	2,043	771	219	248	**16,190**	(21,420)	(150)	(905)	**(22,475)**
0	0	0	0	0	0	0	0	**0**		0	0	**0**
0	0	0	0	0	0	0	0	**0**	(23,121)	(5,500)	(1,152)	**(29,773)**
0	0	0	0	0	0	0	0	**0**	0	0	0	**0**
0	0	0	0	0	0	0	0	**0**	0	0	0	**0**
0	0	0	0	0	0	0	0	**0**	0	0	0	**0**
0	0	0	0	0	0	0	0	**0**	0	0	0	**0**
151,978	**11,240**	**26,465**	**158,336**	**46,186**	**48,060**	**10,654**	**11,427**	**497,726**	**(736,860)**	**(52,370)**	**(94,707)**	**(883,937)**

SCHOOL ESTATES MANAGEMENT REVIEW - NON CONTROLLABLE EXPENDITURE

School	NON CONTROLLABLE COSTS		
	Recharges	Capital Charges	Total
	£	£	£
Aith Nursery	5,240	2,453	7,693
Baltasound Nursery	4,636	2,310	6,946
Bells Brae Nursery	25,396	9,174	34,570
Brae Nursery	14,310	4,342	18,652
Bressay Nursery	403	4,368	4,771
Cunningsb'h Nursery	12,698	0	12,698
Dunrossness Nursery	12,698	4,700	17,398
Fair Isle Nursery	1,411	906	2,317
Fetlar Nursery	0	1,618	1,618
Foula Nursery	0	877	877
Happyhansel Nursery	6,853	3,121	9,974
Mid Yell Nursery	7,256	1,285	8,541
Mossbank Nursery	8,465	2,020	10,485
Sandwick Nursery	6,248	3,902	10,150
Scalloway Nursery	9,564	2,010	11,574
Skeld Nursery	4,636	2,607	7,243
Skerries Nursery	403	2,942	3,345
Sound Nursery	31,644	3,249	34,893
Urafirth Nursery	4,233	2,116	6,349
Whalsay Nursery	6,248	3,254	9,502
Whiteness Nursery	13,101	4,785	17,886
Aith Primary	42,326	21,987	64,313
Baltasound Primary	11,489	26,995	38,484
Bells Brae Primary	186,735	109,445	296,180
Brae Primary	58,245	59,839	118,084
Bressay Primary	18,610	13,135	31,745
Burravoe Primary	12,228	10,279	22,507
Cullivoe Primary	10,459	10,905	21,364
Cunningsb'h Primary	41,198	16,578	57,776
Dunrossness Primary	72,488	48,587	121,075
Fair Isle Primary	8,336	3,169	11,505
Fetlar Primary	7,421	9,707	17,128
Foula Primary	3,570	12,063	15,633
Hamnavoe Primary	32,257	26,076	58,333
Happyhansel Primary	32,016	21,521	53,537
Lunnasting Primary	20,058	19,561	39,619
Mid Yell Primary	23,380	4,662	28,042
Mossbank Primary	36,764	51,901	88,665
Nesting Primary	18,896	20,091	38,987
North Roe Primary	9,502	12,303	21,805
Ollaberry Primary	17,284	21,788	39,072
Olnafirth Primary	16,251	11,087	27,338
Papa Stour Primary	1,860	5,133	6,993
Sandness Primary	7,309	7,401	14,710
Sandwick Primary	56,636	33,450	90,086
Scalloway Primary	62,437	41,344	103,781
Skeld Primary	18,986	20,594	39,580
Skerries Primary	2,217	11,773	13,990
Sound Primary	176,375	49,605	225,980
Tingwall Primary	34,050	22,895	56,945
Urafirth Primary	15,737	16,324	32,061
Uyeasound Primary	8,576	3,850	12,426
Whalsay Primary	57,241	49,298	106,539
Whiteness Primary	46,672	45,749	92,421
Primary Supply	11,320		11,320
Aith Secondary	77,842	51,362	129,204
Anderson Secondary	467,637	355,476	823,113
Baltasound Secondary	39,109	42,496	81,605
Brae Secondary	159,947	102,572	262,519
Mid Yell Secondary	42,400	10,868	53,268
Sandwick Secondary	121,134	110,287	231,421
Scalloway Secondary	86,876	101,957	188,833
Skerries Secondary	4,285	2,942	7,227
Whalsay Secondary	70,295	48,004	118,299
Hostel Accommodation	3,901		3,901
AHS ASN			0
Bell's Brae ASN		7,813	7,813
Additional Support Base		36,250	36,250
TOTAL	2,427,798	1,771,161	4,198,959

SCHOOL ESTATES MANAGEMENT REVIEW - NON ATTRIBUTABLE INCOME AND EXPENDITURE

Cost Centre	Description	2007/08 Budget £	Reason for not allocating to Schools
Non-Attributable Costs			
GRE0006	**Director, Central Support**	**614,283**	Pensions and Central Costs
GRE0102	Bursaries	239,337	Payments to Individuals
GRE0103	Clothing Grants	22,507	Payments to Individuals
GRE0108	Education Maintenance Allowance	(14,337)	Payments to Individuals
	Grants	**247,507**	
GRE1150	Nursery General	47,797	Provides services outwith Schools to Children under five
GRE1160	Commissioned Places	158,218	Payments to Partner Providers
GRE1162	ICT Early Years Strategy	125	External Funding
GRE1362	Discipline Task Force	0	External Funding
GRE1363	Bruce Hostel	11,759	External Funding
GRE1407	Probation Teachers	(61,519)	External Funding
GRE1412	Staff Development	32,386	External Funding
GRE1414	CPD	0	External Funding
GRE1415	Schools of Ambition	4,509	External Funding
GRE1416	Assoc Schools Grp AIFL	178	External Funding
GRE1417	Field Studies	0	Funding from the Charitable Trust
GRE1421	Discipline and Ethos	0	External Funding
GRE1422	Study Support	0	External Funding
GRE1423	School Infrastructure	0	External Funding
GRE1425	Nutrition in Scottish Schools	0	External Funding
GRE1430	Modern Language Funding	0	External Funding
GRE1431	ASN Strategic Grant	0	External Funding
GRE1432	Assessment is for Learning	143	External Funding
GRE1433	Masterclass	0	External Funding
GRE1435	Coaching and Mentoring	0	External Funding
GRE1436	Youth Music Initiative	(6,811)	External Funding
GRE1437	Add Fund Class Contact Reduction	550	External Funding
GRE1439	Numeracy	0	External Funding
GRE1441	Enterprise in Education	342	External Funding
GRE1443	Social Inclusion	0	External Funding
GRE1444	Support of Teachers	21,106	External Funding
GRE1445	Support Staff	(322,106)	External Funding
GRE1448	NPAF Parental Involvement Bill	0	External Funding
GRE1455	T/Nadu Sch Exch	6,000	Council Project
GRE1493	Careers Convention	4,080	Funding to Careers Service to provide the Careers Convention
GRE1499	School Estates Review	10,913	Costs related to the review
GRE1500	Improvement Plans	24,929	Central Service Planning
GRE1502	Anti Bullying Initiative	5,250	Not appropriate to allocate out
GRE1508	PGDE	7,680	Not appropriate to allocate out
GRE1510	Science & Technonlgy Fair	4,122	Not appropriate to allocate out
GRE1513	A Curriculum for Excellence	0	External Funding
GRE3500	Link Courses	9,062	Christmas Leavers
	Other Non-Allocated Costs	(124,696)	Costs requiring further analysis before allocation
	Other Non-Attributable Costs	**(165,983)**	
TOTAL COSTS NOT ALLOCATED OUT		**695,807**	

Please note that External Funding Cost Centre's show a zero buget because the grant funding received matches the expenditure.

