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## Shetland's Joint Future

Shetland Islands Council

### Foreword

Shetland's Joint Future partnership has seen a number of key service developments begin to take shape during 2006 – 2007.

Significant progress has been made with the Dementia Redesign Project and Long Term Care Review. Locality management models are well established and Local Service Delivery Groups are being promoted across seven localities, which are co-terminus with the new electoral ward boundaries.

Public involvement in service planning will be increasingly sought and supported by the Local Service Delivery Groups as we establish a Public Participation Network across Shetland. Our aim is to create opportunities for everyone in Shetland to express their views on our services and our performance and to contribute to the shape of service provision.

The challenges for the coming year are to complete the service redesign projects for long term care and dementia in order to establish the blue print for modern, affordable and sustainable health and care services that meet the needs of our community now and in the future.

We are confident that by continuing to work well together with the public and with our partners in the independent and voluntary sector we shall be able to achieve our goal.

Sandra Laurenson

Chief Executive  
Shetland NHS Board

Hazel Sutherland

Executive Director  
Education & Social Care, SIC



**Shetland's Joint Future** Shetland Islands Council

## **Executive Summary**

### **Shetland's Joint Future Extended Local Partnership Agreement and Community Care Plan 2007 – 2010 (ELPA 2007-10)**

The ELPA sets out the funding and management arrangements that underpin the Joint Future services in Shetland. Community Care Plans cover 3 years and are set out by care group.

The ELPA 2007-10 covers the three financial years from 1 April 2007 through to 31 March 2010. The gross outturn in 2007/08 is expected to be approximately £21.5M. This includes funding streams as follows :

- £13.1M Shetland Islands Council,
- £2.8M Shetland Charitable Trust and
- £5.6M NHS Shetland.

Generally, in Shetland, Joint Future budgets are aligned rather than pooled although where services are jointly commissioned from a third party, the budgets are pooled e.g. for independent advocacy services.

In Shetland, the expenditure per capita is the highest in Scotland. The levels of service are very high as is the standard of care provided.

Two issues highlighted by communities across Shetland during a consultation exercise undertaken by the Community Planning Board are particularly relevant to community care services. These are:

- How we respond to our ageing population: the population is now showing signs of stabilising, but the proportion of older people is increasing and numbers of people requiring care are increasing and will continue to increase;
- How we support rural areas, when increasing numbers of people want to live in and around Lerwick.

A major difficulty for both agencies is recruitment and retention of staff. There are problems attracting people to some of the more specialist posts in both the Council and Health Board and in some areas of Shetland it is becoming increasingly difficult to recruit care workers.

Nevertheless, Shetland's Joint Future Partnership continues to make good progress in implementing the Joint Future Agenda locally.



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Progress in implementing the Joint Future agenda is monitored and reported annually to the Scottish Executive through the Joint Performance and Information Assessment Framework (JPIAF.)

Shetland's Final Evaluation Statement for 2005-2006 was issued by the Scottish Executive on 13 October 2006. Overall, the Scottish Executive reports that Shetland's Joint Future partners are making "good progress" towards meeting the JPIAF indicator requirements with performance in some areas above average.

The performance-monitoring framework for Joint Future is changing to focus more on outcomes rather than process. A National Outcomes Project has been commissioned by the Scottish Executive and is working towards a performance framework for all community care client groups comprising national outcome targets based on the visions in Delivering for Health, Changing Lives (the report of the 21<sup>st</sup> Century Social Work Review) and Joint Future.

It is envisaged that Local Improvement Targets will continue to be required as part of the new outcomes reporting model which will be introduced during 2007/08.

### **Achievements in 2006/07**

1. *Long Term Care Review*  
Funding has been secured to support the review. A conference involving a wide range of stakeholders was held in February 2007. Work on service redesign is making good progress, starting with a review of the facilities available at Isleshavn in Yell.
2. *Dementia Redesign*  
Work to scope options for change is substantially complete.
3. *Interim Placement Unit*  
The IPU has been expanded to offer 16 places and will be available until 2013 to allow time for redesigned services to be put in place.
4. *New Services for Adults with Learning Disabilities*  
Newcraigielea, the new respite facility for adults with learning disabilities, opened in January 2007. Additional supported accommodation has been opened at Rudda Park and Sea View providing up to 12 new tenancies.

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5. *Assessment and Care Management*  
A new training programme has been developed and two courses were run in the early part of 2007. More courses are planned. The first full revision of the SSA procedures is almost complete.
6. *Day Care*  
Revised day care criteria have been approved and the service is being used increasingly as part of intensive care packages supporting people in their own homes.
7. *Joint OT Store*  
A feasibility study looking at options for a Joint OT Store and new office accommodation has been completed. A proposal for this to be developed as a new build on the Brevik House site has been accepted in principle by both Shetland NHS Board and the Council.
8. *Community Health Partnership and Locality Working*  
Local Service Delivery Groups are being established in 7 localities across Shetland. The LSDGs will link with existing groups and work to reach the hard to reach members of their local communities to establish the Public Participation Forum Network for Shetland.
9. *Carers*  
Good progress has been made on the implementation of the Carers' Strategy and Carer Information Strategy. A Young Carers' Strategy has been drafted in consultation with a wide range of stakeholders. Funding has been obtained to set up support groups on the Westside and North Mainland of Shetland.
10. *Mental Health Services*  
The number of MHOs in Shetland has been increased and a first contactable rota put in place.

**Areas where progress has been disappointing**

1. Some of the joint management teams in the Joint Management Framework have not met regularly during 2006/07 due to staff vacancies and absence on long term sick leave.
2. There has been no progress with development of additional capacity in the community to meet increasing levels of need, due to resource constraints, both financial and human.
3. Work on a revised policy and procedures for the protection of Vulnerable Adults is still at an early stage.

**Priorities for 2007/08**

1. To complete the long term care review and feasibility study into replacement facilities for Viewforth and Isleshavn;
2. To look at options for assistive technology (Telecare) in the context of long term care solutions;
3. To promote the LSDGs and the Public Participation Forum Network across Shetland with a view to having on-going dialogue with the community on health and care issues;
4. To produce a revised Advocacy Development Plan;
5. To complete work on a Mental Health Strategy for Shetland looking at the next 10 - 15 years;
6. To take forward proposals for a joint OT store and office accommodation at the Brevik House site;
7. To implement the learning disabilities day services redesign;
8. To publish the CHP Access Guide;
9. To aim for continuing improvement against local targets for completion of assessments and reviews;
10. To continue work on electronic data sharing across partner agencies;
11. To develop and articulate a joint Respite Strategy; and
12. To review health and care services for younger adults with physical disabilities, in particular options for independent living.

## Section 1:

### Our Vision, Mission, Aims & Objectives

#### Our Vision

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

#### Our Mission

To work together to deliver a range of quality care services, which are where possible:

- based in local communities
- designed in partnership with service users and carers
- based on assessed needs.

#### Our Aims

- More flexible and better quality services
- Resources targeted at areas of greatest priority, based on clearly defined evidence of need
- A shift in the balance of provision towards community based services
- Agencies working together in partnership within local communities
- More joint strategic and operational planning
- Access to joint budgets
- Actively engaging people and their carers in plans for their care
- Services integrated around the needs of patients, clients or carers
- Joint systems and assessment criteria
- Quicker and better decision-making
- Less bureaucracy
- Clear accountability for decision-making and spending decisions
- Listening and responding to community needs and aspirations

## Our Objectives

**A Healthier Community** – a demonstrably healthier local population.

**Better services** - for users and carers, in particular:

- There will be in place a seamless method of service delivery, not restricted by organisational or professional boundaries – modelled on a “one-stop-shop” method of service delivery, so achieving a faster journey along the service route
- There will be ease of access to services, with clear understanding within the community of who to contact and where to go
- The balance of activity/spend will have moved towards home delivered services or services delivered in a homely environment
- The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so
- There will be more flexible services and more choice for service users, within available resources
- There will be a fair and equitable distribution of resources – based on a shared understanding of local community need
- Any unnecessary duplication, bureaucracy and managerial or administrative overheads will be removed from the system
- Information will be available to each household in Shetland which explains how to access services, what service standards they can expect and how each organisation is performing through an effective public performance reporting regime

**Equality of Access** – there will be equity in access to services through better information, more locally based services and better transport arrangements where provision needs to be centralised.

**Diversity** – all service users and their carers will be able to access services to meet their needs irrespective of their race, religion/faith, sexual orientation, age, disability or gender.

**People** – there will be in place a system of team working which recognises and values individuals' skills and knowledge, encourages joint training and secondment opportunities and works to meet the needs of the service users and carers.

**Effective Use of Resources** - resources will be effectively targeted at areas of greatest priority, which are clearly determined by evidence of need.

**Reduced Bureaucracy** - systems, procedures and information will be shared between organisations and there will be clarity in the decision-making

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process, so reducing bureaucracy and delays in decisions about service delivery.

**Value for Money** – services are delivered to the best possible standard and quality, at the best possible price.

**Property** – public and voluntary sector buildings are accessible and available for multi-use by all agencies to ensure that community resources are maximised.

**Equipment** – there is a shared bank of equipment, locally based where possible, jointly managed and accessible to all agencies on shared assessment criteria.

**Money** – financial resources will be shared and accessible to practitioners from any agency with clarity of accountability for spending decisions.

**Information and Communication** – organisations will share knowledge of individual and community needs and aspirations, share priorities and service objectives and clearly communicate these to all staff.

**Single, Transparent and Shared Assessment Criteria** – there will be no need for a user or carer to be assessed for eligibility for services by more than one relevantly qualified member of staff .

**Key Workers** - a user or carer will have allocated to them a named individual who looks after their service needs so that they need only have to “tell their story once.”

**Joint Planning and Shared Priorities** – organisations will have a single planning and design process with clarity in what they are trying to achieve in the short, medium and longer term.

**Consultation Mechanisms** – services will be planned and designed in partnership with service users/carers and the general public.

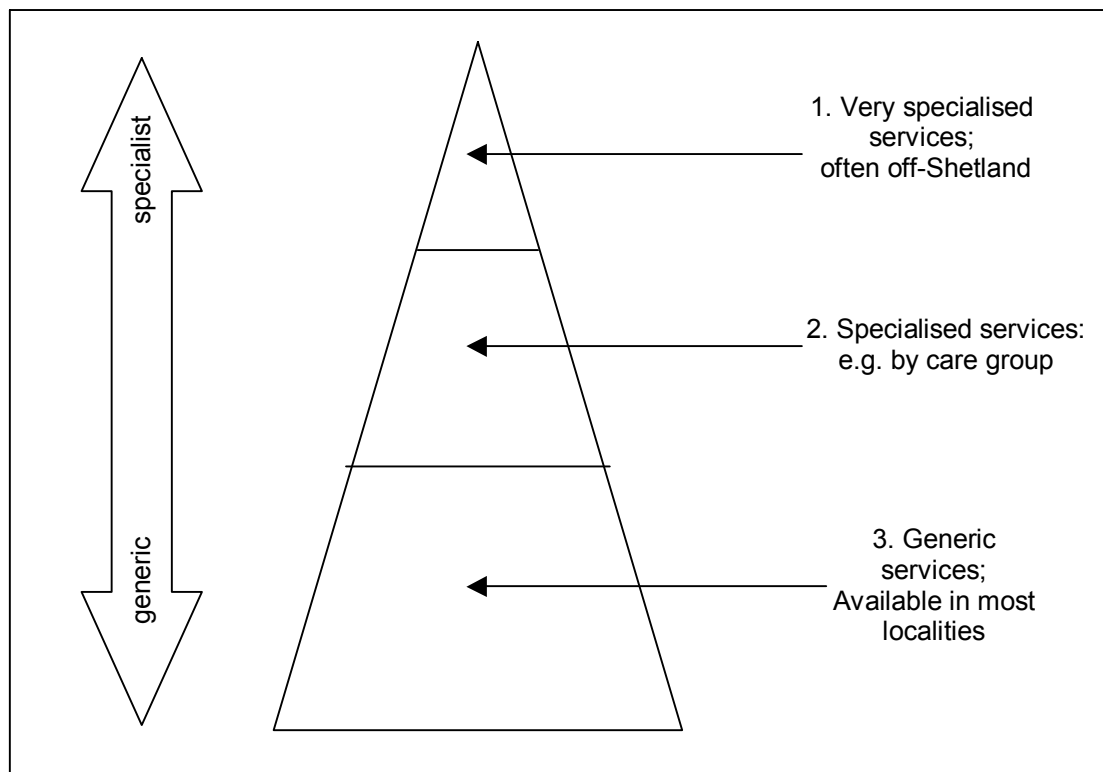
**Complaints Procedures** – we will have a shared understanding and joint framework for handling complaints, which ensures co-ordination of the investigation and response.

**Delegated Decision Making** – decisions on service delivery will be agreed jointly between organisations, within an agreed service framework; the allocation of resources, within approved budgets, will be made to front line operational staff as far as possible – so securing a shorter route to services.

**Streamlined Management Arrangements** – there will be an individual within Shetland who is publicly recognised as being the manager of each service area.

Figure 1 is a simple model showing the range of services available. The aim is to provide care as close to the generic services end as possible, whilst recognising that people will span across the range of services provided depending on the complexity of care and input that they require to meet their individual assessed needs.

**Figure 1 – Pyramid of Service Provision**



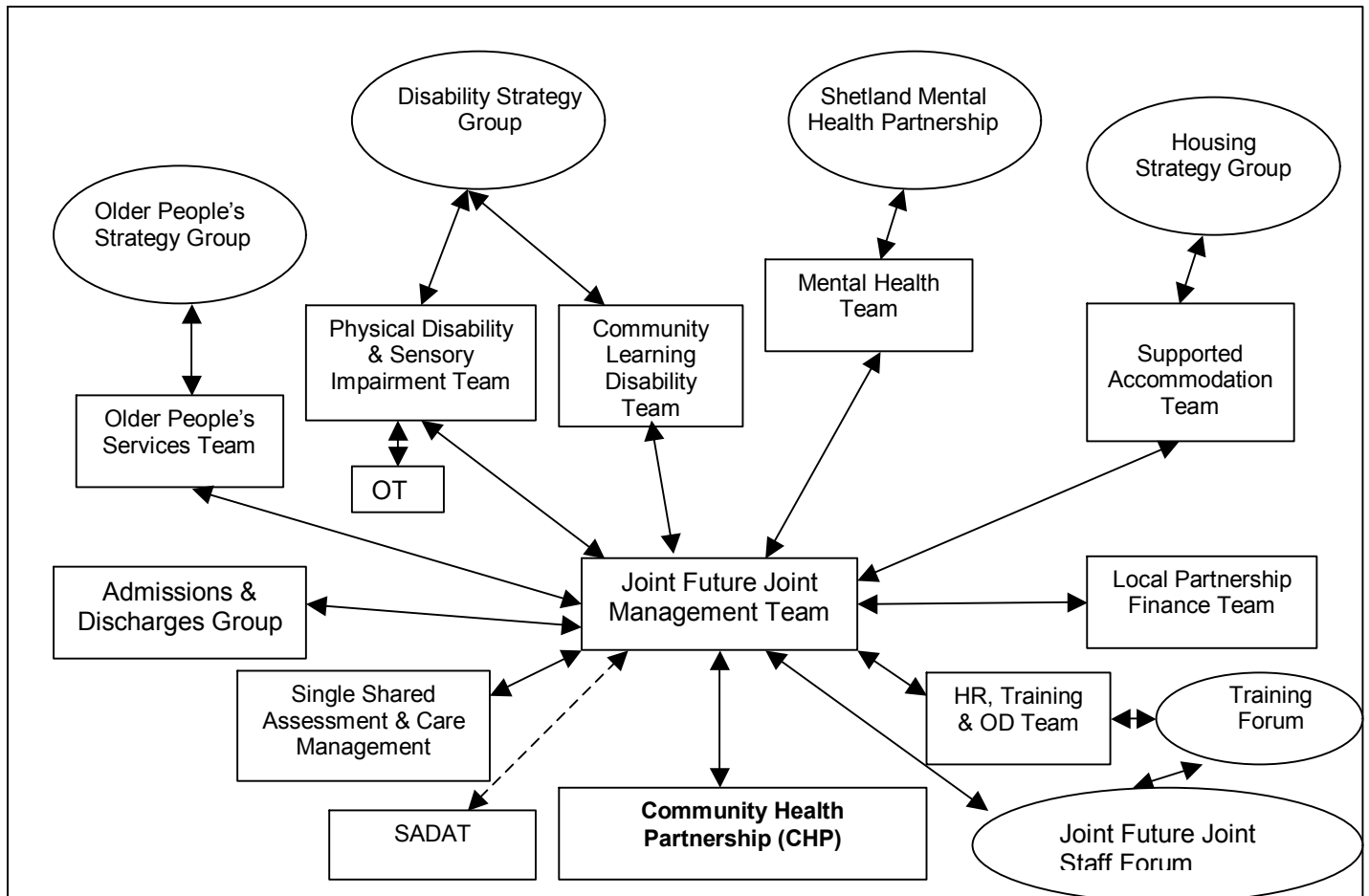
## Section 2:

### Joint Management Arrangements

#### Joint Future Management Framework and the Community Health Partnership (CHP)

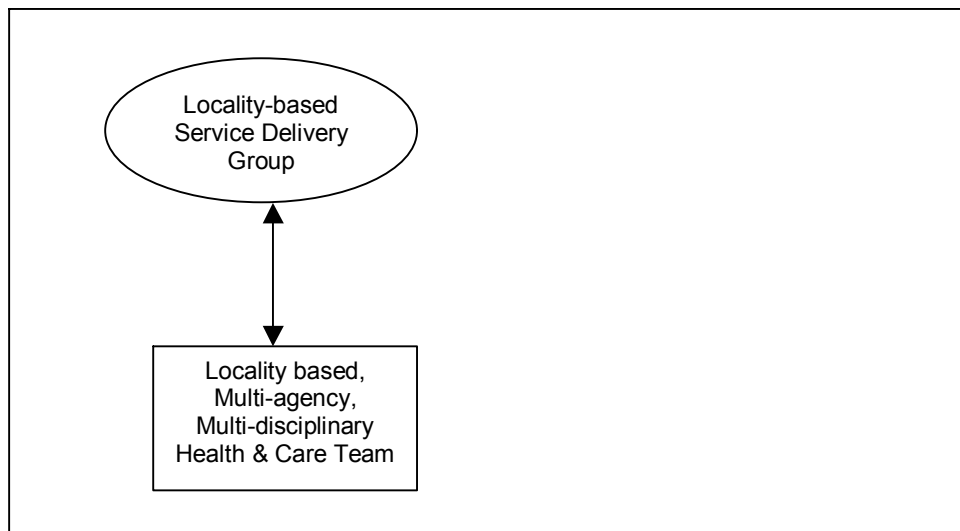
1.1 The Joint Future management model outlined in Figure 2 shows the organisational structure for all Joint Future services in Shetland. Each strategy group links with one or more multi-agency, multi-disciplinary operational management team. The strategies they produce inform and drive the work of the management teams. Each management team has a team leader who sits on the Joint Future Joint Management Team chaired by the Head of Community Care. The Head of Community Care is jointly appointed by the Council and Shetland NHS Board and is the lead officer for Joint Future locally. The post holder is responsible for the planning, provision and quality of all community care services provided or commissioned by the Council and Shetland NHS Board.

**Figure 2 – Joint Future Management Model**



- 1.2 The joint management teams each have an action plan derived from the strategy for their locality or specialist service area/care group. The action plans are consistent with Joint Future/Community Health Partnership aims and objectives.
- 1.3 Each management team is free to act within broad guidelines and delegated pooled/aligned budgets.
- 1.4 The team leader is responsible for ensuring that performance and expenditure is monitored and reported regularly to the Joint Future Joint Management Team.
- 1.5 The teams provide the support structure for frontline practitioners/professionals who are able to act independently to meet needs in their locality or field of expertise.
- 1.6 The Joint Future Joint Management Team takes the lead on overarching pieces of work e.g. independent advocacy, services for carers. Plans for 2007/08 include separate steering groups for each of these areas.

**Figure 3 – Locality Arrangements**



- 1.7 Figure 3 outlines the organisational arrangements for the range of generic services delivered in localities across Shetland. Shetland's Community Planning partners have agreed on seven localities. These are:
- North Isles
  - Whalsay & Skerries
  - North Mainland
  - West
  - Central
  - Lerwick & Bressay
  - South
- 1.8 Each locality-based Service Delivery Group will include a wide range of service users, representatives of the local community council and the councillor for the area. The operational management team will bring together professionals from agencies operating in each locality. The detailed model at this level is outlined in Figure 12 on page 31 of the Scheme of Establishment of the CHP.
- 1.9 The CHP will assume overall responsibility for implementing the Joint Future Agenda locally on behalf of Shetland NHS Board. The CHP will work with the Council to set, monitor and review Local Improvement Targets.
- 1.10 The terms of reference for the Joint Future Joint Management Team is included below. The terms of reference for all the other groups constituted within the Joint Future management model in Figure 2 are included in the appropriate care group or other section of the ELPA.

Shetland Alcohol and Drugs Action Team (SADAT) is constituted separately following national guidelines for DATS.

## Shetland's Joint Future

### Joint Future Joint Management Team (JFJMT) Terms of Reference

#### Purpose

The Joint Future Joint Management Team is responsible for the management of all Joint Future Services in Shetland.

The Joint Future Agenda is designed to:

- Facilitate better outcomes for people who use services and for their carers
- Ensure better use of resources with decisions on their deployment which are transparent and according to shared priorities
- Create better management of services and where appropriate under single managers; and
- Develop better systems with less bureaucracy and duplication and clearer responsibilities.

This will be done to produce the best fit to suit local circumstances within Shetland.

#### Membership

The Group is made up of:

Chairperson, Head of Community Care SIC/NHS  
Chairs of Joint Future Service Management Teams

A range of NHS Shetland and SIC personnel are seconded to the Group or in attendance as and when necessary for the attainment of the Team's objectives.

#### Role

- To provide joint Local Authority/NHS Board strategic direction, leadership and management of the Joint Future Agenda in Shetland
- To monitor and review the infrastructures for both joint resourcing, service management and Single Shared Assessment (SSA).
- To act as a single management board, to oversee the work programme for the implementation of the Joint Future Agenda, including management and budgeting arrangements.

## Shetland's Joint Future

### Remit

To ensure continuing progress in all the relevant service areas, against the relevant policies and guidance, towards:

- joint management of service (including the potential for single managers of service where appropriate);
- joint resourcing of services (including aligned or pooled budgets);
- joint training and organisational development.

The Team will develop and maintain a communication strategy which will include user involvement, and will be incorporated into the SIC and NHS Shetland's individual organisation's communications strategies.

The Team will monitor progress on all Joint Future service developments and be responsible for initiating and progressing overarching developments e.g. independent advocacy services.

The Team will at all times seek to maximize the use of all community resources within Shetland, including the voluntary sector, in drawing up innovative solutions to suit local circumstances.

### Accountability

The Team will report regularly to the Community Health Partnership, and will report progress to the individual organisations via the appropriate channels within NHS Shetland and the SIC every six months.

The Team will be responsible for developing and maintaining the Extended Local Partnership Agreement (ELPA).

The Team will be responsible for ensuring that all necessary progress reports are made to the Scottish Executive as and when required. This will include reports on:-

- Joint Performance Information and Assessment Framework (JPIAF);
- Local Improvement Targets (LITS) for Joint Future; and
- Delayed Discharge Action Plans.

## Section 3:

### Joint Resourcing

#### Financial Framework

##### 1. Aligned Budgets

NHS Shetland and Shetland Islands Council are committed to aligning budgets for all Joint Future services. Details of Joint Future service budgets are included in the Local Partnership Agreement and monitored by the Local Partnership Finance Team (LPFT).

The Financial Regulations and Standing Orders of each partner agency will apply to the individual budgets. Copies of these documents are available separately.

##### 2. Budget Setting

The partner agencies annual planning cycles are shown in the diagram attached at paragraph 12 below.

This process includes the preparation of medium and long term service projections. Budget estimates will be prepared as an integral part of the process by each partner agency and discussed by the LPFT who will report details to the Joint Future Joint Management Team (JFJMT) with any recommendations.

JFJMT will in turn advise the partner agencies and the Community Health Partnership (CHP) as appropriate.

##### 3. Devolved Budgets

Budgets for all community care services are devolved to team/unit level. There are currently no ceilings on the value of individual care packages

##### Care at Home Services

Indicative budgets are set for each locality at the start of the year. The Service Manager Community Care Resources who has overall responsibility for the delivery of Care at Home Services maintains an overview. The Service Manager will assist the Service Manager Community Care

## Shetland's Joint Future

Fieldwork in ensuring equitable service provision across Shetland and advise on areas of under/overspend. Any virements affecting locality budgets would be agreed with the relevant BROs and reported to the JFJMT via the Local Partnership Finance Team.

### **Aids and Adaptations**

Specialist equipment over £500 and adaptations to property require the countersignature of the Senior OT Community or a Service Manager.

#### **4. Budget Monitoring**

Budget responsible officers (BROs) in each partner agency will work with the members of the LPFT to ensure up to date financial information is available on all Joint Future services.