Comparable Local Authority Statistics - from Scottish Executive Statistical Services

Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Notes
Primary School Teacher Numbers											This section shows that Primary School Teacher numbers have remained fairly steady over the past nine years. The Scottish Average Class Size in 2006 was 23.6 pupils - this would equate to 83 teachers being required in Shetland compared to 176 currently allocated to Primary.
Orkney Islands	124	124	122	119	113	129	132	130	135	137	
Shetland Islands	184	182	178	180	176	200	180	189	187	186	
Eilean Siar	197	195	192	194	186	191	184	190	190	202	
Highland	1,078	1,098	1,097	1,097	1,075	1,093	1,117	1,118	1,096	1,127	
Primary School Pupil Numbers											In this section there is a definite downward trend in Primary School Pupil numbers, which have reduced by 20% since 1997.
Orkney Islands	1848	1823	1757	1773	1745	1689	1670	1684	1630	1558	
Shetland Islands	2337	2311	2207	2124	2097	2069	2010	1987	1944	1867	
Eilean Siar	2561	2457	2381	2289	2218	2172	2158	2097	2128	2037	
Highland	19188	18995	18868	18759	18434	18190	18082	17758	17535	17347	
Primary Pupil/Teacher Ratios											The Primary Pupil/Teacher Ratios show that whereas Teacher numbers have remained fairly steady, Pupil numbers have reduced and therefore the ratio has lowered as there are now more teachers per pupil. Also Shetland consistently has the lowest Primary Pupil/Teacher Ratio from the most comparative Authorities shown.
Shetland Islands	12.7	12.7	12.4	11.8	11.9	10.3	11.2	10.5	10.4	10.0	
Eilean Siar	13.0	12.6	12.4	11.8	11.9	11.4	11.8	11.0	11.2	10.1	
Orkney Islands	14.9	14.7	14.4	14.9	15.4	13.1	12.6	13.0	12.0	11.3	
Highland	17.8	17.3	17.2	17.1	17.1	16.6	16.2	15.9	16.0	15.4	
Scottish Average	19.9	19.4	19.1	19.0	18.9	18.0	18.2	17.6	17.1	16.3	
Primary Gross Expenditure per Pupil											The Primary Gross Expenditure per Pupil data shows that Shetland's cost per pupil has grown by 50% since 2001, whereas the Scottish average has grown by 70%. This is as a direct result of the small class sizes in Shetland, which were already in line with Scottish Executive targets.
Eilean Siar					4490	4840	5816	6513	7375	7869	
Orkney Islands					3484	3788	4984	5350	6159	6517	
Shetland Islands					4325	3890	5337	5870	6241	6390	
Highland					2533	2682	3446	3927	4112	4252	
Scottish Average					2451	2674	3148	3541	3855	4138	
Secondary School Teacher Numbers											Secondary School Teacher numbers have remained fairly steady over the past nine years.
Orkney Islands	136	137	142	142	143	130	131	130	135	133	
Shetland Islands	210	211	201	201	206	218	195	193	198	198	
Eilean Siar	218	216	218	220	216	206	208	203	206	213	
Highland	1,259	1,256	1,264	1,290	1,282	1,304	1,280	1,263	1,277	1,285	
Secondary School Pupil Numbers											Secondary School Pupil numbers increased steadily until 2002, and have now levelled out.
Orkney Islands	1428	1370	1392	1363	1366	1460	1441	1427	1427	1451	
Shetland Islands	1596	1604	1628	1648	1624	1671	1669	1668	1673	1660	
Eilean Siar	2027	1987	1940	1936	1948	1981	1952	1921	1882	1854	
Highland	14856	14821	14536	14706	14720	14749	14807	14928	14908	14902	
Secondary Pupil/Teacher Ratios											The Secondary Pupil/Teacher ratios have risen slightly due to the increase in pupil numbers. Again, Shetland consistently has the lowest Pupil/Teacher ratio from the most comparative Authorities shown.
Shetland Islands	7.6	7.6	8.1	8.2	7.9	7.7	8.6	8.6	8.5	8.4	
Eilean Siar	9.3	9.2	8.9	8.8	9.0	9.6	9.4	9.6	9.2	8.7	
Orkney Islands	10.5	10.0	9.8	9.6	9.5	11.2	11.0	11.1	10.6	10.9	
Highland	11.8	11.8	11.5	11.4	11.5	11.3	11.6	11.7	11.7	11.6	
Scottish Average	13.2	n/a	n/a	13.0	12.9	12.7	12.8	12.7	12.3	12.0	
Secondary Gross Expenditure per Pupil											The Secondary Gross Expenditure per Pupil data shows that Shetland's cost per pupil has grown by 40% since 2001, whereas the Scottish average has grown by 60%. This is as a direct result of the small class sizes in Shetland, which were already in line with Scottish Executive targets.
Shetland Islands					7352	6906	9118	9493	9852	10158	
Eilean Siar					6412	6413	7740	8120	8853	9714	
Orkney Islands					4996	5391	5949	6710	7329	7574	
Scottish Average					3598	3938	4657	5064	5428	5771	
Highland					3815	3879	4873	5442	5521	5756	

SCHOOL ESTATES MANAGEMENT REVIEW - PUPIL/TEACHER RATIO

PRIMARY SCHOOLS	Pupil Numbers	Teacher FTEs	Pupil/Teacher Ratio
Scottish Average (2006)			16.3
Aith Primary	80	8.45	9.5
Baltasound PS	22	2.23	9.9
Bells Brae PS	294	21.29	13.8
Brae Primary	110	9.75	11.3
Bressay Primary	24	3.57	6.7
Burravoe Primary	13	1.26	10.3
Cullivoe Primary	14	1.62	8.6
Cunningsb'h PS	62	5.99	10.4
Dunrossness PS	117	12.36	9.5
Fair Isle Primary	6	1.32	4.5
Fetlar Primary	3	1.26	2.4
Foula Primary	2	1.24	1.6
Hamnavoe PS	50	4.16	12.0
Happyhansel PS	47	4.60	10.2
Lunnasting PS	25	2.60	9.6
Mid Yell Primary	44	4.84	9.1
Mossbank PS	55	3.58	15.4
Nesting PS	28	2.47	11.3
North Roe PS	12	1.61	7.5
Ollaberry Primary	23	2.60	8.8
Olnafirth Primary	25	2.73	9.2
Sandness Primary	7	1.21	5.8
Sandwick Primary	107	8.00	13.4
Scalloway PS	105	9.35	11.2
Skeld Primary	22	2.14	10.3
Skerries Primary	4	1.15	3.5
Sound Primary	274	21.87	12.5
Tingwall Primary	55	3.62	15.2
Urafirth Primary	19	2.44	7.8
Uyeasound PS	9	1.53	5.9
Whalsay PS	108	10.05	10.7
Whiteness PS	77	6.59	11.7
Sub-Total for Primaries	**1843**	**167.48**	**11.00**

SECONDARY SCHOOLS	Pupil Numbers	Teacher FTEs	Pupil/Teacher Ratio
Scottish Average (2006)			12
Aith Secondary	98	14.33	6.8
Anderson HS	785	69.18	11.3
Baltasound SS	36	12.72	2.8
Brae Secondary	238	34.56	6.9
Mid Yell SS	50	9.80	5.1
Sandwick SS	173	18.10	9.6
Scalloway SS	122	17.19	7.1
Skerries SS	1	1.04	1.0
Whalsay SS	61	10.46	5.8
Sub-Total for Secondaries	**1564**	**187.38**	**8.35**

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Executive Director of Education and Social Care

Inspection of Community Learning and Development

1. Introduction and Key Decisions

1.1 This Report presents the findings of a recent inspection of the Council's Community Learning and Development service, which was published on 9 October 2007.

2. Links to Corporate Priorities

2.1 Community Learning and Development services contribute to the delivering of the Council's priorities of achieving potential, social justice and active citizenship.

3. Background

3.1 Her Majesty's Inspectorate of Education (HMIE) undertook a review of Community Learning and Development services in May, 2007. The inspection covered the following service areas: adult learning; youth services; and community work. The area inspected was Lerwick, North Mainland and Whalsay.

3.2 The inspection process is based on a 6 point grading system from excellent to weak.

4. Findings and Proposals

4.1 The report is included in full at Appendix 1. In summary, the overall Report is positive and grades are shown in Table 1 below: -

Table 1: Inspection Grades by Category

Category and Service Area	Grade
Improvements in performance	Good
Impact on participants (young people)	Good
Impact on participants (adult learners)	Very good
Impact on staff and volunteers	Adequate
Impact on the local community	Good
Inclusion, equality and fairness	Good

Operational planning	Adequate
Partnership working	Very good
Leadership: Developing people and partnerships	Weak

4. 2 HM Inspectors found the following key strengths: -

- The dedication and commitment of operational staff and service managers.
- Effective partnerships and working relationships with other agencies at a local level.
- High levels of participation and retention of young people and adults in learning and development programmes.
- Effective engagement by staff and partners with ESOL learners. This resulted in significantly increased numbers.
- Effective engagement by staff and partners with local communities around regeneration.

4.3 The inspection highlighted the following examples of good practice: -

- Whalsay Wind2Heat Project
- Eid Developments Ltd
- English for speakers of other languages provision
- COPE Ltd
- Shetland Youth Voice Executive

4.4 It is important to note that other areas of Shetland demonstrate projects which are equally successful but the Inspectors limited this visit to Lerwick, the North Mainland and Whalsay

4.5 A number of areas for improvement have been highlighted by the inspectors: -

- Improve the coordination and provision of high quality youth information and advice for young people;
- Ensure learning opportunities reflect the needs and interests of young women;
- Introduce more challenging, issue-based activities within youth club programmes;
- Improve access to ICT provision for adult learners in Lerwick.;
- Provide relevant training and support for CLD staff and volunteers involved in community groups and enterprises;
- Further develop approaches to community organisations to assist them in developing responses to important local issues;
- Complete and implement the service redesign exercise as a matter of priority.
- Introduce systematic monitoring and evaluation of the impact of CLD on young people, adult learners and communities and use this information to improve operational planning and service delivery.