Budget monitoring reports will be prepared quarterly by the LPFT for the Joint Future Joint Management Team. The reports will include background information where there are any material budgetary variances, over or underspends and details of any corrective action taken or recommended.

#### **5. Changes to Joint Future Budgets**

Once budgets have been set, any changes proposed to Joint Future budgets will be discussed and agreed by JFJMT before being actioned by either partner agency in accordance with the appropriate Financial Regulations and Standing Orders. The LPFT will provide support for BROs and JFJMT in this process.

Any over/underspend will be addressed initially by the partner agency whose budget is directly affected.

Virements will be processed in accordance with each agency's Financial Regulations as appropriate and JFJMT notified via the LPFT.

#### **6. Specific Funding**

The LPFT will share information regarding specific and / or additional allocations of funding, for example from the Scottish Executive and provide information to JFJMT and to BROs in the partner agencies as appropriate.

The JFJMT has delegated authority from the partner agencies to agree the detailed allocation of specific funding for the implementation of Joint Future Services locally.

**7. Capital Expenditure**

Details of each partner agency's capital programme will be made available to the LPFT and JFJMT in so far as this relates to the Joint Future Agenda locally.

**8. Joint Commissioning Arrangements**

Any formal commissioning arrangements are progressed by either agency following that agency's standing orders and financial regulations and underpinned by a specific financial agreement that effectively pools the aligned budgets.

For example, independent advocacy services have been commissioned through a formal tender process led by the Council's Social Care Service. The detailed financial arrangements between the Council and NHS were agreed prior to the contract being let. Under this arrangement, the contract has been formally agreed between the Council and the successful contractor and the NHS funding is paid across to the Council to support the commissioning arrangement from a pooled budget. The contract terms include financial monitoring arrangements reported via LPFT.

Similarly, NHS capital funding for the joint development of specific capital projects has been paid to the Council and the projects have been taken forward as part of the Council's capital programme, e.g. the additional support needs base linked to Anderson High School in Lerwick and more recently a respite care facility for adults with learning disabilities which opened in January 2007.

**9. Local Partnership Finance Team (LPFT)**

The Terms of Reference for the LPFT is included in Section 2 of the ELPA.

**10. Risk Assessment Framework**

A Risk Assessment Framework has been agreed by the LPFT and is included below.

## Current Risks and Actions for Local Partnership Finance Team

Risks	Actions
<b>Governance and Management</b>	
The LPFT lacks direction, strategy and forward planning	A Strategic and Financial Plan for the future needs to be developed.
Conflicts of interest – between role of NHS and Council	Determine joint priorities.
Organisational structures – two bodies, one set up by democracy the other a SE function. One has more control over financial resources than the other.	Manage as far as possible effects of external decisions.
Reporting to NHS and SIC - accuracy, timeliness and relevance	A system of monitoring reports is now in place.
<b>Operational Risk</b>	
Contract risk – unclear relationships between NHS, SIC and other external organisations funded by NHS and SIC.	There is a need to develop Service Level Agreements.
Client satisfaction – unrealistic expectations, unmet need, bad publicity.	
Risk that Finance drives the service rather than the service priorities.	There should be a proper plan in place for services, which is then tailored to meet finance available.
Government / External Funding – reduced funding, ring fenced funding, too much reliance on SIC to “pick up the tab”.	This should be addressed through future Financial Plans.
One-off initiative funding raises expectations when often there is no follow up funding.	Exit strategies would give clarity and expectations would be more realistic.
Unable to demonstrate effectiveness of additional funds on Services.	Joint Performance Management System

## Shetland's Joint Future

<b>Financial Risks</b>	
Budgetary control and financial reporting – adequacy and frequency of reports	Regular management accounts are now presented to the SIC and NHS (Inequality of information available between organisations needs to be addressed).
<p>Unaffordable level of commitments</p> <p>NHS has no reserves available to balance.</p> <p>Plans are ambitious and exceed resources available. Need to take care to ensure plans and funds match.</p> <p>Savings plans never achieve outcomes and destabilise services.</p>	<p>This is being addressed through the Budget Strategies for both SIC and NHS.</p> <p>The NHS is pursuing savings and efficiencies to deliver an overall balanced budget</p> <p>Match Service and Finance plans. Do joint plans involving Finance in both agencies.</p> <p>Make realistic plans that are achievable by reducing expectations.</p>
Inappropriate or expensive activities	This is being addressed through the work of the Joint Future strategy groups and Council and Shetland NHS Board corporate financial strategies.
<b>Environmental / External factors</b>	
Adverse publicity – budget strategy may lead to service reductions	This needs to be actively managed as we work through the implications of the Budget Strategies for SIC and NHS.
Demographic consideration – increased demand for certain services e.g. older population growing	This will need to be built into future projections when the Budget Strategies are updated each year for SIC and NHS.
<b>Compliance Risk (law and regulation)</b>	
Compliance with legislation and regulations	Continual monitoring of activities to ensure compliance of legislation and regulations.

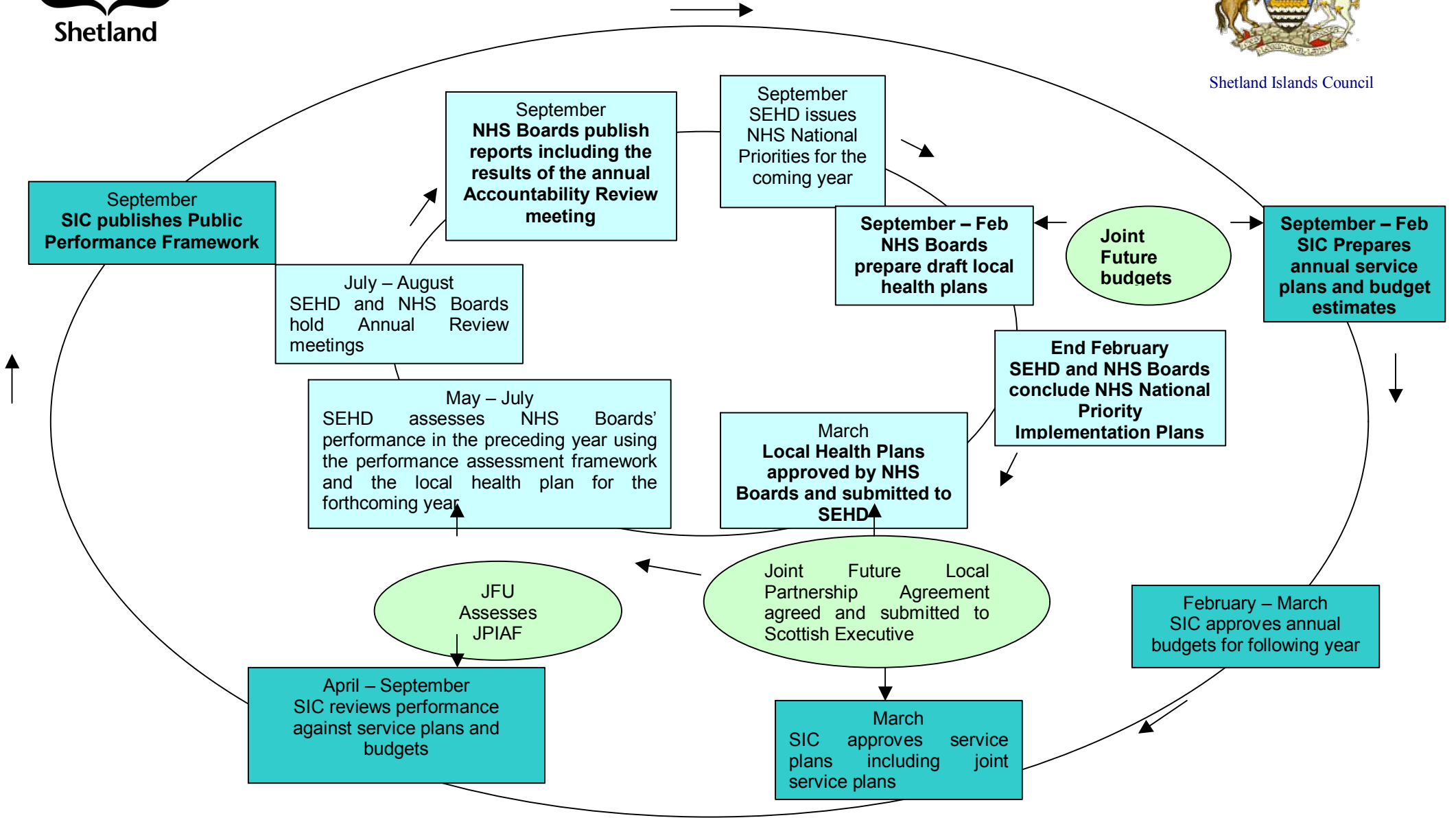
11. **Dispute Resolution**

Any failure to agree by LPFT will be reported to the JFJMT.

12. **Planning Cycle Diagram**



# Health and Community Care Planning Cycle



## Capital Projects

13.		07/08 £000s	08/09 £000s	09/10 £000s
	Eric Gray Resource Centre - feasibility study - new build	£35	£2,000*	£1,500*
	Viewforth - feasibility study - new build	£90	£3,000*	£1,500*
	Isleshavn - feasibility study - new build		£2,000*	£1,500*
	Joint OT Store	£1,000*	£1,500*	

All figures marked \* are indicative at this stage and subject to confirmation at a later date.

All the projects identified above are being taken forward through the Council's Capital Programme. They will be subject to the Capital Programme Review Process. This means that once each feasibility study is complete, the project will be scored and ranked alongside other projects in the capital programme. The principles and weighting used are included below.

*Principles:*

- Objective measures applied to all projects to determine a priority;
- Simplification of the process;
- Full involvement of Council Members in determining the weighting criteria;
- Opportunities within the process for political input at a local and Shetland level;
- Clear guidelines for Council Officers to recommend the programming of capital projects in accordance with the Council's priorities;
- Some certainty of outcome to manage aspirations;
- Transparency and so, an improved and wider understanding of how a particular project was prioritised.

*Weightings:*

- Statutory need / legal risk
- A clear service need, in the short/medium/long term

- Option appraisal
- Work necessary to maintain current services or assets
- A clear link to the corporate plan
- Number of people that will benefit or be served by the project
- Positive financial impact / cost benefit analysis
- Value taking into account the whole life cycle cost
- Community support at a local, Shetland or national level

	Total 2007/08 Budget £'000's	2007/08 Budget £'000s	
		SIC	NHS Shetland
<b>Older People</b>	-	-	-
<u>Care Services at Home:</u> *	-	-	-
· Personal Care Service	2,150	2,150	0
· Domestic Tasks	983	983	0
· Community Nursing	2,179	0	2,179
<u>Residential Care:</u>	-	-	-
· Local Placements ^	7,206	6,357	849
· Mainland Placements	153	153	0
Day Care ^	1,046	1,006	40
Interim Placement Unit (IPU)	213	0	213
Long Stay Hospital	793	0	793
* Includes Scottish Executive free personal care development funding and MHSG funding for care for people with dementia.			
^ Resource transfer funding from NHS Shetland.			
<b>Totals</b>	<b>14,723</b>	<b>10,649</b>	<b>4,074</b>

	Total 2007/08 Budget £'000's	2007/08 Budget £'000s	
		SIC	NHS Shetland
<b>Mental Health*</b>			
<u>Community Mental Health Team:</u>	-	-	-
· Community Mental Health Nursing	234	0	234
· Specialist Social Worker	42	42	0
· Community Support Service	524	524	0
<u>Joint Local Implementation Plan (JLIP)</u>	134	0	134
· Specialist Advocacy for PWMH Problems	12	7	5
· Self Advocacy for PWLD	9	9	0
· Dedicated MHO posts	41	41	0
<u>Shetland Link Up</u> (SCT grant funding)	47	47	0
* Includes MHSG funding for community mental health services and Mental Health (Care & Treatment) (Scotland) Act 2003 funding.			
<b>Totals</b>	<b>1,041</b>	<b>668</b>	<b>373</b>
<b>Occupational Therapy</b>			
· Joint OT Service	363	163	200
<b>Totals</b>	<b>363</b>	<b>163</b>	<b>200</b>

	Total 2007/08 Budget £'000's	2007/08 Budget £'000s	
		SIC	NHS Shetland
<b>Aids &amp; Adaptations</b>			
Including SCT grant funding			
· Specialist Aids	354	354	0
· Independence at Home Scheme / Adaptations	703	703	0
· Housing Adaptations	126	126	0
· Community Alarm	101	101	0
· Staffing	127	127	0
<b>Totals</b>	<b>1,411</b>	<b>1,411</b>	<b>0</b>
<b>Learning Disabilities (Adult Services)</b>			
· Respite Provision	627	627	0
· Supported Accommodation ^	1,871	1,740	132
· Learning Disabilities Nurse	35	0	35
· Outreach	8	8	0
· Day Care	854	854	0
· Local Area Co-ordinator	36	36	0
^Resource transfer funding from NHS Shetland.			
<b>Totals</b>	<b>3,430</b>	<b>3,264</b>	<b>167</b>

## Shetland's Joint Future

Shetland Islands Council

	Total 2007/08 Budget £'000's	2007/08 Budget £'000s	
		SIC	NHS Shetland
<b>Advocacy Services</b>			
· Generic Advocacy	32	24	8
· Carers*	15	15	0
· Self Advocacy for People with Learning Disabilities ^	9	9	0
· Specialist Advocacy for People with Mental Health problems ^	25	7	19
· Advocacy and Homelessness	15	15	0
* Includes Carers Strategy funding			
^ LA funding met by JLIP listed above under Mental Health			
<b>Totals</b>	<b>96</b>	<b>69</b>	<b>27</b>
<b>Supported Employment Opportunities</b>			
Including SCT grant funding			
· Moving On Employment *	53	53	0
· COPE *	166	166	0
· Workstep	14	14	0
* Includes Carers Strategy funding			
<b>Totals</b>	<b>232</b>	<b>232</b>	<b>0</b>
<b>Homelessness*</b>	380	380	0
* Includes HRA and General fund			
<b>Totals</b>	<b>380</b>	<b>380</b>	<b>0</b>
<b>Carers*</b>			
· Respite care at home	106	106	0
· Advocacy ^	15	15	0
· Carers Groups	18	0	18
· Training for carers	3	3	0
* Includes Carers' Strategy funding			
^ Also included under Advocacy Services above			
<b>Totals</b>	<b>142</b>	<b>124</b>	<b>18</b>

## Shetland's Joint Future

Shetland Islands Council

	Total 2007/08 Budget £'000's	2007/08 Budget £'000s	
		SIC	NHS Shetland
<b>Physical Disabilities</b>			
<u>Supported Accommodation:</u>			
· Care Services ^	328	215	113
· Outreach	49	49	0
· Physio	400	0	400
^Resource transfer funding from NHS Shetland.			
<b>Totals</b>	<b>776</b>	<b>263</b>	<b>513</b>
<b>Sensory Impairment</b>			
· Audiology Service	73	0	73
· Specialist Equipment	7	7	0
· Speech and Language Therapy	40	0	40
<b>Totals</b>	<b>120</b>	<b>7</b>	<b>113</b>
<b>Children &amp; Young People with Disabilities</b>			
· Respite care services	449	449	0
· Shared Care	10	10	0
· Speech and Language Therapy	130	110	20
· Friends of Special Needs Playschemes	52	52	0
<b>Totals</b>	<b>640</b>	<b>620</b>	<b>20</b>

	Total 2007/08 Budget £'000's	2007/08 Budget £'000s	
		SIC	NHS Shetland
<b>Substance Misuse</b>			
Including SCT grant funding			
· Rehabilitation placements	52	52	0
· Specialist Social Worker	40	40	0
· Family Support Worker	30	30	0
· Shetland Community Drugs Team	196	111	85
· Shetland Alcohol Trust	150	150	0
· Health Service Provision	111	0	111
<b>Totals</b>	<b>578</b>	<b>382</b>	<b>196</b>
<b>Supporting People</b>			
<u>Supported Accommodation and Very Sheltered Housing Supports</u>	-	-	-
· Physical Disabilities Supported Accommodation (included in Physical Disabilities section above) ^	342	229	113
· Learning Disabilities Supported Accommodation (included in Learning Disabilities section above) ^	1,871	1,740	132
· Mental Health Supported Accommodation (included in Mental Health section above)	155	155	0
· Older People Very Sheltered Accommodation	123	123	0
^ Resource transfer funding from NHS Shetland			
<b>Totals</b>	<b>2,491</b>	<b>2,247</b>	<b>245</b>

- NHS BUDGET FIGURES ARE FROM 06/07, 07/08 STILL TO BE ADVISED  
 - NHS RESOURCE TRANSFER FUNDING CURRENTLY INFLATED AT 2.5% ACTUAL

**Section 4:**

**Joint Development Priorities and Targets**

All community care service developments will be progressed within the framework of this agreement.

All Shetland's Joint Future projects must:

- be planned in partnership with the public;
- demonstrate beneficial outcomes for the people in receipt of services;
- be evidence based;
- demonstrate health gain;
- have clear costed, timescaled action plans for change management;
- demonstrate value for money.

**Progress on Major Service Developments in 2006/07**

**1. Dementia Redesign Project**

Work to scope options for change is substantially complete. A dedicated Dementia Project Manager employed on a fixed term contract by NHS Shetland has taken the work forward working closely with a steering group comprising staff from agencies involved in dementia care services and family carers. The views of a wide range of stakeholders have been sought using a variety of techniques e.g. focus groups and workshops. More recently, a consultation paper has been circulated to the public. The final report of the Redesign Project will be considered by the Council and Shetland NHS Board in the autumn of 2007, together with the preliminary findings of the Long Term Care Review. Formal consultation on proposals for any new models of service provision will be required depending on the outcome.

**2. Long Term Care Review**

Funding has been secured through the Council's Capital Programme for a combined feasibility study to look at replacement facilities for Viewforth House, the specialist dementia unit in Lerwick and Isleshaven, the care centre in Yell. This will draw on the work of the Dementia Redesign Project and the Long Term Care Planning Conference held in February 2007. Work has started with project meetings taking place at Isleshavn in Yell involving a wide range of stakeholders. A report will be produced in the autumn of 2007.

### 3. **Interim Placement Unit**

The IPU was opened in January 2005 providing 10 places for patients waiting for discharge. During the first 6 months of 2006/07, there were on average 16 patients in hospital who were ready for discharge and the number of places in the IPU has been increased to 16. Shetland NHS Board has agreed in principle a Hospital Capital Plan whereby all clinical services would be located on the Gilbert Bain Hospital site. This would see all services move from Montfield, subject to public consultation. During staff consultation sessions there was a number of questions asked about future population demographics and about how services would be provided across health and social care to meet the expected demands on services. These issues will be explored through the long-term care review. Shetland NHS Board propose to maintain and fund the IPU until 2013 to allow time for redesigned services to be put in place. This proposal is dependent on agreement of the plans for the move from Montfield with the loss of one hospital bed and discussions on the future provision of services for younger adults with physical disabilities. It is anticipated that there will be two formal public consultation exercises on the plans for hospital services in the future, the first in 2007 and the second in 2009.

### 4. **New Services for Adults with Learning Disabilities**

Newcraigielea, the new respite facility for adults with learning disabilities built on the Kantersted site opened in January 2007. Additional supported accommodation for adults with learning disabilities has been opened at Ruddy Park and Sea View, providing up to 12 new tenancies.

### 5. **Local Area Co-ordinator**

The Local Area Co-ordinator for learning disabilities has developed this role further during the last 12 months. The post holder works closely with a number of cases where clients are moving into adult services from children's services.

### 6. **Assessment and Care Management**

Shetland's Single Shared Assessment (SSA) procedures have been redrafted and will be re-issued in 2007. A new training programme for SSA and care management has been developed and the course has been delivered twice so far, the first in January 2007 and again at the end of April 2007. Staff from across both the Council and NHS Shetland attended. Further courses are planned for 2007/08.

## Shetland's Joint Future

7. **Day Care**

Revised day care criteria have been approved and the service is being used increasingly as part of intensive care packages supporting people in their own homes for longer than would otherwise be possible as the profile of the population changes.
8. **Joint OT Store**

A feasibility study looking at options for a Joint OT Store and office accommodation has been completed. A proposal for this to be developed as a new build on the Brevik House site has been accepted in principle by both Shetland NHS Board and the Council. Work is on-going with a view to start on site in 2008.
9. **Community Health Partnership and Locality Working**

Local Service Delivery Groups (LSDGs) are in the process of being established in 7 localities across Shetland. A small steering group has been set up comprising staff from across the Council and NHS Shetland. Shetland Council of Social Services is also represented on the Group. The CHP is committed to engaging with the public via the Public Participation Forum (PPF). This is set out in the Scheme of Establishment. In Shetland work to set up the PPF is being taken forward through the LSDGs who will link with existing groups in their localities.
10. **Carers**

Implementation of the Carers Strategy and Carer Information Strategy has been taken forward by the Primary Care Facilitator in the Community Health Partnership, who has worked closely with colleagues across the NHS, the Council and the voluntary sector. Shetland Council of Social Services has established a Carers Support Group in Lerwick and work to set up other groups is in hand. Events were organised across Shetland in Carers Week in June 2006 and on National Carers' Rights Day in December 2006. The Carer Information Strategy was revised and re-issued in October 2006. A Young Carers Strategy has been drafted and will be published in 2007/08.
11. **Mental Health Services**

Vacant MHO posts in the Community Care fieldwork team have been filled. MHO training is being offered and supported locally. There is an MHO designated first contact as part of the Social Care 24/7 emergency duty rota. MHOs meet quarterly with MHOs working in Orkney to discuss issues involved with working in remote island communities. MHOs are also working more closely with staff in Cornhill Hospital to improve outcomes for Shetland patients.

## Shetland's Joint Future

### 12. Local Improvement Targets (LITs)

Performance against the LITs in 2006/07 shows:-

- Single Shared Assessment (SSA) – There has been some improvement in recording data on SWIFT. Performance against targets for the time taken to complete assessments has improved over the last 6 months, although there are still long delays for OT assessments, which adversely affects overall performance in this area..
- Occupational Therapy (OT) – The target to reduce the waiting list is not being met. Numbers increased in the last quarter of 2006/07 having fallen in the earlier part of the year. The demand for Community OT Services remains high.
- Care at Home – The target for increasing the number of people receiving more than 10 hours per week has been met. A report by the Chartered Society of Physiotherapy published in February 2007 shows that more older people are supported at home in Shetland than in any other Scottish local authority area. 142 out of every 1,000 people aged 65 or over are supported at home. The second highest is Orkney with 114 out of every 1,000. However, there are difficulties in recruiting staff in sufficient numbers to meet the needs of increasing numbers of older people and people with disabilities so that they can remain in or return safely to their own home. This is causing delays in discharge from hospital in some cases. Some packages are being reduced on review in order to meet higher priority needs of other clients.

### Areas where progress has been disappointing

1. Some of the joint management teams in the Joint Management Framework have not met regularly during 2006/07 due to staff vacancies and absence on long term sick leave.
2. There has been no progress with development of additional capacity in the community to meet increasing levels of need, due to resource constraints, both financial and human.
3. Work on a revised policy and procedures for the protection of Vulnerable Adults is still at an early stage.

## Shetland's Joint Future

### Priorities for 2007/08

1. To complete the long term care review and feasibility study into replacement facilities for Viewforth and Isleshavn;
2. To look at options for assistive technology (Telecare) in the context of long term care solutions;
3. To promote the LSDGs and the Public Participation Forum Network across Shetland with a view to having on-going dialogue with the community on health and care issues;
4. To produce a revised Advocacy Development Plan;
5. To complete work on a Mental Health Strategy for Shetland looking at the next 10 - 15 years;
6. To take forward proposals for a joint OT store and office accommodation at the Brevik House site;
7. To implement the learning disabilities day services redesign;
8. To publish the CHP Access Guide;
9. To aim for continuing improvement against local targets for completion of assessments and reviews;
10. To continue work on electronic data sharing across partner agencies;
11. To develop and articulate a joint Respite Strategy; and
12. To review health and care services for younger adults with physical disabilities, in particular options for independent living.

### Section 5

#### Joint Future Plans 2007– 2010

Shetland's Joint Community Care Plans for 2007-2010 have been incorporated into the Joint Future Plans in this section.

There is a sub section for each of the main care groups. These bring together the key aims and objectives for the care group; information on needs and needs assessment; any gaps in service provision; planned actions and progress on service developments over the last 12 months.

The reporting mechanism for the relevant strand within the joint management arrangements is included at the end of each sub-section. The sub-sections are designed to stand alone and are available separately as a series of leaflets.

The Discharge Action Plan is included in its entirety in the sub-section on older people although some of the planned actions refer to other care groups and are also included there.

The care group sections are listed below:

- Carers
- Learning Disabilities
- Mental Health
- Sensory Impairment
- Physical Disabilities
- Palliative Care
- Older People
- Dementia
- HIV and AIDS
- Head Injury

There is a separate section on Independent Advocacy Services.

Plans for children with disabilities are covered in the Integrated Children's Services Plan; for Housing and Homelessness in the Local Housing Strategy and Homelessness Strategy; and for substance misuse in the Shetland Alcohol and Drugs Action Team (SADAT) Corporate Action Plans.

Health Care plans and targets are set out in the Local Delivery Plan for NHS Shetland.

# Carers

“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 (assisting) 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.”<sup>1</sup>

There are approximately 660,000 unpaid carers in Scotland.<sup>2</sup>

Local research shows that by 2020 we can expect to see a 3-fold increase in the number of people with disabilities who will need health and social care services. Population projections for the next 15 years predict an increase in the numbers of older people of approximately 40% and simultaneously a 15% decrease in the adult working population.

Consequently the need for unpaid and family carers is going to grow and carers are key partners in care provision alongside the statutory agencies and organisations in the voluntary and independent sector.

<sup>1</sup> Introduction of NHS Carer Information Strategies Draft Guidance – August 2004  
<sup>2</sup> 2001 Census

## Carers’ Rights include:

- the right to a carer’s assessment and equal rights for young carers (carers aged under 16)
- the right for carers to be informed by local authorities and the NHS of their entitlement to an assessment
- the right for carers to have their views and their contribution to the care provided taken into account in decisions made about the services to be provided for the cared-for person<sup>3</sup>.

## Aims

- To support carers 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.
- To meet the specific needs of young carers (aged under 16); of older carers and of carers from black and minority ethnic groups in ways appropriate to their circumstances.
- To identify carers at an early stage and provide them with the information and advice they need.
- To promote independence and self-managed care programmes.

## Carers’ Assessment

Assessments for carers are an integral part of Shetland’s Single Shared Assessment process<sup>4</sup> and

<sup>3</sup> Carers: Community Care & Health (Scotland) Act 2002 Guidance on Sections 8-12: Scottish Executive Circular CCD2/2003

<sup>4</sup> Shetland’s Joint Future Single Shared Assessment Joint Procedure for

are available to anyone who provides “a substantial amount of care on a regular basis”.<sup>4 & 5</sup> In interpreting the term “regular and substantial,” consideration is given to each carer’s individual circumstances including their age; the carer’s own health and well-being; the potential impact on other family members; the caring tasks and amount of time and effort required; the carer’s other responsibilities and any employment.

The assessment will establish the carer’s ability to provide or continue to provide care for another person.

### Eligibility Criteria

A support package/access to resources will be offered where: -

- the caring role is unsustainable without additional support/resources;
- the carer is unwilling or unable to provide care at the level required to meet the cared-for person’s needs;
- the current pattern of caring is having an adverse effect on the social, leisure and educational opportunities of a young carer; or
- the cared-for person or their carer is at risk of harm, abuse or neglect.

### Services Available

Services specifically designed to meet the needs of carers include:-

- advice and information

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Community Care Referral, Assessment and Review

<sup>5</sup> Community Care & Health (Scotland) Act 2002

- training opportunities
- independent advocacy
- peer support
  - A carers group is facilitated by staff at Annsbrae House to support carers of people with mental health problems.
  - Shetland Council of Social Services facilitates a Carers Support Group in Lerwick. Additional funding has been obtained from the Queen’s Nursing Institute Scotland, to establish carer support groups in the West and North areas of Shetland.
- short breaks
  - residential short breaks for older people (20 places)
  - residential short breaks for older people with dementia (4 places)
  - day care for older people (76 places)
  - day care for older people with dementia (10 places)
  - day care for adults with learning disabilities (35 places)
  - residential short breaks for adults with learning disabilities (9 places)
  - residential / day care for children and young people with learning disabilities (6 places)
  - residential short breaks for adults with mental health problems (1 place)
  - hospital based respite care
  - short breaks at home – Crossroads Care Attendant Scheme
  - short breaks in the community for children with disabilities – Hame fae Hame
  - supported employment

Other services provided for vulnerable people in the community also help their carers by providing relief from caring tasks or by increasing the independence of the person for whom they provide care. These include:-

- care services delivered at home – personal care, community nursing, help with domestic tasks, meals on wheels;
- occupational therapy;
- physiotherapy;
- speech and language therapy;
- counselling;
- specialist equipment;
- adaptations to property.

### Funding

#### Funding for 2007/08

Residential respite for older people	1,140,000
Day care for older people	1,046,000
Residential respite for people with learning disabilities	627,000
Day services for people with learning disabilities	854,000
Residential / day care for children with disabilities	501,000
Residential respite for people with mental health problems	17,200
Short breaks at home e.g. Crossroads Care Attendant Scheme	106,000
Supported employment opportunities	232,000
Training for carers (Grants to Carers)	3,000
Local Area Co-ordinator	36,000
Information Services	7,500
Advocacy Scheme for Carers	15,000

Carers Support Groups	18,000
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Budgets include £82,000 Carers Strategy funding from the Scottish Executive. The detailed allocation of this funding stream is shown below.

	Amount (£)
COPE	21,000
Moving On	26,844
Advocacy Shetland	15,000
Local Area Co-ordinator	10,756
Crossroads	5,900
Grants to individuals – travel & training	2,500
<b>Total</b>	<b>82,000</b>

### Unmet Needs / Issues

- There is very little known about young carers in Shetland and their needs.
- There is increasing demand for all existing service provision and this trend is expected to continue for the foreseeable future.
- Lack of affordable transport, particularly in the more remote parts of Shetland limits access to some services.
- There are 144 people on the waiting list for an Occupational Therapy (OT) assessment. Referrals to the community OT service average 70 per week.
- Home-based care in an emergency is generally not available e.g. where the main carer at home becomes ill and cannot provide essential care. Residential short breaks are usually offered in this type of situation.
- There are limited training opportunities for unpaid carers.

- Volunteer services to support vulnerable people to go shopping or undertake other activities in the community would provide respite for carers and improve the quality of life for the cared-for person.

#### **Further Reading**

- Carers' Strategy 1 April 2005
- Carer Information Strategy October 2006
- Shetland's Young Carers' Strategy
- NHS Shetland 2020 Vision of Shetland's Healthcare

**To support carers 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.**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Responsibility/Progress</b>
Review public information with carers in mind	On-going	WER	Director of Service Improvement through PFPI group; Planning and Information Team for Social Care
Increase amount of information available on websites	On-going	WER	Senior Planning and Information Officer, NHS/SIC
Review distribution processes for information on services to ensure up-to-date versions are available in locations across Shetland e.g. GP surgeries, hospital wards, Council offices, websites, voluntary sector organisations and social care settings	Sept. 2006	WER	Senior Planning and Information Officer NHS/SIC
Increase number of carer assessments undertaken.	On-going	WER	Single Shared Assessment (SSA) and Care Management Team
Develop rapid response home based respite services	2005-08		JFJMT
Develop more flexible, responsive home-based respite options	2005-08		JFJMT
Develop wider range of day care options	2005-08		JFJMT
Implement revised day care criteria	2005-08		JFJMT
Increase employment opportunities for people with disabilities and with mental health problems	2005-08		Disability Management Teams; Moving On and COPE continue to provide additional supported employment opportunities
Develop support for people with disabilities and / or mental health problems in further education	2005-08		Disability Management Teams
Develop a Respite Care Strategy	2008	WER	JFJMT

***To meet the specific needs of young carers (aged under 16); of older carers and of carers from black and minority ethnic groups in ways appropriate to their circumstances***

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Responsibility/ Progress</b>
Ensure that issues of inclusion and diversity are covered in carer awareness training for all frontline staff	On-going	WER	NHS and SIC Training Managers
Develop training programmes appropriate to the needs and circumstances of all carers e.g. young carers and carers from black and ethnic minority groups.	Reviewed Annually	WER	NHS and SIC Training Managers
Publicise training plans for carers and include training for staff on carers issues in Joint OD and Training Plans	On-going	WER	NHS and SIC Training Managers
Finalise and Implement Young Carers' Strategy	2007	WER	Integrated Children's Services Planning Group (ICSPG) On target
Investigate options for specialist independent advocacy services for children and young people	TBA		ICSPG
Ensure SSA and care management processes are responsive to the needs of black and minority ethnic groups	On-going	WER	SSA and Care Management Team

***To identify carers at an early stage and provide them with the information and advice they need.***

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Responsibility / Progress</b>
Develop carer friendly employment policies	On-going	WER	NHS and SIC Human Resource Managers
Provide carer awareness training for all frontline staff	On-going	WER	NHS Staff Development Dept and SIC Human Resource Managers
Raise carer awareness in wider community e.g. in Carers' Week June 2007 and Carers Rights Day in Dec 2007	On-going	WER	JFJMT
Promote carers issues via GP surgeries and Primary Care staff <ul style="list-style-type: none"> <li>❑ Include carers issues in training for all staff including receptionists</li> <li>❑ Provide literature for patients and their carers e.g. leaflets, fact sheets</li> <li>❑ Develop health promotion libraries at health centres for patients and their carers</li> <li>❑ Publicise contact details for carers services, information and advice</li> <li>❑ Produce and maintain a register of carers.</li> <li>❑ Liaise with partner agencies locally.</li> <li>❑ Develop the role of community and GP practice nurses in identifying and supporting carers</li> </ul>	On-going	WER	Primary Care Development Manager
Promote carers issues via community pharmacists <ul style="list-style-type: none"> <li>❑ Ensure community pharmacists have a range of up-to-date information available for carers e.g. sign posting</li> <li>❑ Develop community pharmacists role in identifying and supporting carers</li> </ul>	On-going	WER	Primary Care Development Manager
Revise Discharge Protocols to include explicit reference to the identification of carers and their right to an assessment of need	2007-08		Admission and Discharges Group
Revise the Joint Carer Information Strategy in the light of comments from the Scottish Executive	Oct 2007	WER	JFJMT & Primary Care Development Manager

***To promote independence and self-managed care programmes***

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Responsibility</b>
Develop training programmes for carers and include in Joint Training Plans e.g. moving & handling (assisting), benefits advice, stress management, administering medication, challenging behaviour	Review Annually	TBA	NHS and SIC Training Managers
Develop on-line carers' support network and interactive website	2006-08		JFJMT
Promote carer support groups; Establish support groups on West side and in North Mainland	On-going 2007-08	£18k	Primary Care Development Manager; Shetland Council of Social Services
Support Direct Payments Scheme	On-going	£12.5k	JFJMT and Shetland Citizen's Advice Bureau
Promote self-assessments	On-going	WER	Single Shared Assessment (SSA) and Care Management Team

# Learning Disabilities

Learning disability refers to a significant lifelong condition, present at birth or arising in childhood that can lead to problems in understanding information, learning and living independently. The information presented here relates to adults with learning disabilities i.e. people aged 16 and over.

## Policy and legislation

In 2000 the Scottish Executive published 'The Same as You?' a report into services for people with learning disabilities in Scotland. Every statutory provider of services (local authority and NHS) has to report on progress against the recommendations in the document. This is outlined in the Partnership in Practice (PiP) agreement which is published locally.

The following legislation has had an impact on service delivery, locally for people with learning disabilities:

- Adults with Incapacity (Scotland) Act 2000
- Regulation of Care (Scotland) Act 2001
- Mental Health (Care and Treatment) (Scotland) Act 2003

Comprehensive information on the provisions of the legislation is available from the Scottish Executive website [www.scotland.gov.uk](http://www.scotland.gov.uk)

## Statistics

At present there are 107 adults living in Shetland who are known to have learning disabilities. By 2020 this number will increase to approximately 183. On average 7 young people will leave school each year in need of support throughout adulthood on account of their learning disabilities.

## Service Users' Rights include:

The right to dignity, privacy, choice, safety, realising potential, equality and diversity, as stated in the national care standards.

## Aims

Services for adults with learning disabilities aim to provide:

- A person-centred approach to assessment and care planning.
- Services and support which meet assessed needs.
- Diverse services which comply with national care standards and other relevant legislation.

## Needs Assessment

Adults with learning disabilities and/or autistic spectrum disorders have a wide range of needs in relation to accommodation, health, communication, day opportunities, leisure and social activities. In addition many people need assistance with activities of daily living, such as washing and dressing.

A significant number of people will have additional disabilities, for example, sensory impairment or physical disabilities. Some will have age-related problems.

Transition from Children's to Adult Services and then from Adult to Older People's Services is becoming more seamless within Social Care. Work is on-going to improve performance in this area.

Further development of medical and allied health professions input to adults with learning disabilities is required.

There is a recognised need for additional resource to ensure that the role of Community Learning Disability Nurse is available equitably.

Whilst Community Care can provide some advice and support, statutory and independent sector services must work together with families and people with learning disabilities themselves to ensure supportive networks are in place to ensure inclusion in all aspects of daily life.

### **Eligibility Criteria**

Access to most Community Care services is via a Single Shared Assessment (SSA), usually carried out by a Social Worker. For some services additional information is required. This is detailed in each service's leaflet.

To receive services for people with learning disabilities and / or autistic spectrum disorders, a person must normally have learning disabilities and/or an autistic spectrum disorder.

If no formal diagnosis has been made, information about the person's abilities will be gathered during the Single Shared Assessment (SSA) in order to make a judgement as to whether the person will benefit from these services.

### **Services Available**

#### **Assessment and care management**

Requests for Single Shared Assessments (SSAs) should be made to the Community Care Fieldwork Team.

If the SSA indicates that on-going care management and support is required this is the responsibility of the Community Care Fieldwork Team, subject to prioritisation criteria.

#### **Day opportunities**

The main provision is based at Eric Gray Resource Centre (EGRC) where a range of educational, leisure and social activities are on offer, with some pre-work opportunities in association with COPE, a local award winning social enterprise firm. EGRC can offer certificated courses to its service users as part of the Awards Scheme Development and Accreditation Network (ASDAN). EGRC is registered and inspected by the Care Commission against national care standards for support services.

The demand for day opportunities has outstripped the provision available and the building is no longer fit for purpose, so a feasibility study is underway to

replace and extend the services available.

The short break facility at Newcraigielea is also registered to provide day care to a small number of people.

#### **Supported accommodation**

Adults with learning disabilities who move away from home usually become tenants of supported accommodation provided by the Independent Living Project (ILP) ,Stocketgaet or Sea View. All of these services are registered and inspected by the Care Commission against the national care standards for support services - care @ home and housing support.

The demand for supported accommodation is such that an additional 13 tenancies have been created within 2006/7. More are planned for early in 2009.

#### **Short break (respite) accommodation**

A purpose-built 9 bedded short break service was opened at Newcraigielea in January 2007. This service replaced and expanded the previous short break accommodation. The new service is registered and inspected by the Care Commission against the national care standards for care homes for adults with learning disabilities.

#### **Outreach services**

A few support packages are managed by learning disabilities services in line with national care standards for support services - care@ home and housing support. The number is expected to increase.

#### **Community learning disability nursing**

The learning disability nursing service is a single-handed post providing a service to children and adults who have specific needs. The service operates an open referral system and can be accessed by individuals, parents, carers, professionals or voluntary groups. The service is usually provided through home visits and is available throughout Shetland.

#### **Local area coordination**

There is a Local Area Coordinator post, as recommended by the Scottish Executive's report 'Same as You?' This post has been developed to assist people with learning disabilities and their families to access services.

#### **Specialist psychiatry and clinical psychology**

A visiting Consultant Psychiatrist and a visiting Clinical Psychologist offer out-patients appointments or home visits as appropriate. Further information can be obtained via the Community Learning Disability Nurse.

#### **Older people with learning disabilities**

People in need of care home support on account of physical illness, frailty or dementia have access to generic care home accommodation, regardless of whether or not they have learning disabilities. All care homes are registered and inspected by the Care Commission against the national care standards for care homes.

**Funding**

Funding 2007/08

<b>Service Area</b>	<b>Budget 07-08</b>
Respite Provision	627,000
Supported Accommodation	1,871,000
Learning Disabilities Nurse	35,000
Outreach	8,000
Day Care	854,000
Local Area Co-ordinator	36,000
<b>Total</b>	<b>3,430,000</b>

The above figure does not include the cost of generic services accessed by some people with learning disabilities, e.g. Care @ Home, Occupational Therapy.

**Further Reading**

- Scottish Executive 'The Same as You? A report into services for people with learning disabilities' 2000
- Shetland's Partnership in Practice (PiP) 2004-2007

**Unmet Needs / Issues**

- The rapid increase in the number of adults with learning disabilities and / or autistic spectrum disorders, especially those with complex needs.
- Other demographic and social changes which will result in less people being available to provide both paid and unpaid care.
- Underdeveloped medical and therapeutic services to support service users and carers.

**Action plan**

**Assessment and care management**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
To further develop and publicise prioritisation criteria for assessment and care management	Sept 2006	WER	Completed
To implement flexible modular-based training to support the implementation of updated Care Management Guidance issued by the Scottish Executive	Sept 2006	WER	Rolling training programme underway
To implement 'Vulnerable Adults' bill	2006	TBA	NHS / SIC working group commencing June 2007
To improve arrangements for supporting individuals and their families in the process of transition from child to adult and adult to older people's services	On-going	WER	Community Learning Disabilities Team

**Day opportunities**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
To build up pre-employment activities	On-going		Manager – Eric Gray Resource Centre (EGRC) has this underway
To continue to develop community links	On-going	WER	Manager – EGRC has this underway
To consolidate recent achievements, e.g. ASDAN	On-going	WER	Manager – EGRC has this underway
To complete feasibility study (which will address the needs of people with ASDs, complex & other needs)	Stage 1 by June 2006	Funding identified	Design stage commencing

To develop some day opportunities using the communal flats at Rudda Park & Quoys Phase 2	Rudda Park– autumn 2006 Quoys - 2008	WER	Manager – ILP is progressing links with Shetland Arts to provide some activities for tenants
To develop the new day service at Newcraigielea	On-going	WER	Manager - Newcraigielea

**Supported accommodation**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
To consolidate existing services.	On-going	WER	Manager – ILP & Manager – Newcraigielea
To continue to develop community links	On-going	WER	Manager – ILP & Manager – Newcraigielea
To open Rudda Park (up to 8 tenancies)	Summer 2006	£251k	Manager – ILP completed in 2006
To develop ‘Experience Independent Living’ packages to give potential tenants the opportunity to find out exactly what is involved.	2007	WER	Manager – ILP has developed ‘Transition flat’, opening June 2007
To open the permanent supported accommodation @ Kantersted (4 tenancies)	January 2007	£394k	Manager – Newcraigielea has opened ‘Sea View’ January 2007
To remove short break bed from Stocketgaet and replace with permanent tenancy	January 2007	WER	Manager – Newcraigielea completed this on schedule
To open Quoys Phase 2 (up to 13 tenancies)	2009	TBA	Manager - ILP
To review the need for further supported accommodation, especially for older people with learning disabilities and those with more complex needs.	2007	WER	Service Manager – Adult Services

**Short break (respite) accommodation**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
To open the Newcraigielea short break service	Jan 2007	WER	Manager – Newcraigielea opened it on schedule
To close Craigielea and the Stocketgaet short break bed and the Stanegarth facility	Jan 2007	£5,000	Manager – Newcraigielea completed this on schedule
To continue to develop community links	On-going	WER	Manager – Newcraigielea

**Outreach services**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
Consolidate existing support packages	2006	WER	Service Manager – Adult Services completed this
Extend number of support packages in line with assessed needs.	2007	WER	Linked to the development of Care @ Home

**NHS services**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
Develop a second Community Learning Disability Nurse post	Under review	£30,000	Director of Clinical Services – funding to be identified
Ensure the review of NHS OT and Physio Services takes account of the needs of adults with learning disabilities	2006	£0	Hospital Manager – not completed
Ensure new health screening targets (access to services and links with other organisations) for people with learning disabilities are implemented by GP practices within the Enhanced Services scheme	2006-9	WER	CHP General Manager – Community Learning Disabilities Nurse is supporting this development

**Local Area Coordination**

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
To further develop life planning	2006	WER	Ongoing
To develop volunteer support for people with learning disabilities within care homes if there is an assessed need for additional leisure and social activities	As & when required	WER	Local Area Coordinator has facilitated this.
To develop self-advocacy further	2007	WER	Service Manager – Adult Services & Local Area Coordinator – need to progress further
To firmly establish the LACo within the Social Care structure	2006	WER	Completed

***Older people with learning disabilities***

<b>Action</b>	<b>Timing</b>	<b>Cost</b>	<b>Progress</b>
To continue to offer specialist learning disabilities training to care home care staff.	On-going	WER	Available if identified as training need
To develop day care provision, predominantly for older people with learning disabilities at Newcraigielea	2007	TBA	Manager – Newcraigielea – it may not be possible to focus on this group until the needs of another group of day care users have been addressed through the re-design of EGRC

# Mental Health

The Shetland Islands Council, Shetland NHS Board and the voluntary and independent sector continue to work together to deliver a comprehensive mental health service to meet the needs of people who require care and support as a result of their mental health problems.

*The Mental Health (Care and Treatment) (Scotland) Act 2003* 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.

Delivering for Mental Health (2006) ([www.scotland.gov.uk/Publications/2206/11/30164829/0](http://www.scotland.gov.uk/Publications/2206/11/30164829/0)) sets out national policy for 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.

## Needs

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.

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

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 with dementia.

## Mental Health Strategy

Over the last year the Shetland Mental Health Partnership, the local multi-agency group that is leading on the development of mental health services in Shetland, has developed a mental health strategy.

The strategy sets out the 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.

## Aims

In developing the 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 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.
- The strategy includes:
  - An inclusive approach
  - The range of services from prevention to treatment and care
  - A lifespan approach
  - A range of models including wellness / recovery / treatment models
  - An individual / family / community focus
  - Services that are integrated and co-ordinated
  - Evolutionary redesign
- We need to address the stigma attached to mental illness, and treat all people with dignity and respect.
- We should use the evidence on what works in organizing services and delivering treatment to improve outcomes.

The strategy includes an action plan, which will ensure local delivery of Delivering for Mental Health.

## Current Services

A range of agencies both statutory and voluntary provide current services in Shetland. The main services for people with mental health problems are included here.

## HEALTH AND SOCIAL CARE SERVICES

**The Community Mental Health Team (CMHT), which is based in Lerwick** includes:

Consultant Psychiatrist  
Community Psychiatric Nurses (CPN)  
Child & Adolescent CPN  
Specialist Social Worker

The CMHT provides both office based and home appointments, with out-patient clinics being held in all Health Centres throughout Shetland.

A local Consultant Child and Adolescent Clinical Psychologist is in post and has a number of training posts currently in place.

There is a visiting Consultant Child & Adolescent Psychiatrist service provided via NHS Grampian.

Specialist in-patient provision is provided via NHS Grampian.

### **Annsbrae House Supported Accommodation & Mental Health Community Support Service**

Annsbrae is integrated within the CMHT under Joint Future. Annsbrae House provides 8 supported tenancies and one respite 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. It is proposed that there will be ongoing development of services based at Annsbrae.

The Skills Centre at Annsbrae provides personal and social skills training to those with mental health problems. Various groups are also held at Annsbrae e.g. hearing voices group, anxiety management group.

A multi-disciplinary management team has been established to ensure the ongoing development of mental health services at Annsbrae. This brings together Community Care, Housing, CMHT management and meets weekly. There is also a tenant's forum to address housing needs.

### **Mentally Disordered Offenders**

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

### **VOLUNTARY SECTOR SERVICES**

**Shetland Link Up** - provides support, advice, outreach and drop in facilities to those with mental health problems throughout Shetland.

**Advocacy Shetland** – provides independent advocates to support and represent vulnerable people. There is a specialist support service for those with mental health problems.

**Supported employment schemes**

- **Moving On** identifies work placements and provides support to people on the scheme who have a wide range of needs including mental health difficulties.

**Depression Alliance** - is a self-help group who have regular fortnightly meetings and are now based at Annsbrae House.

**SAS (Sexual Abuse Survivors)**

**Group** - is a self-help group, facilitated by a professional care worker, which meets monthly at Annsbrae House and provides a telephone helpline.

**Funding**

**Mental Health \***

Community Mental Health Team

▪ Community Mental Health Nursing	250,000
▪ Specialist Social Worker	42,000
▪ Community Support Service	524,000

Joint Local Implementation Plan 134,000

▪ Specialist Advocacy for PWMH Problems	12,000
▪ Self Advocacy for PWLD	9,000
▪ Dedicated MHO posts	41,000
▪ <u>Shetland Link Up</u>	47,000

\* Includes MHSG funding for community mental health services and Mental Health (Care & Treatment) (Scotland) Act 2003 funding.