- Develop systematic approaches to celebrating learners' achievements.

4.6 There is a requirement to draw up an Action Plan to address the area for service improvement. This will be developed over the next few weeks and reported to Committee for approval at a later date.

5. Financial Implications

5.1 There are no direct financial implications arising from this Report.

6. Policy and Delegated Authority

6.1 Community Learning and Development services stand referred to the Services Committee. In accordance with Section 13 of the Council's Scheme of Delegations, the Services Committee has delegated authority to make decisions on the matters within approved policy and for which there is a budget.

7. Recommendations

7.1 I recommend that Services Committee: -

(a) note the findings of the Inspection Report on Community Learning and Development services; and

(b) note that the Action Plan will be drawn up to address the Recommendations for service improvements and reported for approval at a later date; and

(c) express thanks to the staff and volunteers in the Community Learning and Development service for their hard work throughout the inspection process and for delivering high quality services to the community throughout the year.

Ref: HAS/sa Report no: ESCD-20-F

Lerwick, North Mainland and Whalsay
Shetland Islands Council

9 October 2007

Contents

1. Introduction

HM Inspectors gather evidence and make professional evaluations using the quality and performance indicators in the publication *How Good is our Community Learning and Development? 2* (*HGIOCLD?2*). They provide answers to the high-level questions:

1. What key outcomes have we achieved?

2. How well do we meet the needs of our stakeholders?

3. How good is our delivery of key processes?

4. How good is our management?

5. How good is our leadership?

6. What is our capacity for improvement?

Published reports address some of these questions, based on evaluations of the evidence gathered, and summarise the key strengths and main points for action to secure improvement. All reports on community learning and development (CLD) address the outcomes and impact that provision is having on participants and include an evaluation of the provider's overall capacity for improvement. Any self-evaluation which has recently been carried out locally contributes to the inspection process. Most inspections of CLD sample provision within more than one geographic area. The selection of areas for inspection takes account of local circumstances, previous inspection coverage and the priorities for improvement of the local authority.

2. Context and background

The context for CLD in Shetland Islands Council

Shetland is a group of 15 inhabited islands with a total population of 22,000. It is one of the smallest local authority areas in Scotland. Lerwick, the main centre, has a population of 8,500 people. The unemployment rate of 1.8% is well below the national average of 2.7%. Fisheries, oil and the public sector are the three largest sectors in the economy. As the oil industry declines the authority has been actively supporting the development of traditional industries to ensure its importance in economic terms is replaced. The largest employer is Shetland Islands Council (SIC) with a staff of over 3,000. Shetland is among the five least deprived areas in Scotland (SIMD 2004). Three point six percent of adults were in receipt of income support set against the national figure of 7.3% (Scottish Neighbourhood Statistics). SIC had recently completed its own research into deprivation and social exclusion to raise awareness of the challenges faced in such a dispersed and remote rural area. Fuel poverty levels and fuel costs are high in comparison to the national average.

Volunteering plays a large part in community life in Shetland with over 750 voluntary community groups and over 300 registered charities.

The area agreed with SIC for inspection was the Lerwick, North Mainland and Whalsay area. This included the communities of Lerwick, Gulberwick, Bressay, Brae, Northmavine and Whalsay, an island community with a population of 1,000.

Who delivers CLD in the authority?

CLD in the authority was delivered through three service areas. These were youth work, adult learning and community work. Each service area was led by an operational service manager. Prior to June 2006, CLD was delivered by the Community Development Service. At the time of inspection the Adult Learning Service and Community Work Service were undergoing redesign as part of a wider restructuring of services within the local authority. A finalised structure was yet to be agreed. The Adult Learning Service, based in Lerwick, was responsible for adult literacy work as well as English for speakers of other languages (ESOL) and community-based adult learning (CBAL) across the authority. The community work team took an area-based approach with full-time Community Learning and Development Officers (CLDO) based in community offices in five locations. Adult learning was delivered by four Lerwick-based adult learning staff, 60 sessional and 30 community-based volunteer tutors. Youth work staff were part of Children's Services and operated from a network of nine youth centres across the isles, each with a youth development worker, as well as in 25 youth clubs. In Lerwick there was the equivalent of a full-time youth development worker and a large team of part-time youth work staff who operated from both council and community-run centres.

All three services were part of the Education and Social Care (ESC) Department which had been led by an Interim Director for two years. A new Director had recently been recruited and was due to take up post in June 2007. HM Inspectors also examined aspects of the work of Shetland CLD strategy group who were contributing to the delivery of CLD in the area.

Community planning arrangements and the CLD strategy

The community planning partnership (CPP) set out its framework for development of community priorities in its strategic document *Together Shetland*. The Council was committed to partnership working and community planning. It had facilitated the development of community priorities as a result of two community consultations, *The Long Range Forecast* and *Sustaining Shetland,* on behalf of the CPP. These priorities had been approved in April 2007. The key themes of the shared long-term vision were linked to the key strategic objectives of the Council.

The partnership had agreed Shetland's priorities and targets up to 2025. These were to:

- increase employment opportunities, by 1,000 full-time equivalents by 2025, and increase average personal and household income by 15% above 2005 in real terms;
- increase the supply of housing to 12,000 by 2025;
- stimulate the demand for living in the remoter settlements of Shetland by ensuring that the ratio of jobs to people and housing is the same;
- continue to improve quality of life as well as decreasing inequalities;

- be world renowned for being clean and green islands, by decreasing CO_2 emissions by 20% by 2020; and

- increase the population of Shetland to 25,000 by 2025.

The CLD strategy action plan was themed around the three national priorities for CLD. Progress on delivery of the CLD strategy action plan, *Vibrant Shetland,* was reported to the CPP every six months.

3. What the inspection team evaluated

Decisions on which localities and aspects of CLD provision to inspect were made after considering information from previous inspections, information supplied by the authority, and discussions with senior officers of the Council.

HM Inspectorate of Education (HMIE) undertook to evaluate the impact of aspects of provision in relation to all three national priorities for CLD in the Lerwick, Whalsay and north mainland areas. The authority also submitted a self-evaluation report on the strategic context, operational arrangements and the extent and impact of provision in the inspection area.

HMIE issued questionnaires to participants in CLD activities, CLD staff and staff of partner agencies. They collated and analysed responses from 80 young people, 37 adult learners, 32 staff and 41 partner agencies.

Quality indicators were identified within the overall *HGIOCLD?2* framework and were used by the team to evaluate key aspects of CLD as follows:

- the outcomes and impact of CLD provision on young people and adults;

- the outcomes and impact on communities of support for community organisations;

- the impact on paid and volunteer staff of arrangements for their training and support;

- how well CLD provision promoted inclusion, equality and fairness;

- the effectiveness of operational planning for CLD;

- the effectiveness of partnership work in CLD;

- how well the authority managed and supported paid and voluntary staff; and

- how well the ESC developed people and partnerships.

During the course of the inspection, the team of inspectors held 30 focus group meetings with participants and active members of the communities and 12 focus group meetings with staff. They carried out six observations of practice and interviewed 27 full- and part-time staff and 13 staff from partner agencies.

4. Key strengths

HM Inspectors found the following key strengths.

- The dedication and commitment of operational staff and service managers.
- Effective partnerships and working relationships with other agencies at a local level.
- High levels of participation and retention of young people and adults in learning and development programmes.
- Effective engagement by staff and partners with ESOL learners. This resulted in significantly increased numbers.
- Effective engagement by staff and partners with local communities around regeneration.

5. How well did CLD provision meet the needs of stakeholders?

How well did CLD impact on young people?

Youth work staff worked effectively in partnership with a number of statutory and voluntary organisations to provide a good range of youth club and project type provision. Specific targets for youth work were set and monitored. Staff demonstrated high levels of commitment to providing supportive and enjoyable youth work experiences. Inter-agency projects such as the* Bridges Project *provided effective support and guidance to young people not in education, employment or training. The* Shetland Youth Voice Executive *engaged and empowered young people. Access to youth information provision was limited and of poor quality. Youth club activities were too heavily focused on social and recreational activity and did not reflect the needs and interests of young women.