**Next Steps / Priorities**

- Continue with the implementation of the new Mental Health Act;
- Completion of the Mental Health Strategy
- Implementation of the Action Plan arising from the Strategy
- Undertake a review of out of hours mental health cover across health and social care
- Continue with programmes of mental health promotion to raise awareness of mental health and mental health problems
- Continue the development of facilities in the Gilbert Bain Hospital as a place of safety for patients in a crisis situation with mental health problems, to provide both a safe environment for patients and increased training and awareness among the staff.
- Ongoing work across North of Scotland Region as part of regional forensic mental health service provision

<b>ACTION</b>	<b>EXPECTED OUTCOME</b>	<b>TIMING</b>	<b>COST</b>	<b>AGENCIES INVOLVED<sup>6</sup></b>
Complete overarching mental health strategy through Shetland Mental Health Partnership	Improved co-ordination of services across agencies and the voluntary sector	June 2007	WER	<b>Shetland NHS Board, Social Care,</b> voluntary sector, Housing
Agree action plan arising from strategy	Priorities actions to meet identified needs and gaps in service.	Sept 2007	TBA	<b>Shetland NHS Board, Social Care, voluntary sector, Grampian NHS Board</b>
Develop local action plans based on National Mental Health Delivery Plan.	Enhanced services for patients	Dec 2007		<b>Shetland NHS Board, Social Care, voluntary sector, Grampian NHS Board</b>
Continue with work on the review of admission and discharge protocols with Royal Cornhill Hospital	Establish clear roles and responsibilities for services	Dec 2007	WER	<b>Shetland NHS Board, Social Care, voluntary sector, Grampian NHS Board</b>
Undertake a review of Out of Hours mental health services	Improved inter-agency working and enhanced availability of services out of hours	October 2007	WER	<b>Shetland NHS Board,</b> Social Care, voluntary sector
Deliver ASIST training: 3 x two day courses, to targeted groups and general population	More people trained to recognise and help those considering suicide	March 2008		<b>Shetland NHS Board, Social Care,</b> voluntary sector
Deliver suicide prevention training to at least 10% NHS frontline staff (towards Delivering Mental Health target of 50% by 2010).	Increased awareness, recognition and reduced stigma of mental health problems across community	March 2008		<b>Shetland NHS Board</b>

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<sup>6</sup> Lead agency in bold

Work on a regional basis to ensure service provision throughout 2007/08 for <ul style="list-style-type: none"><li>• Mothers and babies</li><li>• Young people</li><li>• mentally disordered offenders</li><li>• people with eating disorders</li></ul>	Enhanced outcomes for patients. Requirements of new Act met	Ongoing	WER	<b>Shetland NHS Board</b> , Social Care, voluntary sector
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## **THE SHETLAND MENTAL HEALTH PARTNERSHIP (SMHP)**

### **REMIT**

The SMHP will take an over view of all mental health services in Shetland. In addition the SMHP 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. In the longer term, it will be used by the 2020 vision project.

The partnership will have a multi agency approach and include representatives from the Health Board, Council services and the Voluntary Sector, assisted by service users and carers.

The partnership will have an annual work plan, which will include overseeing initiatives such as Choose Life, the Suicide Prevention Action Plan and the Joint Local Implementation Plan (JLIP).

Responsibility for the strategy will rest with the SMHP. The SMHP 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;
- Development of services including a local 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 Mental Health Operational Management Team (MHOMT) and the Mental Health Forum (MHF) will provide support to the partnership. In return the partnership will feed back its results to the Management Team and the Mental Health Forum.

The partnership will promote good communication between all agencies working on mental health issues.

Agreed at the Shetland Mental Health Partnership meeting on 14<sup>th</sup> July 2005.

## 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 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 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.

# Sensory &/or Communication Impairment

Sensory impairment usually refers to problems with sight and/or hearing and can include other communication difficulties. Sensory impairment may co-exist with other disabilities. There are a range of causes, with some people blind or deaf from birth and others becoming progressively impaired when they are older. A significant number of people with sensory impairments will have other impairments too.

## Aim

To support people with sensory and/or communication impairments to minimise the impact of their impairment on their daily lives.

## Needs Assessment

People with sensory and communication impairments have a wide spectrum of needs.

Some people need support to minimise the impact of their impairment on their daily lives. Others need support with general problems, such as parenting, which are made more complicated due to their sensory and/or communication impairment.

Sensory and/or communication impairments can be acquired at any age. However, a significant number of people with sensory and/or communication impairments will have other disabilities e.g. learning disabilities or problems associated with old age.

In the past Shetland's Social Care Service has concentrated all its resources for people with sensory and/or communication impairments in a singleton post. This has resulted in unmet need when the post-holder is absent or leaves. To avoid a re-occurrence of this situation Social Care is improving the skills and knowledge of a number of its staff in these areas.

Audiology services in Shetland have historically been from visiting providers, whether from the NHS or private sector. As part of a Scottish Executive Health Department initiative, a Shetland based modernised NHS audiology service has been set up.

## Services Available

Access to non-hospital based specialist services, aids and equipment is via a referral to Community Care's Duty OT. Several outcomes are possible, alone or in combination:

- Social Care assessment
- Occupational Therapy
- Purchase of specialist service, e.g. BSL signer, mobility assessment
- No further action

Access to the NHS Shetland Audiology Service is via a general practitioner or by recall from the Audiology Service.

NHS Shetland provides Speech and Language Therapy Services, part funded by Shetland Islands Council.

Specialist services from south are bought in as and when required when there is an assessed need which cannot be met locally, for example, CALL Centre input (advice on alternative and augmentative communication) or mobility training.

Service Level Agreements are being set up with service providers from south.

NHS Shetland's Audiology Service provides hearing aids.

Community Care's Occupational Therapy and Independence at Home scheme can provide other equipment and adaptations to meet assessed needs.

The voluntary sector provides some social and support groups.

## Expenditure

Dedicated budgets for sensory impairment are few. However, several generic budgets, such as training, are also used.

Service area	Budget 2007/08
NHS Audiology Service	73,000
Specialist Equipment	7,000
Speech and Language Therapy	40,000
<b>Total</b>	<b>£120,000</b>

## Unmet Needs / Issues Identified

The assessment, rehabilitation and support services available to adults with sensory or communication impairments within Shetland are underdeveloped and there is a need for more joint work between the component parts, although this is improving all the time.

Additional training is on-going for a range of staff, e.g. OTs, to better equip them to meet the needs of people with sensory and communication impairments

Some needs can only be met via practitioners from south.

Access to BSL signers is patchy. There is no one qualified to interpreter standard in Shetland. A more robust arrangement is being set up by SIC's Policy Unit.

There is no central bank of sensory equipment or communication aids for people to try out, this should be addressed by the planned Joint Equipment Store.

Budgets to purchase specialist advice, interpretation and assessment services need to be identified.

Work to establish a route for commissioning specialist independent advocacy services via Advocacy Shetland has started.

Action	Timescale	Cost	Lead
<b>Improved joint work</b>			
<ul style="list-style-type: none"> <li>Address via Joint Management Team for Physical Disabilities and Sensory Impairment</li> </ul>	On-going	WER	Chair – Joint Management Team for PD/SI
<b>More specialist training</b>			
<ul style="list-style-type: none"> <li>Teams to identify needs via annual Training Needs Analysis (TNA)</li> </ul>	Annually	WER	Team managers or equivalent
<ul style="list-style-type: none"> <li>Each team's TNA to be checked to ensure sensory and/or communication training has not been overlooked</li> </ul>	Annually	WER	Training Manager
<ul style="list-style-type: none"> <li>Expansion of Community Care's OT Team to enable the development of this area of work</li> </ul>	2006-7	£45,090	Service Manager – Community Care Resources
<b>Arrangements for purchasing external services</b>			
<ul style="list-style-type: none"> <li>Set up procedures for purchasing specialist external services to meet assessed needs including independent advocacy services</li> <li>Identify budgets</li> </ul>	2007-8	WER	Service Manager – Community Care Resources
<b>NHS Audiology Service</b>			
<ul style="list-style-type: none"> <li>Review to ensure it is in line with recommendations of Public Health Institute of Scotland's Needs Assessment on NHS Audiology Services (2003)</li> </ul>	2006-8	WER	To be determined by Joint Management Team for PD/SI

# Palliative Care

Palliative care is the active total care of an individual whose disease is not responsive to curative treatment and who is in the end stage of life. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life for individuals, their families and carers.

Palliative Care services will:

- focus on the quality of life;
- respect autonomy and choice;
- provide good pain control;
- respond to psychological, social and spiritual needs;
- communicate openly among individuals, families, carers and staff;
- support individuals to help them have a full and active life for as long as possible;
- support families and carers to help them cope during an individual's illness and in their own bereavement.

## Aims

- To provide appropriate, high quality palliative care in all care settings.
- To provide a comprehensive rapid response service for palliative care.

## Needs

There are on average between 200 and 230 deaths each year in Shetland. Of these it is estimated that between 55 and 60 people will require palliative care. This will include people with cancer related illness, heart or respiratory disease, multiple sclerosis and motor neurone disease.

## Current Services

People living at home or in residential care will be supported by their GP, community nursing service, primary care counsellor and social care services. Specialist support is available from the Macmillan Nurse nursing team. Tele-conferencing facilities are used to help with the management of health care needs.

All agencies work together to provide a flexible, rapid response for palliative care cases including a fast track Single Shared Assessment for both the client and any unpaid carers. Community care services available include residential care, day care, personal care at home, help with domestic tasks, occupational therapy, specialist aids, adaptations and community alarm. Respite care in the person's own home is purchased from the Crossroads Care Attendant Scheme.

Respite in hospital may also be provided particularly where specialist health assessments are needed.

## Expenditure

Most of the expenditure on palliative care is included in budgets for services provided to other care groups and cannot be identified separately.

## Unmet Needs

- Increasing pressure on all community based resources due to an ageing population is making it difficult to continue to respond effectively to provide intensive home based care 24/7.
- The issues around supporting people at home who meet continuing health care criteria should be examined.

- Better information materials are needed to support carers and the people for whom they provide care.
- The voluntary sector have identified a need for bereavement counselling.
- There are difficulties in providing some specialist equipment and adaptations timeously due to delivery times from the mainland and limited capacity in the construction industry.

### **Further Reading**

- Shetland NHS Board Local Delivery Plan.

Action	Timing	Cost	Responsibility
<b><i>To provide appropriate, high quality palliative care in all care settings.</i></b>			
Complete review of cancer nursing team	July 2007	WER	NHS Shetland
Review cancer nurse specialists training needs by October 2007	October 2007	WER	NHS Shetland
Implement palliative care service to patients with non-cancer diagnosis by April 2008	April 2008	WER	NHS Shetland
Establish Working group to review current palliative care practice	July 2007	WER	NHS Shetland/Social Care
Produce Draft Palliative Care Strategy	March 2008	WER	NHS Shetland/Social Care
Provide inter-agency training on palliative care including <ul style="list-style-type: none"> <li>▪ Care management</li> <li>▪ Specialist care and support</li> </ul>	On-going	WER	NHS Shetland and Social Care Training Managers
<b><i>To provide a comprehensive rapid response service for palliative care</i></b>			
Implement revised SSA including fast track processes	2007/08	WER	SSA and Care Management Team
Provide a comprehensive information and advice service for service users and carers	On-going	WER	Social Care and NHS Shetland

# Physical Disabilities

Shetland's Disability Strategy 2005 – 2020 uses the following definition:

“A disabled person is any person in Shetland, of any age, with a physical, sensory or mental impairment, resulting (or likely to result) in long term (more than one year) substantial adverse affects on day to day activities.”<sup>7</sup>

This was adapted from the definition used in the Disability Discrimination Act 1995.

It is thought that there are approximately 3,300 people living in Shetland with some form of disability. Physical disability refers to a wide range of difficulties in carrying out physical tasks that are usually due to an underlying problem with the nervous system, muscles, bones or joints.

Examples of physical disabilities include difficulties in walking, using hands, balance, co-ordination, strength, swallowing and speaking. Depending on the cause, there may be associated problems including pain, fatigue, difficulties with bladder and bowel control, cognitive impairment, involuntary movements and stiffness or spasms.

## Key Objectives

- To work with people with disabilities of all ages; promoting their rights and independence.
- To respond to their needs by targeting resources to support them effectively so that they can achieve their full potential.

## Assessment of Needs

Aggregate needs assessments were completed for the Disability Strategy. Detailed information from birth is collated routinely through the Child Development Initiative. This has formed the basis for local projections particularly of the numbers of people with learning disabilities and their anticipated levels of dependency in future years.

Overall the numbers of people with disabilities who will require some support is expected to increase 3 fold by 2020.

Individual assessments of need are carried out using age appropriate shared assessment tools; the Single Shared Assessment (SSA) for adults and the Integrated Assessment Framework for children.

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<sup>7</sup> Shetland's Disability Strategy published April 2005

## Services Available

Services designed primarily to meet the needs of people with physical disabilities include:

- 4 places at Montfield Hospital
- occupational therapy services
- aids and adaptations to property
- 2 flats providing specialist supported accommodation at Banksbroo.

Other services are used by people with a wide range of needs including those with needs arising from physical disability, e.g. community nursing, physiotherapy, Care at Home and Meals on Wheels.

Disability Shetland provides a range of services for people with disabilities including:

- Computer Project
- Internet Project
- social activities at Montfield Hospital
- publication of the Access Guide to Shetland
- disability awareness training
- recreational clubs and swimming club
- new Horizons minibus, operated by volunteer drivers.

Other services provided by the voluntary sector to vulnerable people including those with physical disabilities include:

- Crossroads Care Attendant Scheme
- Independent Advocacy

## Expenditure

Occupational Therapy	£363,000
Aids & Adaptations	£1,411,000
Supported Accommodation	£360,085
Physiotherapy	£400,000

## Unmet Needs / Issues Identified

- Delays sometimes occur in the delivery of specialist equipment ordered from the mainland or with adaptations to property due to shortage of building contractors interested in this type of work. This can mean unmet needs for some people in the short to medium term resulting in loss of independence or placing the person at risk, for example, of falling.
- The numbers of places available in supported accommodation that are suited to the needs of younger adults with high dependency levels arising from physical disabilities are limited. This may mean inappropriate admission to hospital or residential care on a long-term basis.
- Many of the recommendations for service developments in Shetland's Disability Strategy 2005-2020 are unfunded and cannot be taken forward until funding is made available from elsewhere. Stakeholders find it very difficult to reprioritise services and service levels to release funding for new service developments.

- Many facilities have restricted access for people with physical disabilities including some Council offices and premises used by voluntary organisations working in the care sector.
- Better information on the services available and better access to information is needed for people with disabilities.

### **Planned Actions**

The action plans from Shetland's Disability Strategy 2005 – 2020 are monitored by the multi-agency Disability Strategy Group. The plans are included below with the actions divided into 5 sections according to the lead agency or group responsible for implementation. These are: the Disability Strategy Group itself; the Joint Future Joint Management Team(s); the Voluntary or Independent Sector; NHS Shetland or Shetland Islands Council.

### **Further Reading**

- Shetland's Disability Strategy 2005 – 2020
  - 2020 Vision of Shetland's Health Care
- Shetland Disability Strategy –  
Planned Actions

## Shetland Disability Strategy Planned Actions

### KEY:

\* reference in original Action Plan (part of full Disability Strategy document)

**Shaded** – work completed

**Bold** – source of funding still to be identified

*Italic* – originally a medium or long term outcome in Strategy

WER – Within Existing Resources

TBI – To be Identified

TBA – To be advised

### Disability Strategy Group (DSG)

*	Action	Lead	Cost	Timescale
2.19.1	Representation of service users and carers on Disability Strategy Group	VISP / Disability Shetland	WER	Public meeting to set up 'Shetland Disability Group' held on 27.09.06. One representative now on Strategy Group (Nov 06) – further representation sought (at least one individual.) SDG will continue to hold regular meetings.
2.1.5	Produce inter-agency guidelines for appropriate use of resources	DSG working group	WER	Not yet progressed. Small working group to be set up 2007-08
2.3.5	Produce information on roles of staff and services	DSG working group	WER	Not yet progressed. Small working group to be set up 2007-08
2.5.1	Audit of availability of information (service users / public)	DSG working group	WER	Not yet progressed. Small working group to be set up 2007-08

## NHS Shetland

*	Action	Lead	Cost	Timescales
5.2.1 5.2.4	Audiology Modernisation Project	NHS Shetland / NHS Grampian	£71,429	New service in place Dec 2005 – to be reviewed re waiting time pressures by June 2007
5.2.3	Introduction of universal neonatal hearing screening programme	NHS Shetland (national programme)	Met within NHS Board budget	Commenced April 2005
2.13.3	Access to continence service	Community Health P'ship	£38,000 Within CHP budget	Specialist nurse took up post in 2004
4.2.2	Specialist neurology/ community rehab nurse	NHS Shetland/ MS Society	WER / MS Society (national & local branch)	MS nurse recruited: took up post in May 2006
4.2.1	Support development of stroke services	NHS Shetland	WER	On-going Current work on Stroke Services Strategy and Managed Clinical Network. <i>(Note - the development of a local CT scanning service was not in the original Disability Strategy – but will have an impact on stroke and other services - due end 2007)</i>
4.2.3	Visiting neurology service	NHS Shetland / NHS Grampian	WER	Visiting service not required at present : local physicians will see neurological patients and liaise

*Physical Disabilities*

				with Grampian neurologists re investigations and management
2.13.2	Ensure needs of people with disabilities are met within dental services	NHS Shetland dental services	WER	On-going
2.14.1-4	Access to screening / health promotion activities	NHS Shetland (Health Promotion / Public Health)	WER	Ongoing. Further work to be done in 2007- through a number of local programmes and equity and diversity assessments
4.1.1 4.1.2	Review & cost proposals for wheelchair and seating services	NHS Shetland MARS	WER	Working group set up in 2005. Progress being made with proposals to improve service provision within existing service level agreement with (MARS) Grampian. Local orthotic services to be reviewed by September 2007.
4.2.4	Head injury protocol	NHS Shetland (Public Health)	WER	For 2007-08 <i>(Note - the development of a local CT scanning service was not in the original Disability Strategy – but will have an impact on head injury and other services – due end 2007)</i>
4.3.2	Local guidelines for osteoporosis	NHS Shetland (Public Health)	WER	In progress: plan to complete by end 2007.
2.2.2	Information on prevalence of specific conditions	NHS Shetland (Public Health /	WER	Part of project to develop use of GP

		CHP)		data for epidemiological and planning purposes 2006-07
4.2.5	Review services for people with epilepsy	NHS Shetland / North of Scotland region	WER	There is ongoing development of the Regional Managed Clinic Network
5.1.8	Review current ophthalmology services	NHS Shetland / NHS Grampian	WER	Ongoing work through the Eye Care Redesign programme

### **Shetland Islands Council**

	<b>Action</b>	<b>Lead</b>	<b>Cost</b>	<b>Timescales</b>
2.2.1	Further development of Additional Support Needs (Special Needs) database	Social Care	WER	Work ongoing
2.6.1	Review of short break services for children with LD at Laburnum	Social Care	WER	Review completed in November 2006. Feasibility study now underway to look at new build to replace Laburnum.
2.6.1	Residential care facilities at Kantersted (Newcraigielea) (4 perm & 9 short break)	Social Care	£2.7 million capital £830k revenue per annum	Newcraigielea - short breaks for adults with learning disabilities - opened on 8.1.07, replacing Craigielea and other respite accommodation. SeaView - a 4 bed house providing long term tenancies for 4 adults with learning disabilities - opened on 4.1.07.

*Physical Disabilities*

2.6.2	Review of services at Eric Gray Resource Centre (adults with LD)	Social Care	WER	Feasibility study group has reported back. Currently prioritising areas of work – beginning with services for people with complex needs. Will need to report to Council and go through capital programme process.
2.16.2	Access to Direct Payments Scheme	Social Care	WER £12.5k per year	DP support service commissioned through CAB
5.1.3	Mobility / rehab officer	Social Care	TBI (£32,000)	Although no local Rehabilitation and Mobility Officer has been appointed, this service can be sourced from outwith Shetland as required following screening of referrals through the Community Occupational Therapy Services
2.9.3	<b>Development officer - disabilities</b>	<b>Community Development</b>	<b>Long term funding TBI</b>	<b>Fixed term appointment made using Quality of Life funding to Jan 2007.</b> <b>Now reviewed – and new post created within Children’s Services with inclusion remit</b>
2.9.3	<b>Recreational services for children with</b>	<b>Community</b>	<b>TBI</b>	Autism awareness training for Shetland

*Physical Disabilities*

	<b>disabilities</b>	<b>Development</b>		Recreational Trust staff due in 2006
2.9.1	Development of ASN Dept at Anderson High School	Education	£1.8 million capital. £778,531 Revenue per annum	Completed
2.9.4	Co-ordinated support plans for children (ASL Act)	Education	WER	Work in progress
2.10.1	Improved Future Needs Assessment at 14+	Education	As above	Work in progress
2.16.1	Improved access to services in remote and rural areas - through community schools	Multi-agency	TBA	

2.8.1	Review & evaluate current Indep. Living / supported accomm. schemes before expansion or further development of schemes	Social work / Housing	WER	On going review New tenancies at Rudda Park (8) – 2006 and Quoys (10) – due 2008 Development of 'Experience Independent Living' packages (2006-07)
2.8.2 2.8.3	Audit of housing stock & review adaptations in social rented stock	Housing	WER	Ongoing. Identification of properties suitable for conversion / adaptation underway to provide homes that meet disability needs in all housing tenures. All new build properties planned to be accessible.

2.8.5	Review medical assessment procedure	Housing / NHS Shetland	WER	Review underway, through Public health and Housing To be completed in 2007
2.8.6	Input into hospital. discharge policies and procedures	Housing / NHS Shetland	WER	Ongoing
2.8.9	Explore named contacts within housing	Housing	WER	2006
2.8.12	Work with partners to support provision of units at phase 2 Quoy to meet disabled housing needs	Hjaltland Housing – partnership with social work	Hjaltland (capital) Social work (revenue)	2008 - 2010

### SIC and NHS Joint Future services

*	Action	Lead	Cost	Timescales
2.2.3	Data sharing protocol	SIC / NHS	WER	In place. Periodic review
2.17.1	Support implementation of DDA in NHS and SIC	NHS SIC	WER	Implementation progressing
3.4.1	Implement Protecting Vulnerable Adults guidance and procedures	SIC / NHS	WER	Work to be completed 2007
2.3.1	Single shared assessment	SSA & Care Management group	WER	Has been further revised: staff training currently underway
2.4.1 2.4.2	Carers: Assessment of needs Information and advice Provision of services	Joint Future Joint Management Team	WER	Continued implementation of Carers Strategy & Carer Information Strategy. Young Carers Strategy to be finalised by October 2007.
6.1.1	Increase number of mental health officers	Mental Health Team	Additional £62,000	completed

*Physical Disabilities*

3.3.1	Development of self advocacy using People First model	Community Learning Disabilities Team	WER	Group is meeting at Anderson High School. Adult service to be developed EGRC has an active users group Advocacy Development Plan to be reviewed by December 2007.
5.1.1 5.1.2 5.1.4 5.1.5 5.1.6 5.4.3	Sensory impairment: <u>review</u> of current service (several issues)	Physical Disability & Sensory Impairment Management Team (PD&SIMT)	WER	To be taken forward in 2007 / 08
4.4.1 4.4.2	Younger physical disabled people – access to information and advice	PD&SI Team	WER	To be taken forward in 2007 / 08 (links with 2.3.5 and 2.5.1)
5.3.4	Formalised commitment to ICT service for people with sensory impairments	PD&SI Team	WER	TBA
<b>5.4.1</b>	<b>Formalise input from specialist teachers to adults with SI</b>	<b>PD&amp;SI Team</b>	<b>TBI</b>	<b>Currently no input with adults Services commissioned on a case by case basis to meet needs</b>
5.4.2	Review Alternative Media Resource Centre	PD&SI Team	WER	TBA
<b>5.1.10</b>	<b>Use of symbols to aid communication</b>	<b>PD&amp;SI Team</b>	<b>TBI</b>	
<b>5.3.1</b> <b>5.3.2</b>	<b>Access to aids and equipment for people with SI</b>	<b>PD&amp;SI Team</b>	<b>TBI</b>	<b>Work on joint Occupational Therapy Store progressing.</b>
<b>5.3.3</b>	<b>Local supply of VOCA to be used immediately after assessment</b>	<b>PD&amp;SI Team</b>	<b>TBI</b>	

<b>5.1.7</b>	<b>Review local provision of rehab. services for people with SI</b>	<b>PD&amp;SI Team</b>	<b>TBI</b>	<b>Although no local Rehabilitation and Mobility Officer has been appointed, this service can be sourced from outwith Shetland as required following screening of referrals through the Community Occupational Therapy Services</b>
2.18.3	Identify training needs across agencies	Training: HR, Training and OD Team	WER	On-going. Joint training plans reviewed annually
2.18.3	Awareness raising as part of induction for officers and councillors	As above	WER	As above
<b>5.5.1</b>	<b>Training in sensory impairment: both general &amp; specialist</b>	<b>As above</b>	<b>TBI</b>	<b>On-going. Joint training plans reviewed annually</b>
<b>5.1.9</b>	<b>Develop local training in lip reading</b>	<b>As above</b>	<b>TBI</b>	<b>As above</b>
<b>2.8.8</b>	<b>Training for housing staff in disability awareness</b>	<b>As above</b>	<b>TBI</b>	

**Voluntary / Independent Sector**

*	Action	Lead	Cost	Timescales
2.5.4	Further development of 'Helping Hands' pack including website	Vol sector	TBI	To be reviewed in 2007 / 08 (links with 2.3.5)
2.11.3	Further develop services to support disabled people in work	Vol sector (Moving On / COPE)	Moving On - Lottery funding £80,000	Moving On ran successful Job Crew pilot (Rocks to Roses) in 2006 and has secured Lottery funding for further job crew projects in 2007/08



## Shetland's Joint Future Shetland Islands Council

### Joint Physical Disabilities and Sensory Impairment Management Team Terms of Reference

#### Purpose

To manage all specialist services provided or commissioned by NHS Shetland and the Council for people with physical disabilities and sensory impairment.

#### Remit

- To take forward the recommendations relating to PD & SI from the multi-agency Disability Strategy 2005-2020 for Shetland.
- To link with and support the work of the Disability Strategy Group.
- To oversee the work of the Joint OT Service Management Team.
- To monitor existing service provision and budgets.
- To plan for the future; reviewing needs and seeking examples of best practice from other areas.

#### Membership

Service Manager Community Care Resources, Community Care (Chair).  
Assistant Director of Patient Services – Nursing  
Quality Improvement Manager, Education  
Service Manager Adult Services, Community Care  
Service Manager Community Care Fieldwork, Community Care

#### Meetings

Meetings will be held quarterly with additional meetings arranged as required to progress work in hand.

All meetings will be minuted. Minutes will be available to staff and to the public under the provision of Freedom of Information (Scotland) Act 2002. Minutes will be reviewed by the Joint Future Joint Management Team (JFJMT).

The Agenda will cover the following:

- National initiatives
- Local Developments – Disability Strategy Action Plan
- OT Services
- External contracts / SLAs for specialist services
- Transitional issues
- Training and CPD



## Shetland's Joint Future Shetland Islands Council

### Joint Occupational Therapy Service Management Team Terms of Reference

**Note: The function of the Joint Occupational Therapy Service Management Team will be reviewed as work to develop a new joint equipment store is taken forward in 2007/08.**

#### Introduction

Occupational Therapy (OT) Services are offered by both NHS Shetland and Shetland Islands Council's Social Work Service. The Joint OT Service Management Team will report to the Joint Physical Disability & Sensory Impairment Management Team.

#### Purpose

To develop a joint approach to the management of the OT Service in order to make best use of existing resources and to plan future service developments.

#### Remit

- To take forward the recommendations relating to OT of the Disability Strategy, Partnership in Practice Agreement for learning disability services and other local and national initiatives.
- To develop joint ways of working which will benefit OT service users within Shetland, including the formalisation of 'care pathways' and joint procedures where this is considered appropriate.
- To keep the Joint Future Joint Management Team apprised of developments within Occupational Therapy that will impact on the Joint Future Agenda.
- To ensure that the collective professional view of Occupational Therapy is represented appropriately at strategic groups and committees throughout NHS Shetland and SIC as appropriate.
- To communicate the activity and development of the service to other therapy teams and the wider community as a whole.



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- To contribute to the activities and remit of the Community Health Partnership (CHP) as appropriate.

The Team will have a standing core agenda:

1. National developments
2. Local developments: Action Plan and Progress
3. Workload
4. Budgets and resourcing
5. ICT Issues
6. Buildings and accommodation
7. Equipment contracts and maintenance
8. Joint procedures

NB Continuing Professional Development and joint clinical discussions will take place in a separate joint forum attended by all OTs.

### Membership

The following will be members of the Joint OT Service Management Team:

- Head of Occupational Therapy (NHS)
- Senior OT (SIC)
- Service Manager – Community Care Resources (SIC)
- Director of Clinical Services or nominee (NHS)

Other staff will be invited to the groups meetings as is felt appropriate. (For example where specialist input / advice is required)

### Chair

The group will be chaired by the Director of Clinical Services or their nominee. In the absence of the Chair and where it is deemed appropriate a meeting should go forward, the Service Manager – Community Care Resources will stand in as chair.



## **Shetland's Joint Future**

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### **Frequency of Meetings**

The group will meet formally on a quarterly basis. The chair may call extraordinary meetings more frequently should this be required with two weeks notice.

### **Communication**

All meetings will be formally minuted and minutes will be available to staff and members of the public under the provisions of the Freedom of Information (Scotland) Act 2002. Minutes will also be passed to the Joint Physical Disability & Sensory Impairment Management Team who will monitor the activities of the group and advise accordingly.

### **Review**

These terms of reference will be reviewed annually by the group.

### Disability Strategy Group Terms of Reference - March 2006

#### 1. Purpose

The Disability Strategy Group will work within the Joint Future and Community Health Partnership framework to drive forward Shetland's Disability Strategy 2005 – 2020.

#### 2. Role and Tasks

- To monitor progress on the implementation of the Disability Strategy 2005 – 2020 and evaluate outcomes.
- To agree and advise the joint management teams on priorities within the Strategy.
- To review and prioritise spending on disability services.
- To prepare an annual update report on the Strategy.
- To ensure that stakeholder views are represented through to joint management teams.
- To promote disability issues and disability awareness across partner agencies and with the public.
- To advise on the scope and requirements for disability service reviews e.g. review of services for people with sensory impairment.
- To take part in and monitor progress of service reviews.
- To discuss and comment on proposals to develop or change services for people with disabilities.
- To discuss national policies concerning disability issues and advise joint management teams on the implications locally.
- To agree responses required by, for example, the Scottish Executive on disability services/issues.

3. **Membership**

Representatives from:-

SIC

- Community Development
- Education - Senior Education Officer
- Housing – Senior Housing Officer, Supported Accommodation
- Community Care – Service Manager Adult Services and Service Manager Community Care Fieldwork
- Elected Members nominated by Services Committee

NHS Shetland

- Director of Clinical Services
- Director of Service Improvement
- Specialist Registrar in Public Health Medicine

Shetland Disability Forum

Disability Shetland

Voluntary & Independent Sector Partnership (VISP)

4. **Subgroups**

The Disability Strategy Group may set up and direct a number of short life working groups to take forward specific items.

5. **Meetings**

The Disability Strategy Group will meet quarterly. Additional meetings may be arranged as required to progress work in hand.

Minutes of all meetings of the Group will be made available to the joint management teams and will be available to the public under the terms of the Freedom of Information (Scotland) Act 2002.



## Shetland's Joint Future

Shetland Islands Council

### 6. External Links

The Disability Strategy Group will provide a link to:

- Shetland Disability Forum
- Shetland Access Panel
- Joint Future Joint Management Team (JFJMT)
- Community Health Partnership (via JFJMT)
- Community Planning Board (via JFJMT and Voluntary and Independent Sector Partnership)
- Health Action Team

# Older People

The population in Shetland is ageing. Population projections for the next 10-15 years show a higher percentage increase in the number of people aged 60 and over than the Scottish average and at the same time, a significant drop in the adult working population.

The table below shows future changes anticipated from a baseline in 2002. Figures are 1,000 persons.

Age Group	2002	2008	2013	2018	% change
0-4	1.3	1.2	1.2	1.2	-4%
5-14	3.1	2.7	2.5	2.5	-21%
15-29	3.8	3.9	3.9	3.7	-3%
30-44	4.9	4.6	4.2	4.1	-16%
45-59	4.6	4.7	4.8	4.8	4%
60-74	2.8	3.3	3.7	3.8	38%
75 & over	1.5	1.6	1.8	2.1	43%

The Council and Shetland Charitable Trust have invested significant resources in services used predominantly by older people. The level of service provision is higher pro rata than anywhere else in Scotland.<sup>8</sup>

The biggest challenge for the foreseeable future will be to maintain, with limited resources, both the level and quality of care the people of Shetland have come to expect.

<sup>8</sup> Audit Scotland

## Aims

- To reduce unplanned, emergency and inappropriate admissions to hospital.
- To facilitate early discharge from hospital.
- To increase levels of independence, self-care and self managed care.
- To enable more older people to remain at home.

## Assessment of Need

The needs of older people are wide-ranging. Many older people have physical disabilities; sight or hearing loss; or mental health problems as well as increasing frailty due to age.

A wide range of services is available to meet assessed needs. Each individual assessment of needs is completed by the most appropriate worker(s) depending on the particular circumstances of the older person. This may be a social worker, occupational therapist or community nurse. Specialist assessments may be requested for example if the older person has dementia. All assessments are completed in accordance with Shetland's Single Shared Assessment Procedures.

## Eligibility Criteria

Services will be offered to meet assessed needs in the following circumstances:

- to prevent admission to hospital or residential care;

- to facilitate discharge from hospital;
- to provide support to someone who is at risk of neglect or abuse.

### **Services Available**

#### **Health Care**

A range of health care services are provided in the community through the Community Health Partnership. These include:

- Primary medical services
- General dental services
- Community pharmaceutical services
- General ophthalmic services
- Community nursing & health visiting
- Podiatry
- Physiotherapy
- Occupational therapy
- Speech & Language therapy
- Mental health and psychological services.

#### **Montfield Hospital**

36 beds providing a range of services for predominantly older people. Services include long-term care provision, assessment, slow stream rehabilitation and some palliative care. 16 of these places have been set aside to create an Interim Placement Unit (IPU) supporting people who are ready for discharge from hospital in a more open and homely environment. The Day Hospital at Montfield provides health care needs assessments and treatment in a multi-disciplinary setting without the need for hospital admission.

#### **Social Care**

Residential and day care services are available for older people, some of whom may have dementia; and for adults with learning and physical disabilities. The establishments providing these services in Shetland are listed below with an indication of the numbers of places normally used for long term and short term residential care.

##### **Edward Thomason House, Lerwick**

- specialist residential care for very frail older people
- 16 permanent places.

##### **Taing House, Lerwick**

- 16 permanent residential places,
- 4 respite care centres
- 12 day care places

##### **Viewforth House, Lerwick**

- specialist dementia unit
- 16 permanent residential places,
- 4 respite care places,
- 10 day care places.

##### **Overtonlea, Levenwick**

- 13 permanent residential places,
- 2 respite care places
- 12 day care places.

##### **Wastview, Walls**

- 13 permanent residential places,
- 2 respite care places,
- 12 day care places.

##### **North Haven, Brae**

- 13 permanent residential places,
- 2 respite care places
- 12 day care places.

### **Fernlea, Whalsay**

- 8 permanent residential places,
- 2 respite care places
- 8 day care places.

### **Isleshavn, Mid Yell**

- 7 permanent residential places,
- 3 respite care places
- 4 day care places.

Day Care at Isleshavn has been reduced due to fire regulations and problems with the accommodation available.

### **Nordalea, Unst**

- 4 permanent residential places
- 2 respite care places
- 8 day care places

### **Walter and Joan Gray Home, Scalloway**

- 13 permanent residential places,
- 3 respite care places
- 10 day care places.

All the care centres are run by the Council with the exception of the Walter and Joan Gray Home in Scalloway, which is run by Crossreach.

Nursing needs in care homes are met by local community nursing services.

Care services available to support older people in their own homes include:-

- Care at Home Services providing high levels of personal care and help with domestic tasks
- Crossroads Care Attendant Scheme
- Meals on Wheels
- Occupational Therapy

- Aids and adaptations
- Lunch Clubs
- Community Alarm
- Community nursing including specialist nursing services – incontinence, palliative care and neurological disabilities.

These services are available to people in all community care groups depending on an assessment of individual needs.

There are a number of voluntary organisations, which provide support to older people. These include:-

- Advocacy Shetland
- Age Concern
- Red Cross
- Senior Citizens Clubs
- Womens Royal Voluntary Service (WRVS)

### **Housing**

King Erik House, Lerwick  
– very sheltered housing, 16 flats

Sheltered housing  
– 34 schemes, across Shetland.

### **Funding 2007/08**

#### Care Services at Home \*

▪ Personal Care Services	2,150,000
▪ Domestic Tasks	983,000
▪ Community Nursing#	2,179,000

#### Residential Care:

▪ Local Placements^	7,206,000
▪ Mainland Placements	153,000

Day Care^ 1,046,000

Interim Placement Unit 213,000  
(IPU)#

Long Stay Hospital# 793,000

*\* Includes Scottish Executive free personal care development funding and MHSG funding for care for people with dementia.*

*^ Resource transfer funding from NHS Shetland.*

*#NHS budget.*

### Unmet Needs

- There are on average between 25 and 30 people on the waiting list for residential care, most of whom are aged 65 or over.
- There are approximately 12 people on the waiting list for Care @ Home Services.
- All the care centres are operating at capacity and providing care for people with higher levels of need than in previous years.
- It is becoming increasingly difficult to recruit health and social care workers and this is affecting the provision of intensive care packages in people's own homes.

### Service Reviews

There have been a number of reviews completed in recent years:

- Review of Day Care Services
- Review of Social Work Service Provision by Social Work Taskforce
- Staffing & Dependency Levels in Care Homes in Shetland – Jan 2005.
- Review of Montfield Hospital service provision.

Further work in the following areas will be completed during the lifetime of this plan.

- Dementia redesign
- Continuing care criteria
- Protection of vulnerable adults
- Range and capacity review of long term care service provision
- Review of Shetland's Single Shared Assessment and Care Management procedures
- Day Hospital redesign

### Discharge Planning

There are growing concerns about the length of time it takes for older people to be discharged from hospital. These include:-

- the time taken for the provision of some specialist equipment and adaptations to property;
- limited availability of very sheltered housing
- failure to meet the increasing demand for long term care both at home and in residential care settings.

Shetland's Discharge Action Plan is wide-ranging and includes actions which combine to give a whole system approach to the challenges in this area. This combination of strategies should give the best performance in the long-term.<sup>9</sup>

The action plans for older people are incorporated in the Discharge Action Plan which is included below.

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<sup>9</sup> "Moving On? An overview of delayed discharges in Scotland" Audit Scotland, June 2005

Progress against the Discharge Action Plan in 2006-2007 has been disappointing. In 2005/2006, this part of the Joint Future business in Shetland was included in the work of the Joint Management Team for Older People's Services. In 2006-2007 the multi-agency Discharge Planning Group was reconstituted to ensure that work in this area is driven forward and given a higher priority, but progress continues to be slow. The target for Shetland is zero delayed discharges by April 2008. To ensure this issue is addressed, a short life strategic group comprising senior managers from both statutory agencies; NHS Health Board and Council representatives has been established.

#### **Further Reading**

- NHS Shetland 2020 Vision of Shetland's Healthcare
- Health Strategy for Older people
- Day Care Review
- Review of Staffing and Dependency Levels
- "Better Outcomes for Older People – Framework for joint Services" Scottish Executive may 2005
- "Moving On? An overview of delayed discharges in Scotland" Audit Scotland June 2005.

## Discharge Action Plan 2007-2008

**Target for April 2008 - 0**  
**Quarterly Targets**

<b>July 2007</b>	<b>0</b>	<b>October 2007</b>	<b>0</b>	<b>January 2008</b>	<b>0</b>	<b>April 2008</b>	<b>0</b>
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<b>INITIATIVE – brief description only</b>	<b>National Priorities and Objectives</b>	<b>Spend 07/08</b>	<b>Lead Responsibility</b>	<b>Who will Benefit and How</b>	<b>Impact of These Measures</b>	<b>Data Collected</b>	<b>Progress/ Key risks</b>
1. Capacity review of long term care options locally including residential care, supported accommodation (sheltered and very sheltered housing) and Care at Home. Specifically, of needs for long term care provision in the north isles following report completed on Isleshavn care centre in Yell.	B, C, E, H	£90K	Head of Community Care	Long term - projected increasing numbers of older people who need support will be maintained at home or in other community settings locally.	Low/zero delayed discharge level maintained. Number of emergency admissions reduced	No of people on waiting list for residential care.  Levels of need (IoRN)  No of people receiving augmented care packages in the community	Progress has been slow due to staff vacancies in 2006. Delays are increasing the pressure on existing resources both financial and human.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
2. Continuing development of the integrated continence service to help avoid hospital admission.	E, G	£38K Delayed Discharge funding.	Director of Nursing	Enhanced continence service for patients at home preventing hospital or residential care admission	Low/zero delayed discharge level maintained. Number of emergency admissions reduced	No of patients supported	Training has improved service delivery in many care settings and people's own homes. Key risk is capacity of service dependent on one specialist post.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
3. Continuing review of admission and discharge protocols to improve processes and information sharing	B, C, D, F, H	WER	Admission and Discharge Group	Improved patient experience on discharge from hospital. Provision of better information for patients and their carers at the point of discharge.	Low/Zero delayed discharge numbers maintained	No. of transfers offered and performance against 10/98 targets. No. of discharge exception reports and outcomes.	Data sharing systems are manual. Work on electronic data sharing is subject to the restrictions of the hardware. Key issues are resource limitations. Discharge processes have been improved with weekly meetings to discuss all patients in hospital who are ready for discharge or whose needs are currently being assessed.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
4. Dementia Services Redesign Project.	B, C, D, E, F, G, H	TBA	Director of Nursing	Expect people with dementia to benefit from more efficient, effective service provision.	Low/Zero delayed discharge numbers maintained	No of people with a diagnosis of dementia. Aggregate data from CareNap D No of people with dementia in specialist care settings	Project is substantially complete. Key risks are insufficient resources to implement recommendations
5. Implement recommendations from day care review.	B, C, D, E, F, G, H	WER	Older People's Management Team	Expect enhanced day care provision to increasingly support people with higher dependency needs enabling them to continue to live in their own homes.	No impact at this stage	Current use of day care services and levels of need. Waiting lists for day care services	Lack of political support for changes to day care criteria. Service is being targeted at those with higher levels of need as part of individual care plans.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
6. Continuing service developments at Montfield including review of day hospital service for younger adults with physical disabilities to better target resources	B, C, D, F, H	TBA	Director Clinical Services	Improved services for patients resulting in early discharge and reducing re-admission rates.	Low/zero delayed discharge numbers maintained	Admissions and discharges statistics.  Waiting list	Opposition to any change in day hospital provision No progress made in 06/07 due to lack of capacity to manage the project.
7. Review of needs for specialist care services for younger adults with physical disabilities (see also 6 above)	B, C, D, E, F, H	TBA	Physical Disability & Sensory Impairment Management Team	More appropriate service provision maintaining people at home or in other community settings.	Low/Zero delayed discharge numbers maintained	Admission and discharge statistics.  Waiting Lists.  Unmet need.	Sustainability of preferred models e.g. specialist supported accommodation. Lack of staff time to undertake review.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
8. Review the role of Montfield Hospital regarding palliative care admissions.	F, I	WER	Shetland Task Force on Cancer and Palliative Care	People in the last stages of life better supported and where possible supported to return home.	Reduce re-admission rates	Outcomes for palliative care cases. Numbers supported at home.	The services at Montfield continue to develop and closer working with colleagues in the community has enabled people to stay at home following an assessment and treatment in hospital. Risk is the continuing availability of sufficient resources to maintain flexible, responsive services both in the hospital and the community.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
<p>9. Review of Continuing Care Criteria and further review of Interim Placement Unit (IPU) in this context. The IPU was established in January 2005 to provide up to 10 places for patients ready for discharge who no longer need acute health care. Review completed in 06/07 resulted in expansion of IPU to 16 places.</p>	B, C, D, F, H	£30k	Director of Clinical Services	<p>Patients discharged to the IPU are cared for in a setting that will maximise their independence until substantive discharge arrangements are implemented. The review of continuing care criteria will give clarity regarding the continuing need for long term hospital care and the role of the IPU.</p>	Low/zero delayed discharge numbers maintained	<p>Turnover in IPU</p> <p>Budget provision and spend</p>	<p>Sustainability of the IPU in future years. Lack of sufficient community based long term care. The future of the IPU is dependent on the long term plans for hospital provision in Lerwick and the successful shift in the balance of care to the community.</p>

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
10. Continued implementation of action plan from agreed multi-agency Disability Strategy	B, C, D, E, F, G, H	WER	Joint Future Joint Management Team	People with disabilities where specialist disability services and therapies are an important part of discharge plans better supported on discharge.	Low/zero delayed discharge numbers	Admission and discharges statistics.  Waiting lists.	Many actions have been completed. Completion of outstanding items depends on being able to focus resources on areas of greatest need in an area where very high levels of service have been widely available.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
11. Pilot generic support worker and contracted relief worker proposals linked to the locality based Care at Home Service.	B,C,D,E,F,G,H	TBA	Community Health Partnership Management Team	Improved service for up to 250 people receiving personal and/or nursing care in the community.	Low/zero delayed discharge numbers maintained. Reduction in admissions to hospital and residential care.	No of people receiving care by number of hours received. Locality based information on care provision.	Work has started linked to the national project on generic health care workers. There are capacity issues in locality management model particularly in the rural areas; staff shortages in some areas and ICT capacity and poor electronic links to care centres are constraints on progress.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
12. Implementation of devolved responsibilities for care services to people at home supported by SSA procedures and training programme including staff from independent sector providers.	B, C, D, E, F, G, H	WER	Single Shared Assessment & Care Management Team	People waiting for discharge from hospital or needing changes in levels of care will have their needs met more quickly.	Earlier discharge from hospital. Reduction in admissions to hospital and residential care.	No of SSA completed by agency, role and locality. Budget allocation and spend by locality	Locality management is established. Difficulties with ICT systems continue to hinder progress in this area..
13. Review of Accident and Emergency (A&E) procedures with a view to reducing unplanned admissions to hospital.	E, F	WER	Admissions and Discharges Group	People receiving assessment/treatment in A & E supported to go home rather than admitted to hospital	Reduction in hospital admissions	No. of emergency admissions. Outcomes for patients in A & E.	Staff commitment to new ways of working. Lack of staff time to complete the review and implement changes based on the findings.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## Discharge Action Plan 2007-2008

INITIATIVE – brief description only	National Priorities and Objectives	Spend 07/08	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress/ Key risks
14. Review the outcomes from the Pilot Falls group run by OT and Physio services to inform future service developments	E	WER	Clinical Falls Prevention Group	People at risk of falling, supported to reduce risk	Reduction in hospital admissions	No. of emergency admissions due to falls.	Lack of funding in both OT and Physio services to develop pilot further. Transport difficulties.
15. Develop Joint OT Store and office base	B,C,D,E,F,H	£2.5M capital over 2 years	Head of Community Care	People with disabilities and mobility problems	More people maintained safely at home and discharged timeously from hospital	Waiting lists for equipment and adaptations.	Resistance to change and a more joined up approach. Lack of resources both financial and human to support the project.

**Total Delayed Discharge funding 07/08    £128K**

**WER = Within Existing Resources**

**TBA = To be Advised**

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

## **Shetland's Joint Future** Shetland Islands Council

### **Joint Older People's Services Management Team Terms of Reference**

#### **Purpose**

To manage all Older People's Services on behalf of both NHS Shetland and Shetland Islands Council within the Joint Future framework.

#### **Remit**

- To take a proactive approach to the management of older people's health and care services.
- To anticipate needs in the community and plan for changes in service provision to meet needs.
- To monitor existing service provision and ensure Best Value.
- To facilitate discussion at the Older People's Strategy Group.

#### **Membership**

Service Manager Community Care Resources, SIC (Chair)  
Director of Clinical Services  
CHP Lead Nurse, NHS Shetland  
Medical Director, NHS Shetland  
Consultant Physician, NHS Shetland  
Head of Community Care, SIC/NHS Shetland  
Service Manager Community Care Fieldwork, SIC

#### **Meetings**

The group will meet on a regular basis and at least quarterly.  
The group will discuss operational management issues and report to the Joint Future Joint Management Team (JFJMT).

The Agenda will cover the following:

- National developments
- Local developments: Action Plan and Progress
- Future needs and capacity
- Budgets / Resources
- Delayed Discharges.

All meetings will be minuted. The minutes will be reviewed by the JFJMT and available to the public under the provisions of the Freedom of Information (Scotland) Act 2002.

## **STRATEGIC PLANNING GROUP FOR OLDER PEOPLE**

### **REMIT**

The Strategic Planning Group for Older People will take an over view of all older peoples' services. Having produced an older peoples' health strategy, the group will oversee the implementation and continued development of the strategy. In the longer term, it will be used to support the implementation of national policy such as Delivering for Health, and local longer term planning such as the 2020 vision project.

The Group will have a multi agency approach and include representatives from the Health Board, Council services and the Voluntary Sector, assisted by service users and carers.

The Group will advise local service planners and providers on the subject of older peoples needs and service provision.

When fulfilling its responsibilities consideration will be given to:

- Relevant national policies;
- The findings of national monitoring;
- The findings of relevant needs assessment;
- Recommendation from the service, and from users and carers;
- Capacity within Older Peoples services;
- Making links to specialists services at a regional and national level;
- Agreeing joint spending plans;
- The variety of funding sources.

The Older Peoples Joint Management Team (OPJMT) will provide support to the Strategic Group. In return the Strategic Group for Older People will feed back its results to the management team and other relevant groups including the Physical Disabilities / Sensory Impairment Joint Management Team.

The Strategic Group will oversee those elements of the Extended Local Partnership Agreement (ELPA) relevant to older peoples' services through the Older Peoples Services Management Team and other relevant teams including the Discharge Planning Group and the Single Shared Assessment and Care Management Group.

The Strategic Group for Older People will promote good communication between all agencies working on older peoples service issues.

Agreed at the Strategic Group for Older People on 15<sup>TH</sup> February 2006.

# Dementia

Dementia is the name given to a group of illnesses that affect the normal working of the brain. These illnesses interfere with memory and the ability to think and reason. It is recognised that dementia has profound consequences for those affected and their families.

A review of staffing and dependency levels in Shetland's care centres was undertaken in 2004 and published in 2005. This showed that approximately 40% of older residents (aged 65 +) had a mental health problem assessed as medium or high. The vast majority of these would have dementia. There is a small number of adults with learning disabilities with early onset of dementia.

The numbers of people in Shetland with dementia are expected to increase as the population ages.

## Aims

- To support family and unpaid carers so that they can continue in their caring role.
- To ensure that people with dementia are cared for in settings appropriate for their individual assessed needs.