Youth work staff demonstrated a strong commitment to providing supportive and enjoyable youth work experiences. Staff engaged with high numbers of young people. The majority of young people who completed the pre-inspection questionnaires were positive about the impact of youth work activities. Levels of participation and achievements were reported on a regular basis as part of corporate performance monitoring. Youth work staff, including the empowerment and participation worker, effectively engaged with young people. Projects such as the Whalsay Duke of Edinburgh's Award Group, and *First Gear* engaged and empowered young people. As a result, young people were increasingly motivated and confident. Young people felt supported by staff and partners and worked alongside adults to make effective contributions to their communities. The *Shetland Youth Voice Executive* had made an active contribution to council decision making. Projects such as the *Young People's Film and Media Club* actively encouraged young people to think about and challenge the world around them. In Whalsay, the *Wind2Heat Project* had encouraged young people to address issues of energy. The *Local Support Network* (*LSN*) was made up of a broad range of statutory and voluntary organisations, to provide joint community based early intervention to young

people at risk. The *LSN* had a strong youth centred approach, ensuring that the young people, or their guardians, were involved in all stages of the intervention process. The network had supported almost 100 young people. Young people felt well supported by the network and noted that partnership working had enabled creative solutions to be found to their problems. The *Bridges Project* effectively supported young people not in education, employment or training to gain important employability skills. Staff working in partnership with the adult literacy and numeracy (ALN) team made good use of contextualised learning to build self-confidence and improve core skills. The *Midnight Football* project offered a positive diversionary activity to anti-social behaviour.

However, some aspects of youth work required to be improved. Young people had limited access to youth information in Lerwick, the rural clubs and community halls, and materials were of poor quality. Too many youth clubs focused purely on recreational activities, and were not capitalising on the available learning opportunities. Young women were not sufficiently involved in the identification of appropriate learning opportunities. Overall, there was no systematic approach to the evaluation of learning outcomes to improve future practice.

Features of good practice: *Whalsay Wind2Heat Project*

Young people and community learning and development sessional staff in the Whalsay Youth Club had worked effectively with the *Wind2Heat Project* to address issues of energy sustainability for this island community. As a result, the club had been able to access funds to support the development and purchase of its own wind turbine. This had resulted in significant energy savings for heating costs for the club. The savings made could now be redirected to other club activities. The young people in the junior club had held a competition to name the turbine and it was now called *Youth Power*. The activities of the club in raising awareness of energy sustainability had resulted in approaches from the local high school to assist them in obtaining a turbine. Young people were now more aware of energy issues in their community. Furthermore the school had now sought to incorporate learning about sustainable energy into the curriculum on rural skills.

More detailed information is available at www.hmie.gov.uk.

Features of good practice: *Shetland Youth Voice Executive*

The *Shetland Youth Voice Executive* was a group of 16 young people from across the authority who met regularly to raise and discuss key issues. *Shetland Youth Voice Executive* members formed the young people's element of the *Shetland Youth Cabinet* and met regularly with elected representatives to ensure young people's views were heard within the council debating chamber. The group had actively contributed to discussion on a range of issues such as local transport and wind farms. The group had positively influenced council decision making regarding to a local cinema project.

More detailed information is available at www.hmie.gov.uk.

Areas for improvement

Inspectors identified a number of steps that CLD staff should take to improve the impact of services for young people.

- Improve the coordination and provision of high quality youth information and advice for young people.
- Ensure learning opportunities reflect the needs and interests of young women.
- Introduce more challenging, issue-based activities within youth club programmes.

How well did CLD impact on adult learners?

The adult learning team and its partners provided a good range of learning and development opportunities for adults. Measurable targets set for recruiting and retaining literacy learners had been exceeded. All adult learners felt included and were positive about their learning experience and the impact learning was having on their lives. Most learners applied their learning within family, work, personal and community contexts. The ALN Strategy Group ensured effective joint planning and support between partners. The CBAL programme was planned in collaboration with Shetland College and was supported by Careers Scotland and the Library and Information Service. There was insufficient emphasis placed on literacies learning in a group work setting. There was no dedicated information and communication technology (ICT) suite for adult learning in Lerwick. There was no systematic celebration of learners' achievements.

Participation in relation to ESOL provision had significantly increased over the previous year. Measurable targets set for recruiting and retaining learners had been exceeded. Motivated and committed staff created a positive and supportive learning environment and ensured that adult learners were engaged and motivated. Adult learners who completed the pre-inspection questionnaires were positive about the impact of CLD activities. Learners were able to articulate the difference that their participation in learning had made to their lives. Almost all had gained in confidence and had enhanced their self-esteem. There were good examples of learners participating in activities and developing their independence. A group of male adult learners in the Isbister Hall maths class on Whalsay reported that the support they received had enabled them to progress in their studies at the North Atlantic Fisheries College Marine Centre (NAFC). As a result, they were now able to explore and access better paid work opportunities. All learners felt supported by highly committed adult learning staff who demonstrated a good knowledge of the needs of learners and potential learners. Staff made good use of this knowledge when planning and promoting provision. *Gie it a Go* learning sessions run in local communities offered good tasters to potential participants and encouraged community activity. Adult learning staff had developed a strong working relationship with the well established, constituted committee of local people in the Whalsay Learning Centre.

Learners were engaged, motivated and interacted well with tutors and other learners. Staff had developed good relationships with learners and had engendered a safe and nurturing environment in which learning could flourish. The pace and content of learning was appropriate to individual or group needs and resulted in positive learning experiences.

Staff made good use of individual learning plans to set targets and monitor progress. In most cases there were systematic arrangements for review of progress. As a result, learners were actively engaged in discussing and monitoring their progress and achievements. Community guidance was provided in partnership with Careers Scotland. This encouraged learners to explore further learning and employment opportunities and facilitated progression. Senior staff also provided motivational interviewing training for frontline staff to encourage and support learners. The ALN team worked effectively with their colleagues in the local further education college to make ESOL provision. This was delivered in structured, certificated and non-certificated classes. Citizenship classes offered accreditation through the local college so removing the need for learners to travel to Aberdeen to sit the citizenship test. A drop-in class was also on offer for ESOL learners to practice their newly acquired English language skills in a conversational group, and find out more about services that were available to support them. The ALN partnership worked effectively to ensure that activities were well resourced and supported. Staff worked well with local volunteer tutors to provide a flexible and responsive service. Older learners in the 50+ ICT group had improved their social networks and increased access to information and services by using the internet. A well attended book launch event in Lerwick library celebrated the achievement of ESOL and communication students who had produced a book of short stories and poetry.

However, there was an over reliance on the use of volunteer tutors in a one-to-one situation and not enough emphasis was placed on using paid full-time and part-time staff to offer literacies learning opportunities in a group work setting. Learners did not have access to a dedicated ICT suite in Lerwick. Learners' achievements were not systematically celebrated.

Features of good practice: English for speakers of other languages provision

Shetland Islands Council Adult Learning Service and Shetland College jointly plan and deliver a range of English for speakers of other languages (ESOL) classes at the Old Library Centre in Lerwick. Provision had increased three-fold. Ninety-two learners from 24 nationalities participated over the last year. Classes were funded partly through the Adult Literacy and Numeracy Partnership and partly through the Regeneration Outcome Agreement. As a result of participation in the ESOL programme, learners were now able to visit their local GP and to access public services without the assistance of another adult as translator.

More detailed information is available at www.hmie.gov.uk.

Areas for improvement

Inspectors identified the following step that local managers and staff should take to improve the impact of services for adults.

- Improve access to ICT provision for adult learners in Lerwick.

How well did CLD build the capacity of the community?

CLD staff had engaged with a number of community initiatives in the inspection area. These initiatives covered a diverse range of activities. Staff had provided effective support to community organisations, such as community halls and community development companies to help them to develop and deliver local services in areas with significant challenges in terms of access to transport and services. In addition, partnership work with other services in SIC and Highlands and Islands Enterprise Shetland had supported the development of very effective and innovative community enterprises. There was a strong focus on supporting people with learning disabilities. However, the Council did not yet have a systematic approach to recognising the significant impact of the work of community development companies and other community initiatives. Training for local people in areas such as the responsibilities of directors was not yet fully comprehensive. There were also areas of underdevelopment. Significant community needs such as access to rural transport and financial skills and support were not yet being addressed.

CLD staff had ensured that community hall committees had very good relationships with adult learning, childcare and youth organisations. As a result, CLD staff and volunteers in community halls such as Bressay, Sound and Sandveien worked very effectively with health, education and the police to deliver a range of services, clubs and classes for all age groups in their local communities. This was of particular importance in the rural areas. In Aith, CLD staff had assisted *Eid Developments Ltd* to purchase a disused factory and provide a much needed community shop and post office. CLD staff, volunteers and staff in community organisations consistently displayed high levels of commitment to their local areas. In addition, volunteers had well-developed skills in fund raising, community consultation and committee work. CLD staff had effectively supported specialist projects for specific groups. Members of *Shetland Skate Park Association* had successfully raised significant funds, designed and identified a site for Shetland's first skate park. The *Shoard Community Recycling Project* in Whalsay had raised significant funds for local and international charities working with disadvantaged children and adults with learning disabilities, as well as recycling clothes, furniture, toys and electrical goods. As a result of their involvement in local groups in Bressay, Northmavine and Gulberwick, volunteers had been elected as councillors and served on community councils. They had also accessed learning programmes to further develop their skills. SIC had given good support to establish *COPE Ltd*, a significant social enterprise working with people with learning disabilities that was involved in a range of social and commercial activities. This organisation now provided individuals with access to qualifications and employment.