## Needs Assessment

Individual assessments of needs are carried out using Shetland's Single Shared Assessment Process. The

main assessment is supplemented by Care Nap D assessment for people with dementia. Carers who provide regular and substantial amounts of care are entitled to a carer's assessment.

## Services Available

- Viewforth House provides a secure environment for people with dementia. There are 16 permanent and 4 respite places; 10 day care places. Viewforth manages specialist support in the community for up to 35 clients.
- The Dementia Care Manager undertakes assessment and care management for the more complex cases and provides training, advice and information to staff and family carers.
- The Community Mental Health Team brings together the consultant psychiatrist, community psychiatric nursing service and mental health officer roles.
- Generic Service Provision – people with dementia whose physical frailty is the main presenting problem are more likely to receive care from the generic care services. These are listed below

### **Edward Thomason House, Lerwick**

- residential care for very frail older people
- 16 permanent places.

### **Taing House, Lerwick**

- 16 permanent residential places,
- 4 respite care places
- 12 day care places

### **Overtonlea, Levenwick**

- 13 permanent residential places,
- 2 respite care places
- 12 day care places.

### **Wastview, Walls**

- 13 permanent residential places,
- 2 respite care places
- 12 day care places.

### **North Haven, Brae**

- 13 permanent residential places,
- 2 respite care places
- 12 day care places.

### **Fernlea, Whalsay**

- 8 permanent residential places,
- 2 respite care places
- 8 day care places.

### **Isleshavn, Mid Yell**

- 7 permanent residential places,
- 3 respite care places
- 4 day care places.

*Day care at Isleshavn has had to be reduced in 2006/07 due to fire regulations and problems with the accommodation available for day care.*

### **Nordalea, Unst**

- 4 permanent residential places
- 2 respite care places
- 8 day care places

### **Walter and Joan Gray Home, Scalloway**

- 13 permanent residential places,
- 3 respite care places
- 10 day care places.

All the care centres are run by the Council with the exception of the Walter and Joan Gray Home in Scalloway, which is run by Crossreach.

Care services available to support people in their own homes include:

- Care at Home Services providing high levels of personal care and help with domestic tasks
- Crossroads Care Attendant Scheme
- Meals on Wheels
- Occupational Therapy
- Aids and adaptations
- Lunch Clubs
- Community Alarm

These services are available to people in all community care groups depending on an assessment of their needs.

There are a number of voluntary organisations, which provide activities and support to older people. These include:

- Advocacy Shetland
- Age Concern
- Red Cross
- Senior Citizens Clubs
- WRVS

## **Housing**

King Erik House, Lerwick  
– very sheltered housing, 16 flats

Sheltered housing  
– 34 schemes, across Shetland.

## **Expenditure**

Specialist dementia services:  
residential care, day care and care at  
home, including £565k Resource  
Transfer from NHS Shetland  
£1,300,000

Dementia Care Manager £41,112

Consultant psychiatric services £TBA

CPN services £TBA

## **Unmet Needs / Issues Identified**

The numbers of people with dementia are increasing as the population ages. There are currently 3 people on the waiting list for residential care for Viewforth. The respite and day care services are running at capacity.

There is no day care in the evenings or at weekends. This is increasing the pressure on the Care at Home Service, which is also running at capacity.

People are often not aware of the services available for people with dementia or the support available for carers.

It is difficult to move people on as their needs change, for example, from Viewforth House to Edward Thomason House in cases where the client has become very frail and their physical needs are more significant than their dementia. This blocks places in Viewforth and means the individual may not receive

the care most appropriate to their change in needs.

Action	Timescale	Cost	Lead
<b><i>To support family and unpaid carers to ensure that they can continue in their caring role</i></b>			
<ul style="list-style-type: none"> <li>Improve information available to the public using leaflets, internet</li> </ul>	On-going	WER	CHP, Social Care
<ul style="list-style-type: none"> <li>Develop training for carers</li> </ul>	On-going	WER	Training Managers Social Care and NHS
<ul style="list-style-type: none"> <li>Promote carers issues through events such as National Carers Week</li> </ul>	On-going	WER	CHP
<b><i>To ensure that people with dementia are cared for in settings appropriate for their individual assessed needs</i></b>			
<ul style="list-style-type: none"> <li>Complete Dementia Redesign project</li> </ul>	<ul style="list-style-type: none"> <li>Service Review complete by March 2007.</li> <li>Implementation of redesign 2007 – 2009</li> </ul>	£20k Delayed Discharge funding;	Nurse Director
<ul style="list-style-type: none"> <li>Complete feasibility study for Viewforth as part of the Long Term Care Review and taking the findings from the Dementia Redesign Project into account</li> </ul>	By December 2007	£90k for the Long Term Care Review	Head of Community Care

# Advocacy

Advocacy is about helping people to have a stronger voice and more control over their lives. It can be a group of people with a common cause getting together to have a stronger voice. It can be about one person needing the support of another person to have their voice heard.

Advocacy has two main themes:

- safeguarding individuals who are in a situation where they are vulnerable;
- speaking up for and with people who are not being heard, helping them to express their own views and make their own decisions.

## Aims

- To ensure any person in Shetland with care needs is aware of the role of independent advocacy and has access to independent advocacy services.
- To develop a range of high quality independent advocacy services in Shetland, which are sustainable in the long term.

## Needs and Needs Assessment

A comprehensive needs assessment was carried out jointly by NHS Shetland and the Council in 2001. Following a period of consultation, the following service needs were identified:

- generic advocacy for health and care service users;
- generic advocacy for (unpaid) carers;
- self-advocacy for people with learning disabilities;
- specialist advocacy for people with mental health problems;
- specialist advocacy for children and young people.

During 2006/07, the need for independent advocacy for a small number of people with hearing impairment has been identified.

The Mental Health (Care & Treatment) (Scotland) Act 2003 sets out specific requirements for the provision of independent advocacy for people with mental health problems who are subject to the provisions of the Act.

The numbers of people who have accessed independent advocacy services over the last few years have been small. However, Advocacy Shetland has provided a service for 68 clients between 1 April 2006 and 31 March 2007.

## Services Available

Advocacy Shetland

- Generic independent advocacy service for health and community care service users.
- Generic independent advocacy services for unpaid / family carers.
- Specialist advocacy for people with mental health problems.
- Advocacy for people who are homeless and general housing needs.

Services are commissioned from Advocacy Shetland under the

terms of a 3 year Service Level Agreement (SLA) which covers independent professional advocacy; collective advocacy and citizen advocacy; promotion of independent advocacy and training.

Advocacy Shetland is exploring options for providing further specialist strands, including independent advocacy using BSL for people with hearing impairment.

Children's Rights Service linked to Shetland Youth Information Services (SYIS) provides some advocacy services for children and young people.

The Special Needs Action Group (SNAG) provides collective advocacy for families of children and young people with learning disabilities.

Self-advocacy for children and young people is supported at the Anderson High School in Lerwick.

## Funding

Funding for 2007/08 is shown below and comprises £68,143 from the Council, and £27,030 from NHS Shetland.

These funding streams are expected to continue at the same level in future years.

### Client Group

▪ Health & community care service users	£19,832
▪ Carers	£15,000
▪ People with Mental Health problems	£41,341
▪ Housing and homelessness	£10,000

▪ Self-advocacy for adults with learning disabilities	£9,000
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<b>Total</b>	<b>£95,173</b>
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## Unmet Needs / Issues Identified

Advocacy Shetland has been the main provider of independent advocacy services in Shetland in recent years.

Unfortunately for most of 2005/2006, Advocacy Shetland have been without a manager and there was a high level of turnover on the management committee.

A new manager was appointed in the summer of 2006 and has spent the first six months in post making sure that systems are in place to ensure the stability and continuity of service provision.

Further work is needed to re-establish training and activities to promote independent advocacy across Shetland.

## Further Reading

- "Independent Advocacy – A Guide for Commissioners" Scottish Executive, Jan 2001
- Shetland's Joint Future Advocacy Development Plan 2004 – 2007.

Actions	Cost	Timescale	Responsibility
<b><i>To raise awareness of the role of independent advocacy and the services available</i></b>			
Undertake a range of promotional activities	WER	On-going	Advocacy Shetland
To promote advocacy via the Single Shared Assessment Process	WER	On-going	SSA and Care Management Team
To raise awareness of advocacy among all care staff through induction and on-going training activities	WER	On-going	Training Managers – Social Care and NHS Shetland
To provide reports on progress and future plans for stakeholders including the public	WER	Six monthly	Joint Future Joint Management Team; Advocacy Shetland
<b><i>To develop a range of high quality independent advocacy services</i></b>			
To evaluate current independent advocacy service provision, specifically services provided under the SLA with Advocacy Shetland	WER	By Sept 2007	Joint Future Joint Management Team
To review the needs assessment for advocacy services and prepare the next development plan for years 2007-2010	WER	By Dec 2007	Joint Future Joint Management Team; Advocacy Shetland
To establish an Advocacy Steering Group linked to the Joint Future management framework	WER	2007/08	Joint Future Joint Management Team

# HIV and AIDS

The treatment and care of people with Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) or other blood borne diseases, e.g. Hepatitis C virus (HCV), poses particular issues for agencies involved in caring for people in the community. In Shetland, the numbers of people with illness relating to these infections are small, and there may be concerns about confidentiality when people access services. However, services are provided on an individual basis, tailored to people's particular needs, and work such as the local Hepatitis C Strategy is helping to raise awareness of these conditions. Early diagnosis is important if people are to receive effective treatment, and prevention is particularly important.

## Aims

- To reduce the spread of HIV infection to a minimum, if not total eradication through prevention strategies and health promotion;
- To offer treatment and care as appropriate for people affected by HIV / AIDS related illness;
  - To ensure people with HIV / AIDS related illness are fully supported in maintaining an independent lifestyle for as long as possible;
  - To support families and carers of affected individuals.

## Assessment of Need

To date, in Scotland, over 4,000 people have been diagnosed as HIV positive. However, at March 2006, there were fewer than ten individuals known to be affected by HIV/AIDS in

Shetland. The number of Shetland HIV-infected residents has remained constant over the last few years. Over 50% have been infected through heterosexual intercourse with an affected individual.

## Services available

The annual AIDS (Control) Act Report,<sup>10</sup> prepared by Shetland Health Board, gives an outline of all HIV – related services.

All the main specialist services for both treatment and care are provided by mainland services, usually coordinated through an individual's GP. This includes combination or other therapies/drugs specific to HIV / AIDS.

A pool of health, social care and voluntary sector staff are trained in counselling individuals pre- and post-HIV testing. Referrals can also be made to services outwith Shetland for services such as counselling, if an individual so wishes.

Preventative activities are co-ordinated through Primary Care Teams and the Shetland Health Board's Public Health and Health Promotion Department. This includes activities for family planning/sexual health as well as education and training opportunities for front-line staff. Specific training is also provided via the local Further Education College.

Routine antenatal screening for HIV is offered to all pregnant women in the UK (and in Shetland) along with syphilis, rubella, and hepatitis B screening as an integral part of antenatal care. There is good evidence that the risk of vertical transmission from a known infected

<sup>10</sup> The AIDS (Control) Act Report, Shetland NHS Board

mother to her child can be significantly reduced with appropriate interventions for each of the four infections.

Vertical transmission (from mother to baby) of HIV can be prevented in most instances through appropriate obstetric management, which may include antiretroviral treatment of mother and child, elective caesarean section and the avoidance of breast-feeding.

## Funding

### 2005/2006 Health expenditure:

Prevention Activities	£55,000
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Expenditure relating to inpatient bed days and the cost of therapies/drugs specific to HIV/AIDS is not given due to the fact that these costs are not separated out from general budgets and where mainland services are used, care is provided within a mainstream service contract.

## Unmet Needs

All patients who require treatment are referred to the specialist services in Aberdeen. No unmet treatment needs as such have been identified.

Continued work is necessary to improve awareness of the issues of HIV/AIDS and other blood borne diseases throughout the community, including extending the provision of advice and educational support to staff in schools, further/higher education, workplaces and other venues.

A piece of local research currently ongoing is looking specifically at the ethical issues and the effect which knowledge of their own hepatitis C status has on intravenous drug users in Shetland. It is hoped that the findings will offer an insight into the

specific issues faced by individuals locally; towards informing better planning and service provision; and identification of potential needs, which may be currently unmet.

## Service Reviews

As a result of the implementation of the Hepatitis C Strategy for Shetland (2006), a local Action Plan makes recommendations for the care of patients with a positive diagnosis for HCV. A review of the provision of services for individuals requiring care of this nature is currently happening as part of that action plan. It is envisaged that this Strategy will form the basis for an overarching Bloodborne Virus (BBV) Strategy for Shetland, encompassing HIV/AIDS and Hepatitis B.

## Further Reading

NHS Shetland, 2006, HIV/AIDS Control Act Report, NHS Shetland

NHS Shetland, 2006, A Strategy for Hepatitis C in Shetland, NHS Shetland

<b>ACTION</b>	<b>EXPECTED OUTCOME</b>	<b>TIMING</b>	<b>COST</b>	<b>AGENCIES INVOLVED</b>
<b>BETTER AND QUICKER DECISION-MAKING &amp; ASSURING QUALITY AND EFFECTIVENESS</b>				
Implementation of Hepatitis C Strategy for Shetland	Improved seamless service		WER	<b>Health Board (public health)</b> , Social Care, voluntary sector
<b>CARING FOR PEOPLE AT HOME</b>				
Monitor incidence of Hepatitis infection	Improved infection control	Ongoing	WER	<b>Health Board (public health)</b> Social Care, Crossreach
<b>WORKING TOGETHER LOCALLY</b>				
Extend provision of advice/ educational material	Staff better informed with up-to-date knowledge	Ongoing	WER	<b>Health (health promotion)</b> Education & Social Care

# Head Injury

A head injury can occur at any time and the resultant consequences may be life-long. People with a serious head injury can have multiple problems: physical, mental, emotional, behavioural, social and economic. This has implications for both service provision and the planning of appropriate resources.

It is estimated (using national rates) that there are 35 – 50 people with lasting effects following a head injury in Shetland.<sup>1</sup>

It is difficult to predict the future for numbers of people suffering from the effects of head injury: accident prevention work should reduce the number of head injuries suffered (in road traffic accidents and injuries at work), but modern intensive care services might mean more people survive severe injuries, albeit with disabilities.

## Aims

The key objectives for people with a head injury are:

- to assess individuals' needs for services in partnership with the individual and their families or carers;
- to ensure individuals have access to the full range of services required for their assessed health and social needs;
  - to work with employers in Shetland to enable people to continue in work;
- to provide services in an integrated way across health

and social care, working with other agencies and community organisations as appropriate;

- to promote independence and self-managed care programmes.

## Assessment of Need

Recuperation from traumatic brain injury can take a long time, it may take 5 years from injury before the social and medical consequences are fully known, though it may result in complete recovery.

The needs arising from head injury are wide ranging:

- physical disabilities may include walking difficulties, poor co-ordination, incontinence, speech and other sensory impairment;
- memory problems, or exceptionally more severe mental health related issues, may develop as a result of head injury;
- social isolation, unemployment and marital breakdown may occur;
- families of individuals with head injury may be subjected to particular strain, often due to a lack of support mechanisms and of information on prognosis.

In the past ten years, there have been few patients requiring long-term NHS support as a result of a head injury, although this can change at any time. Individual packages of care are developed where necessary for individuals with more severe injury.

### Services Available

There are no specific services dedicated to head injury in Shetland. Dedicated intensive acute care, rehabilitation and specialist long stay care for those affected by head injury are located outwith Shetland.

The medical ward in the Gilbert Bain Hospital provides short to medium rehabilitative care for some individuals under the supervision of the local consultants with active therapy services and specialist nursing care, but is not a specialist head injuries unit. Links with specialist services outwith Shetland ensure that individuals with head injury receive appropriate support as required.

Support from primary care staff (GPs and district nurses) and allied health professions (e.g. speech & language therapists, physiotherapy and occupational therapy staff) is available in accordance with assessed need.

There are a range of general services aimed at people with disabilities which might be used by people with head injury including:

- Disability Shetland: a voluntary organisation that aims to provide a variety of services and support for people with disabilities;
- Moving On Project: a voluntary organisation offering a confidential service to anyone with a disability who wants to find work, or take part in work experience;
- A development officer for people with disabilities within the Community Development service

- Support for carers via Shetland's Carer's Strategy.

### Funding

Services are provided in response to specific needs on an individual basis, and there is therefore no specific budgetary allocation within Social Care or Shetland NHS Board for people with head injury.

Any expenditure incurred varies from one individual to another and is dependent on the nature of the head injury, the short- and long-term effects and assessed health and social care needs.

It is difficult to calculate the cost to the individual and society of a head injury. It is not possible, and indeed may not be helpful, to try to identify specific health and social care expenditure in relation to the care of individuals with head injury.

### Unmet Needs / Issues

Unmet needs identified as part of the local Disabilities Strategy, that are particularly relevant to head injury services are:

- Overall coordination of services for people with a head injury & access to specialised services including long term care if necessary;
- lack of a visiting neurology service
- this is now partially met by local clinics run by a local physician with a special interest working closely with the Grampian neurology service;

- access to general services
- being tackled through work on diversity and equality;
- wheelchair services – need for a responsive, reliable, locally delivered service
- the visiting contract for wheelchairs is being reviewed;
- lack of awareness of the needs of people suffering from the effects of head injury
- being met through training of a range of staff within the different services on disability awareness;
- and implementing Protecting Vulnerable Adults guidance and procedures.

### Further Reading

- <sup>1</sup> SNAP. *Huntington's Disease, acquired brain injury and early onset dementia*. Office for Public Health in Scotland, Glasgow. 2000
- NHS Shetland 2020 Vision of Shetland's Healthcare

### Service Reviews

A number of pieces of work currently underway or planned, will have a bearing on the development of services for people suffering from the effects of head injury, including:

- Protection of vulnerable adults
- Range and capacity review of long term care service provision
- Review of Shetland's Single Shared Assessment and Care Management procedures
- The development of a local head injury protocol (on the immediate treatment of head injuries) to ensure services are delivered in line with national guidance.

## Shetland's Joint Future

### Section 6:

## Joint Governance and Accountability

### 1. Definitions

- “The Agreement”  
or  
“ELPA” means the Extended Local Partnership Agreement.  
*These terms are used inter-changeably in this context.*
- “The Council”  
or  
“SIC” means Shetland Islands Council  
*These terms are used inter-changeably in this context.*
- “The Partners”  
or  
“Partner Agencies” means Shetland Islands Council and  
Shetland NHS Board  
*These terms are used inter-changeably in this context.*
- “NHS Shetland” Means Shetland NHS Board in this context.

### 2. Agreement Period

The agreement shall run from 1 April 2007 to 31 March 2010.

### 3. Joint Accountability Arrangements

- 3.1 Joint management and accountability is vested in the Joint Future Joint Management Team (JFJMT) and the Joint Future functional management model. The Terms of Reference of the JFJMT is included in this Agreement.
- 3.2 The level of authority vested in JFJMT is equivalent to the level of authority vested in the individual members of the team.
- 3.3 Decisions which require a level of authority outwith that held by the individual members of the Joint Future management arrangements shall be referred to either or both partner agencies as appropriate.

## Shetland's Joint Future

3.4 The standing orders, financial regulations and policies of each partner agency apply to all contributions made by each partner to Joint Future agreements locally. That is to say Joint Future management arrangements do not replace or usurp the authority of either Shetland NHS Board or Shetland Islands Council.

### 4. **Changes to the Agreement**

The Agreement may only be changed or supplemented with the unanimous written approval of the Partner Agencies.

### 5. **Liability**

Each Partner shall remain separately responsible for resources, including staff and any contracts entered into by that Partner. The responsibility of each Partner shall be made explicit in any Joint contractual arrangements.

### 6. **Complaints**

All complaints in respect of services covered by the Agreement and Joint Future management arrangements shall be dealt with by the appropriate Partner depending on which Partner is responsible for that element of service provision in terms of finance and employer's liability. The framework for handling complaints will be included as part of the Agreement.

### 7. **Resolution of Disputes**

7.1 Each of the Partners shall use all reasonable endeavours to achieve an amicable and timely resolution of any difference or dispute between the partners in respect of the Agreement.

7.2 In the event that a difference or dispute between the Partners cannot be resolved, such dispute may be referred by the Partners to a mutually agreed arbiter. Any such dispute will be reported to the Joint Future Unit of the Scottish Executive.

## Shetland's Joint Future

### Section 7:

### Joint Performance Management Framework

Each person in the community who needs Joint Future services is entitled to:-

- information about Joint Future Services;
- easy access to staff;
- a courteous, helpful and swift response to enquiries;
- equality of opportunity;
- help to protect them from risk but still enable them to live as full a life as possible;
- the right to see written records kept about them, subject to legislation;
- confidentiality at all times, subject to legislation;
- a say in what they think about the services provided;
- be made aware of the performance standards required of each service and make representation about standards of service;
- access to complaints procedures;
- a community care assessment in their own right;
- full participation in planning what help is offered;
- personalised high quality care;
- be represented or accompanied by someone of their own choice when discussing care services;
- access to an independent advocacy service.

#### Joint Performance Assessment and Information Framework (JPIAF)

Progress made in implementing the Joint Future agenda is monitored and reported annually to the Scottish Executive through the Joint Performance and Information Assessment Framework.

Shetland's Final Evaluation Statement for 2005-2006 was issued by the Scottish Executive on 13 October 2006. Overall, the Scottish Executive reports that Shetland's Joint Future partners are making "good progress" towards meeting the JPIAF indicator requirements with performance in some areas above average. A recent circular issued by the Scottish Executive reports that, "*The national picture shows that about one third of partnerships demonstrated good progress in joint working. More than half of partnerships are now making steady progress and only a small number were evaluated as improvement required.*"<sup>11</sup>

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<sup>11</sup> Circular No CCD2/2007, Scottish Executive Health Department, 14 February 2007

## Shetland's Joint Future

Shetland Islands Council

The final evaluation for 2005/06 against each of the four indicators in the JPIAF framework is shown in the table below.

JPIAF Indicator	Number	Evaluation
Whole systems performance A) Comparative model B) Holistic approach	JPIAF 10 - -	above average good progress
Local improvement targets A) Progress for 2005/06 B) New targets for 2006/07	JPIAF 11 - -	Falling short of your targets Require technical/ substantive development
Single Shared Assessment	JPIAF 6	steady progress
Cross agency access to resources	JPIAF 8	steady progress

### National Outcomes Project

The performance-monitoring framework for Joint Future is changing to focus more on outcomes rather than process. A National Outcomes Project has been commissioned by the Scottish Executive and is working towards a performance framework for all community care client groups comprising national outcome targets based on the visions in Delivering for Health, Changing Lives (the report of the 21<sup>st</sup> Century Social Work Review) and Joint Future.

It is envisaged that Local Improvement Targets will continue to be required as part of the new outcomes reporting model which will be introduced during 2007/08.

CoSLA, NHS Scotland and the Scottish Executive have been collaborating on the development of a new national performance management framework for community care. The focus is on outcomes and the new framework will be implemented during 2007/08 and will replace the Joint Performance and Information Assessment Framework (JPIAF) over time.

The objectives of the national outcomes approach are to:

- focus on the benefits for service users and carers;
- drive performance in community care;
- re-focus on partnership working;
- ensure joint responsibilities of service delivery; and

## Shetland's Joint Future

- clarify reporting both locally and nationally.<sup>12</sup>

There are four national outcomes:

- improved health;
- improved well-being;
- improved social inclusion; and
- improved independence and responsibility.

They correspond to the enduring vision for community care services locally and national priorities. A number of performance measures with targets are being developed. The first to be implemented in 2007/08 are those retained from JPIAF and some existing HEAT targets.

Local partnerships are expected to retain Local Improvement Targets (LITs) to support the national outcomes framework.

### Local Improvement Targets (LITs)

The LITs correspond to the national priorities set previously by the Scottish Executive. They are set out in the table below and show performance for the period from 1 April 2006 to 31 March 2007. The LITs include many of the targets for response times from referral to assessment, service provision and review included in Shetland's Single Shared Assessment (SSA) procedures. These are listed at the end of the table for ease of reference.

Performance against the LITs will be reported quarterly to the Senior Management Team of NHS Shetland and the Education and Social Care Management Team and to the Council, the Community Health Partnership and the Community Planning Board every 6 months. Reports will include updates on the implementation of the national outcomes framework.

### Unscheduled Care Collaborative

The Minister for Health and Community Care announced in August 2004 the change programme for unscheduled care. The aim of the programme is to improve patient and carer experience and satisfaction through improving access and reducing waits and delays across unscheduled care patient flows.

The 3-year programme has been developed to support health board areas to adopt a system-wide approach to change, engaging partners throughout the acute, primary and community care and the voluntary sector, to redesign unscheduled care processes and systems across the total patient journey that can look where possible to reduce the number of hospital attendances and admissions.

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<sup>12</sup> Letter from SEHD Directorate of Primary Care and Community Care Partnership Improvement and Outcomes Division, 4 April 2007.

## **Shetland's Joint Future**

The UCC Programme is being taken forward locally through the Community Health Partnership and has close links with the work on the Joint Future Agenda.