Whilst CLD staff had worked well to support local organisations, SIC did not yet systematically recognise the work of local volunteers and voluntary and community organisations. The significant impact of local halls as community enterprises in sustaining and maintaining communities was beginning to be recognised by the Council but this was at an early stage of development. Although some organisations such as the *Gulberwick Together*, *COPE Ltd* and *Northmavine Development Company* had well-developed plans, there was not yet a systematic approach to support local organisations to evaluate and measure the difference they were making to their communities. There was not a comprehensive approach to training and supporting local people involved in community organisations. This was despite the fact that local people were becoming company directors and trustees of charities that either owned or were seeking to buy significant

assets such as buildings and land. SIC had not yet developed approaches to work in partnership with community organisations to address significant community issues such as community transport and access to local financial skills and support.

Features of good practice: *Eid Developments Ltd*

Local residents in Aith had worked very effectively with community learning and development staff to set up *Eid Developments Ltd*. This company had purchased a disused former knitwear factory in this isolated community. They had developed this facility into a much needed local shop and post office, retaining financial services in the local community. Local people, particularly elderly people and parents with young children, now had far wider access to fresh food and vegetables, goods and banking services. As a result, the shop had significantly increased its turnover. Local residents, particularly the elderly noted an increased sense of community spirit since the shop opened.

More detailed information is available at www.hmie.gov.uk.

Areas for improvement

Inspectors identified a number of steps that local managers and staff should take to further build community capacity.

- Provide relevant training and support for CLD staff and volunteers involved in community groups and enterprises.
- Further develop approaches to community organisations to assist them in developing responses to important local issues.
- Develop more systematic approaches to celebrate and recognise the work of communities and volunteers.

How well did the authority meet the needs of staff and volunteers in CLD?

Service staff and volunteers were highly motivated and committed to making a positive difference in the communities where they worked. Staff worked well in their respective service teams and with partners. Staff had good access to training and development opportunities and had benefited from participating in national conferences and international development opportunities. Service teams met on a regular basis offering good opportunities to exchange practice. Overall, staff did not feel valued by senior management or included in restructuring discussions. Frequency of support and supervision and access to annual review varied across the CLD services. The level of administration support was insufficient and reduced the effectiveness of service delivery.

Paid staff and volunteers across all CLD services in the Lerwick, north mainland and Whalsay areas were committed and enthusiastic about their work. Paid staff and volunteers felt valued by their immediate line managers who were seen as accessible and supportive. A formal, recorded support and supervision system operated in line with council requirements, with frequency of meetings reported quarterly to the ESC committee

as a part of SIC performance reporting. Service managers were responsible for continuing professional development (CPD) and produced an annual service training programme. CPD needs were identified through support and supervision and individual staff training records were maintained. Inclusion services offered a structured training programme for youth work staff. The youth worker induction pack was comprehensive and up to date. Staff had good access to relevant training and development opportunities including professional qualifying courses. Staff felt well supported to undertake training and development opportunities and attended conferences on the mainland on a regular basis taking into account the substantial demands of travelling to and from events. Staff had good access to international CPD opportunities. The North Isles CLD staff had participated in a study visit to Norway around local enterprise. As a result, the local community council was investigating the purchase of a croft in a project modelled on a Norwegian initiative. All service staff reported positive working relationships with partner agencies. The *Bridges Project* staff worked closely with the careers service and active schools co-coordinators to deliver a relevant programme. The co-location of youth development workers, active schools co-coordinators and the CLDO in the north mainland office provided a good opportunity for exchanging information and joint working. Council ICT support was prompt and effective. There was a strong team ethos across all service teams with informal but effective peer support in place.

There was no clear plan in place to complete the restructuring of CLD services initiated in March 2006 and no mechanisms existed for staff to contribute to restructuring discussions. The implementation of the annual appraisal system across the three services was inconsistent. Whilst adult learning and youth development staff did receive annual review, community work staff did not. Not all staff had access to appropriate training to ensure effectiveness in developing areas of work such as rural community and economic development. There was insufficient clerical and administration support to professional staff. There was a lack of sharing practice and there was no systematic approach to highlighting service success with elected members and senior officers. Consequently, evidence from pre-inspection questionnaire returns and staff interviews demonstrated that CLD staff morale was low. Whilst staff felt valued by operational managers they felt less so by senior management with whom they had little or no contact. In addition, the profile of the service was not high amongst key stakeholders. As a result, the potential contribution of the CLD service to fulfilling council objectives was not sufficiently recognised.

Areas for improvement

Inspectors identified a number of steps the authority should take to meet the needs of staff and volunteers.

- Develop a systematic approach to recognising the work of volunteers and community organisations.
- Increase the opportunities for staff to reflect on the quality of their work.
- Implement the staff appraisal system across all CLD services.

- Develop more specialised CPD opportunities for staff to enable them to support new areas of work.

- Improve the level of administrative support available to CLD services.

6. How effective were CLD services in key aspects of CLD processes and management?

Leadership of staff at an operational level was very effective and there was a strong team ethos across the service teams. Staff engaged effectively in partnership working and were regarded by partners at an operational level as providing strong support and leadership. Staff and partners were clear about key priorities, and shared practice through regular team meetings. The authority was actively supporting staff in gaining professional qualifications to address the lack of qualified staff. Senior ESC managers were not engaged in the CLD partnership. There was no formal mechanism for the CLD services to share and develop practice and the use of individual worker plans was inconsistent. The delay in restructuring CLD services had impacted negatively on service delivery and needed to be progressed as a matter of urgency.

How well did the authority promote inclusion, equality and fairness?

CLD staff had undertaken a range of effective activities with partner agencies to address equality issues. ALN staff had worked very effectively with adult learners from a number of nationalities who were learning English. This work had resulted in the publication of a book that gave a migrants' perspective of Shetland. CLD staff working with the Shetland Childcare Partnership had worked constructively together to provide socially excluded parents with a range of support services such as assistance with transport costs and parenting support. These services were making a significant difference to both young people and parents by countering isolation. Parents who had experienced mental health issues because of rural isolation now reported feeling more positive about their lives and prospects. There was a particularly strong focus on supporting people with learning disabilities. Both the *Independent Living Project* and *COPE Ltd* worked very effectively with groups of adults with learning disabilities to enable them to access learning, training, qualifications and paid employment. *Shetland Youth Information Service* was actively engaging with more excluded young people through a range of referrals and outreach in two schools. CLD staff worked well with active schools staff and community organisations to develop a range of projects that enabled residents in Shetland to work with and learn with residents of South and West Africa and Southern India.

CLD staff and their partners in the voluntary sector had actively contributed to research into social exclusion in Shetland. However, this work was at an early stage of development and could not show any impacts at the time of the inspection. As a result, a number of issues relating to social exclusion as a result of lack of transport and access to financial services remained to be addressed. This was particularly important in the rural communities where residents identified transport costs and high levels of personal debt as significant issues. There remained a number of areas where further work was required. There was very limited group work with lesbian, gay, bisexual and transgender (LGBT) people.

Features of good practice: *COPE Ltd*

COPE Ltd is a high quality social enterprise that works with and employs people with learning disabilities. This has grown in nine years to a turnover of £1.9m and was working in a variety of enterprises such as the production of soap, coffee, gardening supplies, food, mineral water and bio-fuels. The organisation employed over 50 people, including people with learning disabilities. The organisation also offered access to SVQs for people with learning disabilities at a range of appropriate levels. This enabled them to access a variety of employment opportunities with the social enterprise.

More detailed information is available at www.hmie.gov.uk.

Areas for improvement

Inspectors identified a number of steps that local managers and staff should take to promote inclusion, equality and fairness.

- Promote positive attitudes to social and cultural diversity across the inspection area, particularly in relation to the LGBT community.

- Continue to develop work around engaging with hard to reach groups.

How well did the authority plan its delivery of CLD?

The CLD Strategy was clearly laid out with specific actions against agreed thematic outcomes. CLD thematic action plans and the literacies action plan clearly articulated with the CLD Strategy. There was good linkage between the corporate improvement plan and CLD service plans. CLD action plan outcomes were reviewed on an annual basis by partnership subgroups, with progress clearly recorded. The CLD partnership had recently completed a comprehensive review of thematic actions using a consistent format focused on impact and identifying future action. The literacies partnership produced both midyear and annual reports on the literacy and numeracy strategic plan with a progress subgroup monitoring progress against action plan targets. Staff and partners were clear on the key priorities. *Shetland Youth Voice* members had effectively contributed to the cultural strategy consultation. ALN staff made good use of participants' evaluations to inform future improvements for adult learning and followed up on learners who dropped out. The CBAL programme produced in partnership with Shetland College was informed by evaluations of previous programmes. ALN staff used a range of appropriate methods including individual learning plans, learner progress reviews and exit and tracker interviews to evaluate learner progress. Community work staff used a pro forma to systematically record contact and their input, outcomes and any further action required.

However, there was no explicit reference to lifelong learning within the community plan. The CLD Strategy did not clearly articulate with the recently revised community plan priorities. CLD strategy group meetings had only recently been re-established after a period of abeyance with the appointment of the Community Work Manager as lead officer. Pre-inspection questionnaire returns and feedback from a recent partnership away day reflected partners' frustration about the level of inactivity during this period. CLD partnership and thematic subgroups did not meet on a regular basis to review and discuss

progress. The use of individual worker plans by CLD practitioners was inconsistent with each service at different stages of development and implementation. There were no community work service or individual worker plans for the period 2006-07. The lack of a service plan had resulted in community work staff being given few boundaries to work within with no arrangements for monitoring workloads. Sessional youth work staff reported a lack of involvement in planning and evaluation of youth work as a whole staff group. There was no formal mechanism for staff from across the three services to get together to develop joint working. As a result opportunities to develop and improve practice were missed.

CLD staff did not yet operate a systematic approach to evaluation. The implementation of self-evaluation approaches into practice remained at an early stage of development. Community work staff recognised the need to better record feedback from individuals and community groups and to track community groups. There was no consistent recording system across CLD services. The lack of clerical support limited the ability to keep information up to date. Recent CLD self-evaluation exercises were more descriptive than impact focused.

Areas for improvement

Inspectors identified a number of steps that the authority should take to further improve planning the delivery of CLD.

- Introduce consistent use of individual worker plans across CLD services.
- Develop and implement formalised joint planning arrangements between CLD services.
- Re-establish a programme of regular CLD partnership and subgroup meetings.

How well did the authority coordinate partnership working?

The CLD Strategy had obtained the commitment of a wide range of key partners. All partners were clear and enthusiastic about benefits of joint working and were able to show benefits such as good collaboration between the local college and adult learning staff in taking forward the action points in the literacy and numeracy strategic plan. This had resulted in changes being made to class timetabling to accommodate learners' lives as well as shared marketing to avoid duplication. As a result, learner referrals were made between partners. This meant that learners were placed with provision which closely matched their needs. The community regeneration partnership had well developed partnership working from a wide range of statutory and voluntary partners. Partners were clear about their respective roles and responsibilities. A recent regeneration training event on empowering communities was well organised by a subgroup of both council and voluntary partners with shared responsibilities. This had led to new projects being developed by the partners. CLD staff and their partners in the Shetland Childcare Partnership had developed a range of approaches to share resources to meet the needs of children and their parents. They applied their resources imaginatively to support children, for example, in access to transport or to allow parents to return to learning. CLD staff worked well with staff in schools, libraries, *Shetland Arts* and social care to deliver programmes for young people and adults with learning disabilities. This enabled learners to access services easily and

without barriers. However, the training needs of voluntary and community organisations to enable them to sustain and increase their participation in partnership working and delivery of services was underdeveloped at the time of the inspection. SIC did not yet make systematic use of service level agreements to acknowledge the role of and further develop community and voluntary sector organisations. This was particularly important in the rural areas such as Northmavine and islands such as Whalsay.

Areas for improvement

Inspectors identified a number of steps that the authority should take further improve partnership working.

- Develop training to sustain and increase voluntary and community organisations involvement in partnership working and service delivery.

- Develop the use of service level agreements with clearly agreed outcomes to acknowledge the role of community organisations in local service delivery.

7. How effective were CLD services in key aspects of leadership locally?

CLD service managers offered effective leadership in taking forward development at both an authority-wide and local operational level. The Adult Learning Manager offered effective leadership to the adult literacy partnership. The recently appointed Community Work Manager had been instrumental in re-establishing the CLD partnership meetings. The Inclusion Manager was participating in a national management training programme. As part of this initiative she had been asked to bring forward options for restructuring the adult learning and community work services. All three services recognised the need to develop their own staff to achieve a full professional qualification. Four staff were currently being supported through such a course. One member of staff had graduated last year. ESOL tutors were currently undertaking a range of appropriate qualifications. The Adult Learning Manager had been instrumental in establishing an innovative peer support network with colleagues in the Western Isles which allowed regular sharing of adult learning practice. Operational staff felt encouraged by service managers to use their initiative.

However, senior ESC managers did not maintain effective communication with key partners to ensure effective multi-agency working. Senior managers were not members of the CLD partnership and did not take a lead role in developing joint initiatives. There was no identified link between the senior management team and the CLD partnership. Operational managers had not received consistent support from strategic managers. A regular monthly meeting between the Adult Learning Manager and the ESC Director had recently been introduced but was not formally recorded. Whilst the Community Work Manager had the professional lead for community work he did not contribute to discussions at a corporate and CPP level. Whilst the three services operated effectively as individual teams there was no formal mechanism to support cross service working or to allow operational service managers to meet and agree joint developments. Whilst the youth work staff were clearly located within Integrated Children's Services the location of the community work and adult learning staff remained unresolved. The departure of the

Community Work Manager in late 2005 and Community Development Head of Service in early 2006 had resulted in a lack of clear strategic leadership or direction for CLD staff. Community work staff were without a service manager until the post was filled in October 2006. Adult learning staff were concerned about their possible relocation out of the old library base and the impact this would have on service delivery. The authority needed to provide strategic leadership in the development of an effective and coordinated youth information strategy.

8. What is Shetland Islands Council's capacity for improving CLD provision?

A new director for ESC which includes responsibility for CLD is now in post. All key CLD management posts are now filled. A timescale had been set for bringing forward new structure proposals. The recent re-establishment of regular CLD partnership meetings under the leadership of the Community Work Manager was good progress. Service staff recognised the importance of self-evaluation in planning for improvement. However, there was a need to further embed self-evaluation and to develop measurable targets. All services had in place an operational service plan for 2007/08 and individual work plans were in the process of being finalised. The introduction of the staff appraisal scheme was being rolled out across the CLD services.

Based on the action points within this report being effectively undertaken, HMIE is confident that the authority has the capacity to improve the impact of CLD in the Lerwick, North Mainland and Whalsay area.

9. Main points for action

SIC should take action to address the areas for improvement identified within this report and the following main points for action.

- Complete and implement the service redesign exercise as a matter of priority.
- Introduce systematic monitoring and evaluation of the impact of CLD on young people, adult learners and communities and use this information to improve operational planning and service delivery.
- Develop systematic approaches to celebrating learners' achievements.

10. What happens next?

HMIE will continue to monitor progress on the main points for action contained within this report. HM inspectors will return within two years of the publication of this report to assess progress.

Stewart Maxwell
HM Inspector
On behalf of HM Chief Inspector

Appendix 1: Quality indicators used to evaluate CLD provision in the Lerwick, North Mainland and Whalsay area, Shetland Islands Council

HM Inspectors use performance measures and quality indicators when making judgements in their inspections of CLD. The quality indicators used were selected from those published in June 2006 in the publication *HGIOCLD?2*. This publication is available on the website www.hmie.gov.uk.

In the report and this appendix we make clear the judgements made by using these word scale categories:

Excellent	Outstanding, sector leading
Very good	Major strengths
Good	Important strengths with some areas for improvement
Adequate	Strengths just outweigh weaknesses
Weak	Important weaknesses
Unsatisfactory	Major weaknesses

1.1: Improvements in performance	**Good**
2.1: Impact on participants (young people)	**Good**
2.1: Impact on participants (adult learners)	**Very good**
3.1: Impact on staff and volunteers	**Adequate**
4.1: Impact on the local community	**Good**
5.9: Inclusion, equality and fairness	**Good**
6.3: Operational planning	**Adequate**
8.1: Partnership working	**Very good**
9.3: Developing people and partnerships	**Weak**

Appendix 2: Glossary of terms used in Shetland Islands Council

Bridges Project
A project that supports young people, not in education, employment or training, to gain the skills and confidence to move into employment or training.

COPE Ltd
COPE Ltd is a social enterprise company that provides employment and training opportunities for adults with disabilities. They operate commercially viable social businesses that promote equality of access to a range of opportunities across the islands. They aim to be a socially and environmentally conscious organisation while still operating to commercial targets.