### **Scottish Health Council**

The Scottish Health Council's role is to ensure that people's views are valued and have influence both in their personal relationship with the NHS and as members of communities affected by changes to local health services. The Scottish Health Council will ensure that each Community Health Partnership operates its Public Partnership Fora effectively and in accordance with standards developed by the Scottish Health Council.

The Scottish Health Council has a local office and a local officer to support this work. Further information on the Scottish Health Council can be found at: [www.scottishhealthcouncil.org](http://www.scottishhealthcouncil.org)

### **Inspections**

The inspection regimes of the Care Commission, QIS, the Social Work Inspection Agency and Audit Scotland also contribute to the performance management framework for Joint Future services and recommendations from these agencies are reflected in the action plans as appropriate.

## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Targets	Improvement	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
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1. Supporting more people at home as an alternative to residential and nursing care	<ul style="list-style-type: none"> <li>Intensive home care – increasing the number of people over 65 receiving homecare of over 10 hours per week <b>Local target – 30% of all people receiving long-term care</b></li> <li>Equipment and adaptation services – reduction of number on waiting lists <b>Local target - reduce by 20%</b></li> </ul>	<p><b>32%</b> (Amended Outcome – Baseline at 31 March 2006)</p> <p><b>74</b> over 65's receiving Intensive Home Care of <b>220</b> receiving long-term care.</p> <p><b>111</b> clients on waiting list, reduce to <b>89</b>.</p>	<p>Monthly reports</p> <p>Monthly monitoring reports</p>	<p>Monthly monitoring reports</p>	<p><b>82</b> clients over age 65 receive Intensive Home Care.</p> <p>A further 109 (residential) + 28 (waiting list) = <b>137</b> receiving long-term care (at 31 Mar 07), <b>82/219 = 37%</b> <b>Target met</b></p> <p><b>116 @ 31 Mar 07*<sup>1</sup></b> Increase of 4.5% <b>Target not met</b></p>
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\*<sup>1</sup> During the last 12 months the Waiting List has fluctuated between 95 and 191.

## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Targets	Improvement	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
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<p>2. Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent in hospital and enabling supported and faster discharge from hospital</p>	<ul style="list-style-type: none"> <li>Reducing inappropriate emergency admissions of over 65+ to hospital <b>Local target - to reduce total number by 5%</b></li> <li>Reducing delayed discharges over 6 weeks. <i>Please note that this is a national target agreed with the Scottish Executive</i> <b>Local target- to maintain current position</b></li> </ul>	<p>Total number of people over 65 with 3 or more emergency admissions (1/4/03-31/3/04)= <b>43</b></p> <p>0</p>	<p>Monthly monitoring reports</p> <p>Monthly monitoring reports</p>	<p><b>53</b> in April 2006 <b>Target not met</b></p> <p><b>1</b> in February 2007 <b>Target not met</b></p>
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## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Targets	Improvement	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
	<ul style="list-style-type: none"> <li>Rapid Response Service increasing number of clients, number of admissions prevented and number of discharges speeded up</li> </ul> <p>Local target – increase no's receiving rapid response service by 10%</p>		<p>Covering the period 1/4/03 to 31/3/04, there were 11 referrals. Of these, 4 were from the community and 7 were from the hospital. 4 admissions to hospital were avoided and 7 early discharges were achieved.</p>	<p>Monthly monitoring reports</p>	<p>Figures not available.</p>	

## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Targets	Improvement	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
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<p>3. Ensuring people receive an improved quality of care through faster access to services and better quality services</p> <p>Local targets in calendar days are:</p> <ul style="list-style-type: none"> <li>From referral to initial contact 1 day</li> <li>From referral to completion of assessment 20 days (10 days for simple assessments)</li> <li>From referral to service provision 21 days</li> </ul>	<ul style="list-style-type: none"> <li>Improvements in waiting time for assessments to be started <b>Local target – meet target 75%</b></li> <li>Improvements in time taken for assessments to be completed <b>Local target – meet target 65%</b></li> <li>Improvements in time taken for the first part of a care package to be delivered <b>Local target – meet target 55%</b></li> <li>Increasing number of carers' assessments <b>Local target – increase by 10%</b></li> </ul>	<p>Time taken between referral and initial contact during the period 1/4/03 – 31/3/04, 638 targets met out of 934 = <b>68%</b></p> <p>Time taken between referral and completion of assessment during the period 1/4/03 – 31/3/04, 461 targets met out of 934 = <b>49%</b></p> <p>Time taken between referral and provision of service during the period 1/4/03 – 31/3/04, 402 targets met out of 934 = <b>43%</b></p> <p>Number of carers' assessments recorded during the period 1/4/03 – 31/3/04 = <b>0</b></p>	<p>Monthly monitoring reports</p> <p>Monthly monitoring reports</p> <p>Monthly monitoring reports</p> <p>Monthly monitoring reports</p>	<p>129 of 366, <b>35%</b> (in 6 months to Mar 07) Decrease of 33%*<sup>2</sup> <b>Target not met</b></p>
				<p>190 of 366, <b>52%</b> Increase of 3%*<sup>3</sup> <b>Target not met</b></p>
				<p>9 of 49, <b>18%</b> (based on 3-month period Oct – Dec 06) <b>Target not met</b></p>
				<p><b>30</b> assessments (in reporting period) <b>Target met</b></p>

## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Targets	Improvement	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
		<ul style="list-style-type: none"> <li>Increase number of self-assessments <b>Local target – increase to 5 by 31/3/05</b></li> <li>User/carer satisfaction with Single Shared Assessment <b>Local target – 25% response to Q'aire &amp; 95% satisfaction</b></li> <li>Increase nos of SSA undertaken by community nurses and other health professionals <b>Local target – increase proportion of all SSAs to 10% by 31/3/05</b></li> </ul>	<p>0</p> <p>N/A</p> <p>0</p>		<p>Monthly monitoring reports</p> <p>SSA standard questionnaires and any complaints</p> <p>Monthly monitoring reports</p>	<p><b>1</b> Increase of 1 <b>Target not met</b></p> <p>N/A *4</p> <p>4 of 366 completed <b>Decrease to 1% *5</b> <b>Target not met</b></p>

These figures are greatly affected by the current increase on the OT Waiting List.

Targets within the Community Care Team average at the following figures for the past 6 months;  
\*2 for 'referral to initial contact' 58% met and;

## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Improvement Targets	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
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\*<sup>3</sup> for 'referral to assessment completion' 81% met

\*<sup>4</sup> Questionnaire format agreed and to be sent to service users in July / August.

\*<sup>5</sup> Under reporting, some work required to identify and record work done outwith Social Care.

## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Improvement Targets	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
<p>4. Better involvement and support of carers</p>	<ul style="list-style-type: none"> <li>Increase in people receiving short breaks <b>Local target – increase by 2%</b></li> </ul>	<p>During the period 1/4/03 – 31/3/04;</p> <p><b>RESPIRE CARE</b>  <u>Over 65's</u>  Residential respite (where client has carer) = <b>5,868</b> residential nights per year;</p> <p><u>18 – 64's</u>  Residential respite (where client has carer) = <b>1,305</b> residential nights per yr;</p> <p><b>Under 18's</b>  Residential respite = <b>687</b> nights per yr;</p> <p>Shared care = <b>155</b> nights.</p> <p><b>TEMPORARY CARE</b>  <b>Over 65's</b>  832 nights per yr  <u>18 – 64's</u>  302 nights per yr</p>	<p>Six monthly (from monthly monitoring reports)</p> <p><i>Note - Decrease of respite / temporary care by 4% across all age groups (Mar 07) owing to respite beds being used for permanent residents.</i></p>	<p>No's already very high</p> <p>2,436 (for 6 months)  <b>17% decrease</b>  <b>Target not met</b></p> <p>613 (for 6 months)  <b>6% decrease</b>  <b>Target not met</b></p> <p>Laburnum–183 (6 months)  <b>33% decrease</b>  <b>Target not met</b></p> <p>Hame fae Hame – 50 nights (6 months)  <b>35% decrease</b>  <b>Target not met</b></p> <p>843 nights (for 6 months)  <b>103% increase</b>  236 nights (for 6 months)  <b>56% increase</b></p>	<p>ELPA &amp; Community Care Plans 2007 – 2010</p>



## Shetland's Joint Future

### National Outcomes and Local Improvement Targets for 2006-2007

National Outcome	Local Improvement Targets	Baseline 31 March 06	How LIT will be measured	Progress	Action Required
	<ul style="list-style-type: none"> <li>Increase in no's accessing training opportunities</li> </ul> <p><b>Local target – increase to 20</b></p>	N/A			

## Shetland's Joint Future

### Targets included in SSA

- Day 1:* Emergency provision  
Screening completed  
Cases with no further action required completed  
Cases to be referred to other agencies completed  
Allocation of all other cases to worker assigned to the case.
- Day 2:* Client/referrer notified of outcome of screening.
- Day 3:* (working days) Review of emergency provision.
- Day 20:* Needs assessment completed including any specialist assessment(s)  
User agreement of needs and care plan.
- Day 21:* Implementation of care plan.

#### *Hospital Discharges*

- 6 weeks from date patient is declared fit for discharge

#### *Targets for Reviews*

- 4 weeks following discharge from hospital
- 6 weeks following admission to residential care
- 6 months from completion of the assessment

Performance against these targets is made available monthly to managers.

### Joint Future Service Developments

Performance against Joint Future targets for service development is monitored six weekly by JFJMT using the Joint Future Action Plans and reported to the Council and Shetland NHS Board.

## Shetland's Joint Future

### COMPLAINTS

A complaint is 'an expression of dissatisfaction requiring a response.' Complaints about Joint Future services are currently co-ordinated and resolved by the lead agency about whom the complaint is made. However a service user may initiate a complaint via either agency and the Council and NHS Shetland will work closely together to resolve any complaint where a joint response is appropriate.

The following key principles are adhered to during the resolution of complaints:-

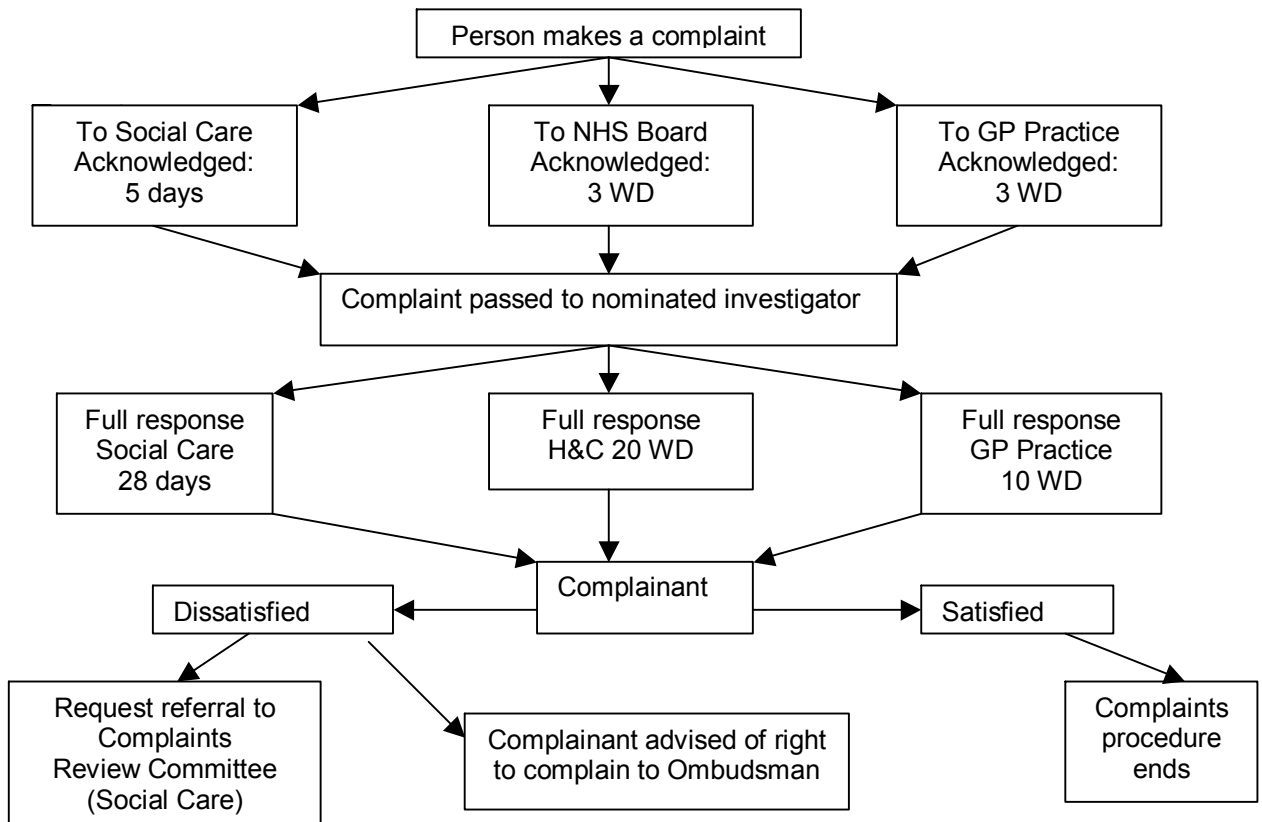
- there should be ease of access for anyone wishing to make a complaint and information available about all stages of the procedure.
- complaints should be given full and fair consideration.
- complaints should be:
  - investigated thoroughly
  - responded to honestly and objectively
  - resolved as quickly as possible
  - resolved as close to the point of delivery as possible
  - scrupulously fair to both the complainant and staff
- a complaint response should:
  - address the concerns expressed by the complainant and show that each element has been fully and fairly investigated
  - include an apology where things have gone wrong
  - report the action taken to prevent a recurrence
- a person will not be discriminated against if they choose to make a formal complaint

The timescales and a flow chart outlining the process are included below.

## TIMESCALES

	NHS		
	Social Care	Primary Care	Hospital and Community Services
Time limits for initiating complaint		6 months from event, or 6 months from becoming aware of a cause for complaint, but no longer than 12 months from event	
Acknowledgement of formal complaint	5 days	3 working days	
Full response	28 days	10 working days	20 working days
Complainant requests referral to Complaints Review Committee (Social Care)	28 days		
Complainant can refer complaint to Ombudsman			

**COMPLAINTS PROCEDURE**



## Shetland's Joint Future

### Section 8:

### Human Resources

The Joint Future Joint Staff Forum has been established in line with Scottish Executive Guidance to ensure that joint management (including the potential for single managers of service), joint resourcing (aligned or pooled budgets) and joint training and organisational development can be delivered. The Joint Staff Forum meets quarterly or more frequently as required to support work in hand.

#### STATEMENT OF INTENT

The partner agencies commit to providing better and more responsive public services using the 5 guiding principles of staff governance: a system of corporate accountability for the fair and effective management of all staff namely that staff are:

1. Well informed
  - a. all staff regularly receive information about their organisation
  - b. all staff have access to communication channels and the opportunity to give feedback on organisational issues at all levels
2. Appropriately trained
  - a. All staff have equity of access to training, irrespective of working arrangements or profession
  - b. Resources including time and funding are allocated to meet local training and development needs
3. Involved in decisions which affect them
  - a. Redesign, service development and organisational change are planned in partnership
  - b. Staff have the opportunity to be involved in planning and development decisions that affect them
4. Treated fairly and consistently
  - a. Pay and terms and conditions are applied fairly and equitably in accordance with job evaluation policies national and local agreements
  - b. Best practice HR policies are in place and communicated to staff
5. Provided with an improved and safe and healthy working environment
  - a. Premises are fit for purpose, and the personal safety of staff, clients, customers and patients are paramount in service design and operation
  - b. National occupational health and safety strategies are implemented

## Shetland's Joint Future

The partner agencies commit to supporting staff as fully as possible and to developing good joint human resources policies, in line with the recommendations of the Integrated Human Resources Working Group whilst understanding and recognising local needs. Staff are consistently reassured that joint working will not result in any detriment to their current terms and conditions of employment.

For each Joint Future service development the lead officer will address the following questions:-

1. What is required?
2. Who are the staff involved?
3. What are the benefits/potential risks of action or inaction?

This work is promoted through the Joint Future management framework and the Joint Staff Forum, involving others as appropriate.

The agreed joint approach is underpinned by open, honest and transparent communication with all stakeholders.

The partner agencies also commit to the following underpinning principles:

1. High quality services, delivered by a well-trained and motivated workforce with security of employment. Training and development opportunities will be provided jointly, wherever possible, for all employees.
2. Equality as a core concept underpinning both service delivery and employment relations. There will be equal opportunity in employment, the removal of all discrimination and promotion of equality and diversity.
3. A flexible approach to providing services to the local community while meeting the needs of employees and employers as partners in the provision of public services.
4. Stable employment relations; negotiation and consultation between employers, and trade unions.
5. To manage change working in partnership with staff.

A key tool in the delivery of a joined up approach to staff development is the Joint Organisational Development and Training Plan, which is reviewed annually.



**Shetland's Joint Future**

Shetland Islands Council

# **JOINT FUTURE STAFF DEVELOPMENT NEEDS**

***Shetland NHS Board***

***Shetland Islands Council  
Social Care Service***

**2007-08**

## **JOINT TRAINING 2007-08**

The training needs identified as part of the Joint Future Local Partnership Agreement pulls together the joint needs of staff employed in the partner agencies. Wherever possible, this training is developed and delivered jointly making the most of shared expertise and resources.

It has enabled the agencies that have staff training needs outside those identified through Joint Future (e.g. Looked After Children, Criminal Justice, Extended Independent Nurse Prescribing) to take account of those elsewhere in organisational strategic planning. Some training is generic, and has been identified as such.

As funding for training is currently held and managed within each agency, the funding agency has been identified in the plan, and other agencies will be recharged as and when appropriate.

The differing mechanisms for identifying training needs (some based on establishments, others specific to an individual) together with differing times for budgeting information to be confirmed, mean that this plan is inevitably representative of training needs and provisional rather than prescriptive, and organisations have to be flexible to respond to changing service and client needs. The training and development needs are consistent with the Joint Community Care Plan 2007-10, which is incorporated into the Local Partnership Agreement.

The following Training Needs Analysis for Shetland Islands Council and Shetland NHS Board indicate the sessions that are being led by each of these organisations and delivered jointly. This is shown under 'facilitation' as NHS/SIC. These needs have been identified systematically through the staff review sessions in place in each organisation.

## Qualifying Training

The registration of social care staff has major implications for the provision of qualifying training and appropriate Continuing Professional Development (CPD).

Provision has been made for eight staff (one Fast Track) to undertake DipSW / BA Social Work; one to qualify as a Mental Health Officer; and one to do the Practice Teachers Award.

Vocational (SVQ) training will include the following:

Registered Manager Award	2
SVQ Level 4 (for seniors)	14
SVQ Level 2/3 Care	60
HNC in Child Care	12

Shetland College will be providing underpinning knowledge and Quality Assurance. The groups receiving underpinning knowledge at the college will include staff from SIC and NHS providing care to a range of client groups.

## Generic Training

Generic training has been identified as training that would be relevant to staff regardless of the client group with whom they work.

SIC + NHS 07/08

Child Protection  
Autism Awareness  
Food Hygiene  
RoSPA Refresher  
Moving and Assisting  
Sexual Health  
Emergency First Aid at Work  
Health & Safety  
IOSH  
NEBOSH  
Effective Relationships  
Equality & Diversity  
Race & Equity Issues for Mgrs.  
I.T.  
Care Plans  
Fire Awareness  
Challenging Behaviour  
Medication  
Policies & Procedures  
Infection Control  
Driving in bad weather  
Continence  
Leadership Development  
Media Awareness  
Time Management  
Project Planning  
Intro to Supervisory Skills  
Developing Supervision  
Recruitment, Selection, Interviewing Skills  
Appraisal Training  
Personal Development Planning

Training will be offered across the Joint Future partners unless the nature of the event will dictate that it is restricted to one team or establishment (e.g. Team Development / Fire Awareness)

Some of the training will be delivered by outside trainers, and some by staff from SIC /NHS

## Older People's Services

There are a range of older people's services provided within Shetland. They are designed to ensure that there is appropriate care for older people in all settings and that older people can enjoy a high quality of life which meets their needs, choices and rights.

The services provided include the following:

- Wide range of personal care, and household tasks in people's own homes.
- Residential, respite, and day care facilities.
- Supported accommodation and housing support.
- Community support services, including community nursing teams and general practice, Aids & Adaptations Service, Occupational Therapy, and specialist services such as palliative care and dementia.
- General medical, surgical and rehabilitation treatment in hospital.
- Short stay admissions and intermediate care with rehabilitation, including assessment, treatment, evaluation, and effective discharge of patients with appropriate care packages into the community.

Ensuring that all staff are trained, developed and supported to enable them to meet the relevant clinical and care standards is a priority.

Training needs will be met by a variety of methods which include on the job training, comprehensive induction programmes, self study packages, interactive learning, using information technology, vocational based training and FE/HE education qualifications.

Training specific to Older People's Services will include:

Care at Home 5½-day induction for staff involved in personal care  
Care at Home 3½-day induction for staff involved in domestic care

### SVQ 2/3/4 Care

A wide range of generic courses will also apply and the following will be of particular relevance:

RoSPA Moving and Assisting, Single Shared Assessment & Care Management, Care Management, Drug Awareness, First Aid, Counselling Skills, Team Development, Supervision, Driver Development, Fire Awareness, Sensory Impairment, Medication, Infection Control, Food Hygiene, Vulnerable Adults, Nutrition.

## **LEARNING DISABILITIES (CHILDREN AND ADULTS)**

### **Children Services include**

Day care, short break respite at Laburnum House, short break respite with foster carers in the "Hame Fae Hame" scheme. Laburnum also offer an outreach service to promote social inclusion.

Staff need to develop their skills in working with service users who have complex needs and specific conditions.

Training specific to Learning Disabilities would include Autism Awareness; generic training including Sexuality Awareness, CALM training, Challenging Behaviour, First Aid and Medication Procedures.

The Learning Disabilities nurse provides training for staff and foster carers as and when required, and support and guidance to care staff and foster carers as to the needs of specific service users.

### **Adult Services include**

Day Care at Eric Gray Resource Centre, short break and permanent accommodation at Craigielea, group tenancies supported by ILP and outreach services from Craigielea and ILP.

Future developments will have training implications. These include the appointment of a Local Area Coordinator, the opening of care and cluster properties supported by ILP at Rudda Park, the opening of new Craigielea and Seaview for short breaks and permanent accommodation, the transfer of older ILP properties into new build units and the opening of core and cluster at Quoys (phase 1 & 2) and the redesign of day care services.

Staff will need to become skilled in working with service users who have complex needs and specific conditions.

Training specific to Learning Disabilities would include ASDAN (a teaching programme for older children and adults) and Autism Awareness; generic training including Sexuality Awareness, CALM training, Challenging Behaviour, Vulnerable Adults, and Appropriate Adults.

The Learning Disabilities nurse provides training for staff as and when required, and support and guidance to care staff as to the needs of specific clients.

## **PHYSICAL DISABILITIES**

At present Adult Services offers supported tenancies at Banksbroo. Implications for training include the need to become skilled in working with service users who have complex needs and specific disabilities, and awareness training on new legislation and policies. Current training needs include specific training on Spinal Injury and Multiple Sclerosis. One staff member is currently studying for the BA in Social Work with Robert Gordon University.

## **OCCUPATIONAL THERAPY**

Occupational Therapists work across the age range and are involved with the Independence at Home scheme. Future service developments include the development of a joint equipment store and further integration with the NHS OT Team.

Implications for training include the need for OT's to undertake CPD to maintain their registration, including occasional specialist OT courses outwith Shetland, continuance of RoSPA training and general manual handling training, the need for awareness training on new legislation and policies and for workshops to support the better integration of services.

## **SENSORY IMPAIRMENT**

Training is accessed through SENSE, RNID and RNIB when required.

The specialist team in Education also provide guidance and support when required.

Care staff will have the opportunity to work through an open learning package (with support) on "Effective Communication with People who have Hearing Difficulties"

**Services for adults with mental ill-health**

At present Adult Services offer the following:

Annsbrae Mental Health Community Support Service  
(supporting people on site, including a short break flat and outreach); and  
Knab Road Skill Centre

It is anticipated that the outreach service will continue to grow to meet increasing levels of need in the community.

Annsbrae staff access the City and Guilds Certificate in Mental Health; social workers and care staff attend the Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid courses provided through NHS Health Promotion.

CPN's offer informal guidance and training on their visits to care centres and the Young Peoples Consultant Psychiatrist and the CPN (Adolescence) offer support to staff at Leog. There is CPN support for the Open University Route to Nursing Common Foundation Programme students and the RGU Nursing Conversion Course Students. CPN's also support Community Mental Health placements / shadowing for NHS staff and RGU students.

A social worker is studying for the Mental Health Officer qualification.

## **CARE AT HOME**

The development of the Care at Home scheme, with designated staff involved in either personal care or domestic tasks has considerable implications for training.

Those involved in Personal Care have a 5½ day induction involving:

- 1 day Manual Handling of People
- 1 day Loss & Grief
- 1 day Food Hygiene
- ½ day Palliative Care
- ½ day Care Files & Recording
- ½ day Emergency First Aid
- 1 day Principles of Care

Those involved in Domestic Care have 3½ days induction:

- 1 day Manual Handling of Loads
- 1 day Food Hygiene
- 1 day Principles of Care (including Grief Awareness)
- ½ day Emergency First Aid

Seniors have Supervisory Skills training.