Eid Developments Ltd
Faced with the prospect of the local shop closing, community activists formed Eid Developments Ltd to buy and renovate a disused knitwear factory and attached land. The refurbished ground floor was then leased to a second social enterprise company, Eid Community Co-op.

First Gear
The First Gear project is delivered through Scalloway Junior High School by youth development staff, Northern Constabulary and local driving instructors. The course, which is delivered twice yearly, raises participants' awareness of the responsibilities of vehicle ownership and safe driving.

Gie it a Go
A series of local community events which promote participation in adult learning and community activities, tailored to individual community need and involving a range of partners.

Gulberwick Together
A community based association which encourages community involvement in the enhancement and development of the rapidly growing Gulberwick area and supports the well-being of its residents.

Independent Living Project
Supported accommodation for adults with learning disabilities.

Local Support Network
A network of Support Coordinators which responds to requests for early intervention and support of children, young people and families. Coordinators work with those who have a role in providing support through an agreed action plan.

Midnight Football
Initiative aimed at keeping young people aged between 12 and 16 off the streets at weekends and reducing youth crime levels and anti-social behaviour. The Midnight league is run in partnership between the Bank of Scotland, the Scottish Football Association, local authorities and local police.

Northmavine Development Company
A community development company adopted by the Northmavine Initiative at the Edge Group which identifies ways to regenerate and develop their rural community, mainly through mobilising community activity.

Shetland Arts
Arts development agency, which promotes and develops the arts in Shetland. Shetland Arts supports artists working in a variety of art forms to develop their practice and has a key role in developing arts education and outreach work throughout Shetland.

Shetland Skate Park Association
A voluntary organisation established by young people and adults to develop a purpose built skate park facility and to promote wheeled sports as a recognised part of local youth culture and recreation.

Shetland Youth Cabinet
A core group of three SIC elected representatives meet every two months with the Shetland Youth Voice Executive to discuss topical issues and to ensure young people's voices are heard in the council chamber.

Shetland Youth Information Service
Shetland Youth Information Service provides Information, advice and support for young people age 12 to 26 years including young people's rights and counselling services. The service has a café drop-in facility and is centrally located.

Shetland Youth Voice Executive
Youth Voice is a Shetland wide forum through which young people are engaged in decision-making and consultation. The Youth Voice Executive forms the young people's element of Shetland's Youth Cabinet, which meets regularly with elected local councillors to ensure young people's views are heard and relayed within council chamber and debate.

Shoard Community Recycling Project
The Whalsay Disability and Special Needs Support Group is wholly run by volunteers and operates a community recycling centre to fund identified special needs in the island community of Whalsay.

Whalsay Learning Centre
One of five Shetland College community-based learning centres run in partnership with the local community. The learning centre is based in the Whalsay leisure centre and offers a range of courses tailored to community needs.

Whalsay Wind2Heat Project
Based in Livister Youth Centre this project focuses on issues of energy sustainability within the context of an island community. The Youth Centre management committee successfully sourced funding to provide sustainable, energy-efficient fuel through a wind turbine, named *Youth Power* by local young people.

Young People's Film and Media Club
A group, led by young people, offering support and opportunities for the development of film and media skills. Shetland Arts and youth development staff support the group.

How can you contact us?

If you would like an additional copy of this report

Copies of this report have been sent to the Chief Executive of the local authority, the Executive Director, senior and local staff, Members of the Scottish Parliament, and to other relevant individuals and agencies. Subject to availability, further copies may be obtained free of charge from HM Inspectorate of Education, Directorate 5, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA or by telephoning 01506 600378. Copies are also available on our website www.hmie.gov.uk.

HMIE Feedback and Complaints Procedure

Should you wish to comment on any aspect of community learning and development inspections you should write in the first instance to Annette Bruton, HMCI, at HM Inspectorate of Education, Denholm House, Almondvale Business Park, Almondvale Way, Livingston, EH54 6GA.

If you have a concern about this report, you should write in the first instance to our Complaints Manager, HMIE Business Management and Communications Team, Second Floor, Denholm House, Almondvale Business Park, Almondvale Way, Livingston, EH54 6GA. You can also e-mail HMIEComplaints@hmie.gsi.gov.uk. A copy of our complaints procedure is available from this office, by telephoning 01506 600200 or from our website at www.hmie.gov.uk.

If you are not satisfied with the action we have taken at the end of our complaints procedure, you can raise your complaint with the Scottish Public Services Ombudsman (SPSO). The SPSO is fully independent and has powers to investigate complaints about Government departments and agencies. You should write to the SPSO, Freepost EH641, Edinburgh EH3 0BR. You can also telephone 0800 377 7330 (fax 0800 377 7331) or e-mail: ask@spso.org.uk. More information about the Ombudsman's office can be obtained from the website: www.spso.org.uk.

Shetland
Islands Council

REPORT

To: Services Committee 18 October 2007

From: Head of Children's Services

Integrated Assessment Framework

1. Introduction

1.1 This reports explains the main purpose of the Integrated Assessment Framework (IAF) and the changes in working practice for all agencies working with children that will be required.

2. Links to Corporate Priorities

2.1 This report supports the (developing) Corporate priority to,

> "Promote practical and practicable joint working, wrapping services for children around their needs and aspirations. This applies equally in care, education and leisure time activities. We will work to ensure that children and young people can access services and leisure time activity, wherever they live."

3. Background

3.1 The IAF has been mentioned in a number of significant national policy and guidance documents over the past four years.

3.2 Until recently the Scottish Executive had its own working team dedicated to the IAF process, helping to assist local authorities to implement the framework.

3.3 In 2006 this working group ceased to operate, as the IAF became a working part of the "Getting It Right For Every Child" (GIRFEC) initiative from the Scottish Executive.

3.4 The Scottish Government has continued the commitment to the GIRFEC initiative with the main purpose being that every child has the right to receive the support he or she needs when they need it.

3.5 There is a particular emphasis on early intervention. The IAF is a very important framework for all services and agencies in identifying the needs of children and young people at as early a stage as possible.

3.6 The Scottish Government give the following as the aim of the IAF:
"The aim of the IAF is to provide a means by which all services for children – universal and specialist – will be able to gather and share appropriate information, assess needs, plan and co-ordinate services for individual children. Core information collected for all children will connect with specialist assessments necessary to meet the needs of those children and families requiring additional support. The IAF will ensure that the child's experience is maintained at its centre and that account is taken of strengths, achievements, and the personal resources of the child and family as well as needs and risk of harm."

3.7 Shetland's Integrated Children and Young People's Services Planning Group has had an IAF sub-group since 2004 looking at how the IAF can be most appropriately used in Shetland.

3.8 The IAF sub-group has completed the paperwork that supports the IAF in Shetland's context. Members can request a copy of this by contacting the Head of Children's Services.

3.9 A training programme has been developed for all staff working with children and young people and is due to start in October 2007. This will be a lengthy and continuing process.

3.10 The IAF will provide the structure for better integrated working and will require commitment from all of those working with children and young people.

3.11 The commitment required mentioned above has been evidenced through the planning process for the IAF over the past four years.

3.12 The IAF will be implemented on 1 November 2007.

3.13 The main benefits of working within the IAF are as follows: -

- Families will consent to the IAF process and appropriate levels of information sharing between agencies.
- Families will only be subjected to one process.
- Needs will be identified, by all those involved in providing services to children and young people, in a co-ordinated manner.
- These identified needs will then be met with minimum delay.
- Any needs that are not met will be recorded as unmet.

4. Proposal

4.1 It is proposed that members note the contents of this report.

5. Financial Implications

5.1 There are no financial implications from this report.

6. Policy and Delegated Authority

6.1 In accordance with Section 13 of the Council's Scheme of Delegation, the Services Committee has delegated authority to make decisions on the matters within approved policy and for which there is a budget. However as this report is for noting only, there are no policy and delegated authority issues to be addressed.

7. Conclusions

7.1 This Report sets out the purpose of the IAF and changes in working practice required by all agencies and seeks Services Committees support for this way of working.

8. Recommendations

8.1 I recommend that Services Committee note the information provided on the Integrated Assessment Framework.

Ref: SM/sa Report no: ESCD-18-F

Shetland Islands Council

MINUTE A & B

Shetland College Board of Management
Council Chamber, Town Hall, Lerwick
Thursday 4 October 2007 at 2.15 p.m.

Present:

A J Hughson	L F Baisley
B Fullerton	G Robinson
W H Manson	J L B Smith

Apologies:
L Angus R Nickerson

In attendance (Officers):
G Smith, Director, Shetland College
I Peterson, Depute Director, Shetland College
L Sinclair, Lecturer and EIS Representative
S Smith, Operations Manager, Shetland College
L Adamson, Committee Officer

Chairperson
Mr A Hughson, Chair of the Board, presided.

Circular
The circular calling the meeting was held as read.

39/07 **Minutes**
The minute of the meeting held on 16 August 2007 was confirmed on the motion of Ms L F Baisley, seconded by Mr J L B Smith.

40/07 **Director's Report**

1. Shetland College Lecturers Pay Claim
The Board noted that the College Lecturers pay claim had been agreed and implemented.

2. Centre for Nordic Studies
The Director advised that the conclusion at Executive Committee on 4 September was that further consideration should be given to the project. Following further discussions with Orkney College and Shetland Amenity Trust (SAT), the Director said that it was proposed that Shetland would pay a proportion of the costs, and 1.5 full-time equivalent researchers would be established at Shetland College to pursue the work of the Nordic Studies Centre. The Director said that it was important that the Nordic Studies Centre complements the cultural heritage work of SAT. There was also the possibility of

a summer school being arranged for next year in conjunction with the Shetland Museum and Archives.

3. Careers Week at the College

The Director advised of recent events held at the College to encourage students to build on their employability skills and to participate in this year's Careers Convention. This included a question time style meeting between students and employers. The clear message from employers was that qualifications are not enough, with employers also looking for experience in the workplace and core attributes such as flexibility, dependency, willingness to learn, creativity and communication skills. The Director advised that the importance of presentation and interview skills had also been highlighted, and during a visit from Careers Scotland, it had been proposed that interview skills could be built into the students' curriculum.

The Director advised that Secondary 3 pupils from Sandwick School had visited the College to experience taster sessions of the various areas of activity at the College. The Director said that it was hoped that this event would be built on and improved for next year, to ensure that when pupils make their career choices they are aware of the courses offered at the College.

4. Visit by Michael Breslin, Director of Argyll College

The Director advised that Mr Breslin had advised of his experience of overseeing the setting up of a number of learning centres throughout Argyll, with the premise that what is available at one Learning Centre should be available at all Learning Centres. The Director said that the discussions had been very interesting and lessons had been learned.

5. Visit by Bob Cormack, Principal, UHI

The Director reported that the Principal of the UHI would be visiting Shetland on Monday, and a dinner had been arranged for Members of the Board to meet with the Principal.

6. Feasibility Study – Phase 3, Shetland College

The Director advised that he had received the feasibility study for the possible Phase 3 building for the College. He said that the Study was very thorough and highlighted a number of options for consideration. The Board noted that the Feasibility Study would be presented to the next meeting.

7. Sources of Funding

The Director advised of two allocations of additional one-off funding for employer engagement and knowledge transfer and that these funds would be used to develop the College's marketing work and to develop the Textile Facilitation Unit ensuring opportunity for knowledge transfer regarding operation of the unit and with industry.

41/07 **Appointment of Vice-Chairman**

The Chairman asked for nominations for the appointment of Vice-Chairman.

Mrs B Fullerton nominated Ms L F Baisley, and Mr W H Manson seconded. There being no further nominations, Ms L F Baisley was duly appointed as Vice-Chairperson of the Shetland College/Train Shetland Board of Management.

42/07 **Student Enrolments September 2007**

The Board considered a report by the Director, Shetland College (Appendix 1).

The Director summarised the main terms of the report and advised that on the whole the enrolments to date were on target however there was some concern regarding the number enrolling in Business and Management courses. The Board noted that the current figure did not include enrolments from the NAFC, Evening Classes, and Train Shetland's short courses. The Director added that as funding was based on student numbers it was important to hit targets wherever possible.

In response to a query, the Director advised that should the enrolment numbers continue to remain low in the areas of Business and Management the portfolio could be amended in future years to concentrate on the more popular courses. In response to a further query, the Director clarified that the concerns related to meeting the SUMS targets for Higher Education enrolments rather than Further Education enrolments. Regarding the Higher Education enrolments, the Depute Director advised that a concerted effort would be made for the intake of part-time students in the areas of Business and Management for Semester 2.

In response to queries from Ms Baisley, the Director provided an explanation on a number of course descriptives, set out in the Appendix.

The Board otherwise noted the report.

43/07 **UHI Academic Partner Review – Action Plan**

The Board considered a report by the Director, Shetland College (Appendix 2).

The Depute Director introduced the report and advised that the Action Plan had been prepared following the UHI Academic Partner Review of the College in March 2007. The Board noted that the 7 Action Points had been reduced to 6, with the UHI agreeing to address the recommendation relating to SITS Training.

The Depute Director reported that the Action Plan had been presented to the Quality Improvement Committee to study the

recommendations and agree timescales for the Action Points. The Depute Director added that the Action Plan would be presented to the UHI Academic and Standards Committee meeting in mid November.

After hearing the Depute Director advise that the targets and timescales in the Action Plan were manageable and could be met, the Board agreed to note the recommendation in the report.

44/07 **Shetland College Policies – 2007/08**

The Board considered a report by the Director, Shetland College (Appendix 3).

The Depute Director introduced the report and advised that the set of policies would be implemented during 2007/08, and the individual policies would be monitored to measure their impact, and reviewed at the end of the year to ensure maximum benefit.

Mr W H Manson said that it was important that the students paid attention to the Policies and suggested that if necessary the documents should be reviewed and adapted to fit the needs of the College.

In response to a query from Mr J L B Smith, the Depute Director explained that the timetabling issues when Colleges have different holidays remains an issue for the UHI Network, however this matter was still being discussed. The Director commented that this was not an easy matter to resolve with Colleges traditionally matching the local school holidays.

The Board approved the recommendation in the report on the motion of Mrs B Fullerton, seconded by Mr J L B Smith.

45/07 **Shetland College Operational Plan 2007/08**

The Board considered a report by the Director, Shetland College (Appendix 4).

The Director summarised the main terms of the report and advised that the priorities in the Plan were based on the strategic aims of the College agreed at the Away Morning in August.

The Director referred to an operational milestone relating to Strategic Policy 2, for the College to best engage with the economic agencies in Shetland, and suggested that with the demise of the local economic development forums, it would be beneficial for Shetland College to have representation on the SIC's Tourism and Culture Forum and the Business Forum. The Board noted that the Forums were still to meet, however the Director's suggestion would be conveyed to the Forums.

The Director then enquired whether Members would consider nominating 'champions' from the new Board of Management to

each of the sections of the College. During the discussion that followed, it was suggested that a Member with experience and knowledge in a particular area as well as a non-expert could cover a particular section, and learn from each other.

During the discussion that followed, Members indicated their willingness to become a 'champion', as follows:

Ms L Baisley – Construction, Cultural Studies and Care
Mrs B Fullerton – Art, Design & Textiles and Hospitality
Mr A Hughson – Engineering and Business & Management
Mr W H Manson – Hospitality
Mr G Robinson – Computing and Care
Mr J L B Smith – Computing and Construction

Mr J L B Smith moved that the Board approve the recommendation in the report. Ms L F Baisley seconded.

46/07 **Feasibility Report into Potential and Demand for Further and Higher Education Music Courses in Shetland**

The Board considered a report by the Director, Shetland College (Appendix 5).

The Director introduced the report and said that the findings from the survey had been very encouraging, indicating a demand for traditional music courses in Shetland. The Director advised that the courses could be delivered at national certificate level and at HNC level articulated to other colleges and universities in Scotland. The Director went on to explain that further consideration would have to be given to the physical and people resources for delivering the courses and that this could take some time. The Board noted that original funding was available to progress this proposal to the next stage with the intent for the courses to be in place for delivery in 2009/10.

After receiving assurance from the Director that sufficient funding was in place to commission the further work, Mr W H Manson moved that the Board approve the recommendations in the report.

During the discussion that followed, Mr G Robinson suggested that any further work to develop the music courses be deferred until such time as a decision is taken on the Cinema and Music Venue.

Mrs B Fullerton stated that the work to further develop the music courses should progress utilising current facilities and should not be dependant on whether or not the cinema and music venue proceeds. She then referred paragraph 6.2 in the report, and requested that the words "before then" be removed from the third sentence.

After further discussion, Mr W H Manson agreed to incorporate Mrs Fullerton's proposal into his motion. Mrs B Fullerton seconded.

47/07 **Skills for Scotland – Lifelong Skills**

The Board noted a report by the Director, Shetland College (Appendix 6).

The Director summarised the main terms of the report and highlighted a number of proposals in the "Skills for Scotland – Lifelong Skills Strategy" relevant to the Shetland College. The Director added that a number of the issues gives the College optimism for the future and the test would be in the comprehensive spending review and monies allocated to the College.

During the discussion, Mr G Robinson commented that Strategic Workforce Development would incur additional costs to Shetland and he hoped that additional funding would be made available.

Ms L F Baisley said that it was important that the Strategy included re-skilling to meet workforce requirements, however Adult Learning should also incorporate learning something new, for self-improvement.

The meeting concluded at 3.40 p.m.

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A J Hughson
CHAIRPERSON