## **SUBSTANCE MISUSE**

Awareness training is provided by colleagues in the Community Drugs Team and the Alcohol Advice Resource Centre. In addition to this, more specific training is accessed through the STRADA courses made available through NHS Health Promotion.

## **PALLIATIVE CARE**

Community and Macmillan nurses offer guidance and support to centres. Staff access the 3 and 1 day courses in Palliative Care provided by primary care colleagues.

## **CARERS**

There is an obligation to provide training support to carers who provide a “substantial amount of care on a regular basis”. This includes access to training opportunities including locally based courses on moving and assisting, benefits advice, stress management, medication and challenging behaviour as appropriate.

Some training opportunities on the mainland may be accessed where specialist advice on particular conditions and the related care needs are not available locally. There is funding available which covers reasonable travel and accommodation expenses on mainland Scotland. This is accessed through Social Care following a carer's assessment.

Carer awareness training is required for all frontline staff.

## **Moving and Assisting**

It is recognised that to meet legislative requirements and relevant clinical and care standards certain staff must attain a certain level of competency in client moving and assisting. Some staff currently work for more than one organisation.

It has been agreed that there is a need for staff, working in similar settings, to receive the same core underpinning knowledge and practical skills competencies. This ensures that staff who work between services are confident of their skills and do not have to undergo separate core training for more than one organisation. It is accepted that further training may be required to enable staff to meet specific client needs in this area, deal with environment/location specific factors and equipment.

A working group comprising two SIC RoSPA trainers, the Social Care Training Manager, the NHS Manual Handling Trainer and an Occupational Therapist, meet to agree on the curriculum content of the core training. This group reviews the training and its outcomes on an annual basis, although it is not intended to replace the multi-disciplinary NHS Manual Handling Committee which oversees all Manual Handling training in the NHS.

## Courses attended by Social Work staff and others (\*) during 2005/6

	Course	SIC Figures - Annual
<b>Community Care</b>		
	Care Planning	22
	Return to Learn	12
	Counselling Skills Module1	2
	Counselling Skills Certificate	1
	Continence	18
	Dementia Awareness	120
	EGRC training week	36
	Epilepsy	20
	Fire awareness	104
	Fire awareness Management	28
	First Aid in the workplace	22
	First Aid Refresher	6
	H. & S. for Home Care	tbc
	Home Care Inductions - Psnl	tbc
	Home Care Inductions - Dom	tbc
	Medication	96
	Medication (Nomad)	9
	Medication (Boots)	3
	MIDAS Training	7
	MIDAS Trainer Refresher	2
	MHO	1
	Naso gastric training	15
	Occ. Training For OT	4
	Practice Teaching	1
	Palliative Care	14
	Prader Willie Syndrome	9
	Single Shared Assess	8
	Visual Impairment (SIM) Specs	6
	Substance Misuse	11
	Substance Misuse & Domestic Violence	1

## Vocational

ASSIST	1
Access training	7
Basic IT	20
Budget Responsible Officer	30
Outlook	12
Power point	3
Publisher	1
Contribute for internet	1
Mail merge	3
Employee Review & Development	16
Effective Relationships	2
Customer Care	2
COSHH	22
DICES Risk Asst for Social Workers	10
Intro to Excel	6
Expert Excel	3
Facilitation Skills	4
Intro to Scottish Parliament	3
Freedom of Information	2
Data Protection	24
CHRIS	2
INTEGRA	3
Driver Development	22
Recruitment and Selection	21
Absence Management	15
Harassment and Bullying	6
Employment Law	0
Equality and Diversity	7
Disability Awareness & DDA	15
Disciplinary Procs	22
Conferences	18
Managing stress at work	11
Managing stress for Managers	2
Situational Leadership	18
Management Development Phase 2	4
Chairing meetings	2
More effective meetings	1
Supervision	31
Team building	1
Group Work	1
Time management	5
Minute taking	7



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Report Writing	4
Plain English	1
Negotiating Skills	1
REHIS H&S	8
Accident reporting & investig'n	3
PAT testing	1
Risk assessments	25
Intro to SWIFT	10
SWIFT refresher	20
Msc Child Care & Protection	1 ongoing
Mental Health in the workplace	8
G Map	11
Supporting People Housing	5

## Child Protection

### Inter Agency

Child Protection 1 day	3
Child Protection 2.5 day	93
Child Protection refresher for 2.5	60
Child Protection refresher for 1 day	19
Child Protection refresher inc case conference	4
CP case conference	4
CP Minute taking	2
Child at the Centre	16
Specialist CP - Helen Kenward	68

## Child Residential

Asperger Syndrome Awareness	11
Autism Awareness	26
C.A.L.M.	14
C.A.L.M. Trainer	1
C.A.L.M. Trainer Refresher	48
HNC Equivalent	0
Working Restoratively	1
Self Harm	14
Mental Health Looked After Children	
Working with Child. & Y.P. who have been abused	64



Graduate Cert in Child Protection	1
Children with Attachment issues	36

## Adoption

BAAF	3
Escape Parents of Adolescents	2
Foster Care Training	2
<b>GRA0206 Sub-Totals</b>	

## Diploma Social Care

DipSW - Fast Track	0
DipSW - (3rd yr)	ongoing
Diploma in MS	stopped
Trainee Social Workers	ongoing
Insurance	

## SVQ

Shetland College Assessors	
Insurance	
Registered Manager	2 ongoing
SVQ3 Care	3
SVQ4 Care	10

## BA in Social Work

<b>GRA0209</b>	
BA - (1st year)	ongoing
BA 2 students	ongoing
Practice Teacher Award	1
PG Cert in child Care & Protection	1

## Food Hygiene

Food Hygiene 1 day basic	87
Refresher half day	111
Intermediate 1 week	2
Nutrition for cooks	11
HACCAP	1
Food Safety in Catering	1

## Manual Handling

ROSPA 2 day course	95
ROSPA 1 day handling loads	42
ROSPA Trainer Refresher	6
ROSPA Refresher	201

**Shetland's Joint Future Joint Staff Forum**

**Terms Of Reference**

**1.0 INTRODUCTION**

- 1.1 Shetland NHS Board Partnership Forum (The Partnership Forum) and Shetland Islands Council Employees Joint Consultative Committee (EJCC) aim to progress and support the local implementation of the recommendations of the national report by the Joint Future Group (JFG) entitled 'Community Care: A Joint Future.' The Joint Future Joint Staff Forum (JFJSF) brings together representatives of both the Partnership Forum and EJCC in order to achieve this.

**2. REMIT OF THE JOINT STAFF FORUM**

- 2.1 It is a particular responsibility of the Joint Staff Forum to encourage the development of an open, trusting and supportive culture which recognises and explores solutions to the challenges presented by differing approaches to human resource management within the partner agencies of Shetland NHS Board and Shetland Islands Council.
- 2.2 All agreements/recommendations that are made discretely within the partner agencies and impact on staff involved in joint working will be discussed and taken into account by the Joint Staff Forum and therefore the Joint Future Joint Management Team before implementation.
- 2.3 The Joint Staff Forum does not replace or usurp either the Shetland NHS Board Partnership Forum or the Shetland Islands Council Employees Joint Consultative Committee where staffing issues will continue to be discussed in line with the published constitutions. Its remit is to protect and reassure *all* staff as they become involved in joint working by providing a joint environment where relevant staffing issues and concerns can be raised and discussed; difficulties can be explored and resolved and shared routes forward can be agreed.

### 3. COMPOSITION

3.1 The Joint Staff Forum membership comprises:

- 4 representatives nominated by Shetland NHS Board Partnership Forum
- 4 representatives nominated by Shetland Islands Council Employees Joint Consultative Committee
- Director of Clinical Services (NHS)
- Executive Director Education & Social Care (SIC)

3.2 In addition, it is agreed that the following personnel should be invited to attend to provide particular knowledge and expertise. Such attendance is not intended to give a right to be elected to Joint Chair, except where the individual is also a member under 3.1 above:

- Human Resources Manager Shetland Islands Council
- Director of Human Resources Shetland NHS Board
- Head of Community Care – SIC/NHS
- Director of Public Health Shetland NHS Board

3.3 Each partner agency will elect a Joint Chair from the Partnership Forum/Consultative Committee members at 3.1. above, who will chair each meeting in rotation for an initial period of one year.

3.4 The Joint Chairs will have an automatic right to full membership of JFJMT

3.5 Appropriate deputies will be allowed.

3.6 The Joint Staff Forum will be serviced by the Social Care Service.

### 4. REPORTING MECHANISMS

4.1 The Joint Staff Forum will report to JFJMT and to the Shetland NHS Board Partnership Forum and Shetland Islands Council Employees Joint Consultative Committee.

4.2 The agreed minutes of each meeting will be forwarded to JFJMT, the Shetland NHS Board Partnership Forum and Shetland Islands Council Employees Joint Consultative Committee.

4.3 Each consultative body will take responsibility to ensure that information is disseminated to all staff as appropriate.

**5. FREQUENCY OF MEETINGS**

- 5.1 The Joint Staff Forum will meet quarterly.
- 5.2 The frequency of meetings will be reviewed as progress with joint working demands.

**6. QUORUM**

- 6.1 The quorum for a meeting will be 2 representatives from each partner agency and 1 Manager from either agency (ref. 3.1 above).

**7. RESOLUTION OF CONFLICT**

- 7.1 Recommendations have to be arrived at by consensus or arbitration and unresolved issues brought to the attention of JFJMT, for wider discussion by various groups represented on the Joint Management Team.

**Human Resources, Training and Organisational Development Team  
(HR, Training and OD Team)  
Terms of Reference**

**Purpose:**

- To develop a joint approach locally to strategic human resources issues arising from the Joint Future agenda

**Remit:**

- To prepare a strategic HR plan to support the Joint Future Agenda
- To develop workforce planning collaboratively with managers of health and care services
- To manage the process for the preparation of a fully costed joint Health and Social Care Organisational Development and Training Plan annually as part of the Local Partnership Agreement for Joint Future Services
- To prepare indicative 5 year projections of training needs for health and Social Work services
- To link with the Training Forum and the corporate training functions of NHS and SIC.

**Membership:**

- Director of Human Resources, NHS Shetland (joint chair)
- Human Resources Manager, SIC (joint chair)
- Training Manager, NHS Shetland
- Training Manager, SIC, Social Care

**Meetings:**

Meetings will be held at least quarterly. Joint chairs will chair meetings in rotation and decide on the frequency of rotation. All meetings will be minuted and the minutes will be reviewed by the Joint Future Joint Management Team. Minutes will be available to staff and to the public under the provision of the Freedom of Information (Scotland) Act 2002.

The agendas will cover:-

- national developments: HR, training
- local developments
- registration requirements for the Joint Future workforce e.g. SSSC registration
- supervision and performance appraisal systems
- recruitment and retention
- employment contracts, JF attachments.



## Shetland's Joint Future

Shetland Islands Council

### **Failure to Agree:**

In the event of failure to agree on an issue, the details will be referred to the Joint Future Joint Management Team, in the first instance.

**Training Forum  
Terms of Reference**

**1. Aim**

To explore options to develop more integrated training services within the Care/Health/Learning sectors of Shetland.

**2. Objectives**

SHORT TERM

Sharing training needs analysis and current provision – establish baseline of statutory responsibilities, identify gaps and future developments.

- Develop efficient and cost effective ways of sharing training expertise and experience.
- Work together on maximising the impact of engaging external trainers.
- Work together on the identification of appropriate Shetland wide training accommodation, which is accessible to all.
- Sharing training and development good practice and innovation.
- Promoting and encouraging participation in relevant development activities across Shetland.

LONG TERM

Work towards achieving a common set of principles under-pinning quality assurance and continuing professional development.

**3. Scope**

AGENCIES INVOLVED

- Shetland Islands Council
- Shetland Enterprise
- Shetland NHS Board
- Voluntary Sector

## RESOURCES

- Staff
- Budgets
- Buildings
- Equipment
- Materials
- Additional funding opportunities

### 4. Constraints

- Within existing resources
- Statutory requirements
- Wide range of needs

### 5. Timescales

Draft Terms of Reference to initial meeting – February 2003

First meeting of forum – May 12<sup>th</sup> 2003

Project plan developed for 2004/5

## Proposed Membership of Forum

SIC Education Service (Chair)  
Train Shetland  
SIC Human Resources  
SIC Social Care  
Shetland NHS Board  
SIC Education Service  
Disability Shetland  
SIC Community Development  
Walter & Joan Gray Home  
Shetland Council of Social Service  
Shetland Enterprise  
Shetland Volunteer Development Agency

*(Created on 04/11/2003)*



Course	Number of Requests	Departments who Requested	Number courses	No. participants per course	Number of People	Duration	In House/In Shetland/External	Multi-Agency Lead Agency	Client Group (Majority)	SMT Budget Holder	Facilitator	Course Fee	Travel & Subs (incls refresh)	Venue Hire	Books/Stationery	Staff Cover Costs	Income, Grants etc	Total Cost
Admin Development	2 requests	Podiatry			24							0	0	0	120	0	0	240
Adult Literacy					2							0	0	0	0	0	0	0
AHP Leadership Programme					2							0	0	0	0	0	0	0
Appraisal Training					30							0	0	0	10	0	0	10
ASIST identifying people at risk of suicide	1 request	WD 3			26													
Assertiveness/Confidence skills	10 PDPs	Gen Nsg			1	In house						0	0	0	0	0	0	0
Asthma/COPD	1 request	WD 3			19							0	0	0	0	0	0	0
Audit					1							0	0	0	0	0	0	0
Blood Transfusion Service	1 request	WD 3			19							0	0	0	0	0	0	0
BLS	1 request	WD 3			26							500	0	0	0	0	0	500
business objects training					4							2000	500	0	0	0	0	2500
Cancer data set Seminars												0	1000	0	0	0	0	1000
Cardiac	1 request	WD 3			19													
Child Protection - 1 day	1 PDP & q rec	Medical Imaging/WD 3			37							1800	0	0	0	0	0	1800
Child Protection - 2.5 days	1 request	WD 3			34							0	0	0	0	0	0	0
Child Protection - 1 day refresher					5							2000						2000
Child protection - Consultants and GP's					12							1000	500	0	0	0	0	1500
Cleanliness Champion	1 request	WD 3			19							0	0	0	0	0	0	0
Clinical Governance Afternoons					140							0	0	0	0	0	0	0
Communication skills	6 PDPS	Gen Nsg/Comm Nsg				In house						0	0	0	500	0	0	500
Complaints training	2 PDPS	Gen Nsg				In house						0	0	0	0	0	0	0
Computer Skills	1 request	WD 3			26							0	0	0	0	0	0	0
Corporate Induction Day					60							0	0	0	250	0	0	250
Counselling Skills, Introduction					12													
Conversion Course	1 request	WD 3			2													
Creating Effective Relationships	6 requests	Podiatry			40							0	0	0	950	0	0	950
Crystal Report writing					4							2000	2000	0	0	0	0	4000
Customer Care					20							0	0	0	0	0	0	0
Deaf Awareness					45							0	0	0	250	0	0	250
Dealing with Change			3	10	30							0	0	0	0	0	0	0
Diabetes	1 request	WD 3			19							0	0	0	0	0	0	0
Digital Photography	1 PDP	Podiatry																
Difficult Conversations/Communication	7 PDPs + 5 re	Gen Nsg/Podiatry			50	In house						0	0	0	500	0	0	500
Diversity (Online)					400							0	0	0	0	0	0	0
domestic abuse training					20							0	0	0	0	0	0	0
Driving in Bad Weather					20							70	0	0	0	0	0	1400
EKG's	1 request	WD 3			19													
E-KSF + KSF Awareness					100							0	0	0	0	0	0	0
e-library and critical appraisal					5							0	0	0	0	0	0	0
Emergency Planning Training					?													
Emergency Planning Event					?													
Engaging communities					20						SIC	0	0	0	0	0	0	0

Faculty of family planning					40					Dr Hinton	0	0	0	0	0	0	0
Faculty of Management (Podiatry) meetings					?												
Finance					40						0	0	0	0	0	0	0
Fire Lectures	25 PDPs & 1	Gen Nsg/Comm Nsg/Podiatry			26		In house				0	0	0	0	0	0	0
Frontline Leadership and Management	2 PDP	Gen Nsg/Medical Physics			2												
Handling Stress			12	8							0	0	0	0	0	0	0
Health and Safety	3 PDP	Gen Nsg/Comm Nsg															
Health and Safety (RCN Steward's course)																	
Help I've Got a Vacancy			4	6	24						0	0	0	0	0	0	0
Huntingdons disease course		Mental Health			7						0	0	0	0	0	0	0
Degree in Information Governance					1												
Infusion Devices	1 request	WD 3			19												
Interviewing Skills	6 PDPs	Gen Nsg/Med	4	6	24		In house				0	0	0	0	0	0	0
ILS	1 request	WD 3			19						500	0	0	0	0	0	500
Intravenous Drugs	1 request	WD 3			19						0	0	0	0	0	0	0
IOSH - working safely					8												
KSF for Managers					40						0	0	0	0	0	0	0
Leadership	2 PDPS	Gen Nsg															
Learning difficulties					10					Andrea Holmes	0	0	0	0	0	0	0
LGBT					100						0	0	0	0	0	0	0
Male Catheterisation	1 request	WD 2			19						0	0	0	0	0	0	0
Management- ILM					10						0	2500	0	0	0	0	2500
Managerial Skills	1 PDP	Gen Nsg															
Mandatory Refresher Day	21 PDPs	Gen Nsg/Comm	12	30	360	1 day	In house			Elizabeth Eastham	0	350	0	0	0	0	350
Media Course					10						0	350	0	0	0	0	350
Medical Records coders update course					?						0	900	0	0	0	0	900
Medical Terminology					?						0	100	0	0	0	0	100
Mental Health Study Day	1 request	WD 3			19												
Mentor Development	9 PDPs	Gen Nsg/Med	12	10	120						0	0	0	0	0	0	0
Mentor Preparation					8						0	0	0	0	0	0	0
Mentor Training	1 request	WD 3			19						0	0	0	0	0	0	0
Moving and Handling, Backcare	1 PDP	Public Health	12	8	96	0.5 day	In house			Elizabeth Eastham	0	0	0	0	0	0	0
Moving and Handling, Introduction		All	12	6	72	2 days	In house			Elizabeth Eastham	0	0	0	0	0	0	0

Moving and Handling, Refresher	30 PDPs	Gen Nsg/Med	36	6	216	1 day	IN house			Elizabeth Eastham	0	0	0	0	0	0	0
NEBOSH					2												
Non-invasive ventilation	1 request	WD 3			19												
Nutrition	1 request	WD 3			26												
OU	1 request	WD 3			3												
Palliative Care - 3 day course	1 request	WD 3			4												
Paediatric BLS	1 request	WD 3			26												
Paediatric ILS	1 request	WD 3			19												
Post Grad/CPD Public Health	1 PDP	Public Health															
Project Planning Skills					20						0	350	0	0	0	0	350
Race & Equity	2 PDPS	Gen Nsg	4	8	32		In house				0	0	0	0	0	0	0
Reminiscence Skills					?												
Record Keeping	1 request	WD 3			19												
Report Writing					?												
Risk assessments/Health & safety issues	1 request	WD 3			26												
SHO Induction					18						0	0	0	0	0	0	0
Service Redesign					20						0	350	0	0	0	0	350
SPIRIT course		Mental Health			7					Alan Murdoch	0	0	0	0	0	0	0
SpR meetings					?												
Stroke	1 request	WD 3			19						0	0	0	0	0	0	0
Study Skills for Dental Nurses					12						0	0	0	0	0	0	0
SVQ II	1 request	WD 3			6												
Time Management	5 PDPs	Gen Nsg/Public Health									0	0	0	950	0	0	950
Training for Trainers					1												
Video-conferencing equipment training	2 PDPs	Comm Nsg/Clinical Gov									0	0	0	0	0	0	0
Violence & Aggression	6 PDPs & q re	Gen Nsg/Com	12	8	122	1 day	Y			Elizabeth Eastham	0	0	0	672	0	0	672
Violence and Aggression (trainer refresher)					1						1000	300	0	0	0	0	1300
Wound Care	1 request	WD 3			19												
Zest for Life			4	8	32						0	350	0	350	0	0	400
Total											9550	0	4552	0	0	0	26122

**SOCIAL CARE OTHER TRAINING**

	<b>Facilitator</b>	<b>Client Group</b>		
Accident Reporting & Pins	11 Corporate	All	825	825
Assertiveness	26 Corporate	All	2535	2535
BA - (1st year)	4 External	All	11615	11615
BA - (2nd year)	2 External	All	0	0
BA - (3rd year)	1 External	All	10	10
BA Fast Track	1 External	All	16170	16170
Basic Food Hygiene 1 day Cert	60 External	All	14650	14650
Basic Food Hygiene Intermediate	2 External	All	1275	1275
Basic Food Hygiene Refresher	250 External	All	12800	12800
Basic IT Skills	62 Corporate	All	5425	5425
Chairing Meetings	22 Corporate	All	1100	1100
CHRIS	32 Corporate	All	320	320
Data Protection	45 Corporate	All	0	0
DDA and Disability Awareness	35 Corporate	All	3413	3413
DipSW - (3rd yr)	1 External	All	6070	6070
Disciplinary Procedures	23 Corporate	All	1380	1380
Employee Review & Development	56 Corporate	All	560	560
Employment Law	2 External	All	590	590
Equality and Diversity	20 Corporate	All	1075	1075
Excel	9 Corporate	All	90	90
Expert Excel	8 Corporate	All	80	80
Expert Word	7 Corporate	All	70	70
First Aid in the Workplace	120 Corporate	All	17700	17700
Freedom of Information	29 Corporate	All	0	0
Harasment & Bullying	16 Corporate	All	1560	1560
HNC Business Admin	2 Corporate	All	1960	1960
Induction	42 Internal	All	9188	9188
Integra	11 Corporate	All	110	110
Intro to SWIFT	30 Internal	All	0	0
Managing Stress in the workplace	25 Corporate	All	2438	2438
Mental Health Officer	1 External	All	5430	5430
Minute Taking	16 Corporate	All	1040	1040

Occ. Training For OT	4 External	All	4040	4040
Practice Teaching	2 External	All	10280	10280
Records Management	35 Corporate	All	0	0
Recruitment & Selection	27 Corporate	All	270	270
Report Writing	9 Corporate	All	585	585
Risk Assessment	50 Corporate	All	5875	5875
Situational Leadership development	26 Corporate	All	6890	6890
Social Worker Specialist	5 External	All	5000	5000
Specific Conferences	47 External	All	23000	23000
Supervision Skills	35 Corporate	All	2275	2275
SVQ 3 Induction & Tutorials	30 Shetland College	All	31800	31800
SVQ Assessor costs	Shetland College	All	96000	96000
SVQ3 Business Admin	3 Shetland College	All	1650	1650
SVQ3 Care	30 Shetland College	All	56175	56175
SVQ4 Care	20 Shetland College	All	67450	67450
SVQ4 Induction & tutorials	20 Shetland College	All	21200	21200
Tackling MH in the Work Place .5 day	18 Corporate	All	1080	1080
Team Building	20 Corporate	All	3050	3050
Time Management	14 Corporate	All	2275	2275
Trainee Social Workers	2 External	All	13030	13030
Training Manager & Admin	Internal	All	68318	68318
Word	38 Corporate	All	3705	3705
Grants and Income	Internal	All	-69084	-69084
Adoption	0 External	Children	3000	3000
Autism Awareness	20 External	Children	4150	4150
C.A.L.M.	30 Internal	Children	12300	12300
C.A.L.M. Trainer	1 Internal	Children	2110	2110
CALM REFRESHER	105 Internal	Children	11038	11038
HNC Equivalent	12 Shetland College	Children	59220	59220
Laburnum training week	31 Internal	Children	3913	3913
MSc Child Care & Protection	1 External	Children	5580	5580
NFCarers Assoc	0 External	Children	1000	1000

Specific Training for Leog	23 Internal	Children	2713	2713
Working with Child. & Y.P. who have been abused	20 External	Children	3750	3750
Working with Children& YP who have attachment issues (Holl)	20 External	Children	11400	11400
		Learning		
CRAIGIELEA TRAINING WEEK	52 Internal	Disabilities	3020	3020
		Learning		
EGRC TRAINING WEEK	24 Internal	Disabilities	2740	2740
		Learning		
ILP Team Building	20 Internal	Disabilities	2500	2500
Care\Plan in house	120 Internal	Older People	5850	5850
COSHH HALF DAY	30 Corporate	Older People	3000	3000
Counselling Diploma 2 year	1 Train Shetland	Older People	2241	2241
Counselling Skills Certificate 1 year course	2 Train Shetland	Older People	2795	2795
Counselling Skills Module1	2 Train Shetland	Older People	790	790
Driver Development	32 Corporate	Older People	3120	3120
Drugs Awareness0.5 day	13 Corporate	Older People	1365	1365
Fire Awareness	120 External	Older People	8400	8400
H. & S. for Home Care	20 Internal	Older People	4650	4650
HNC Work Book	30 Shetland College	Older People	12150	12150
Home Care Inductions - Dom	20 Internal	Older People	3150	3150
Home Care Inductions - Psnl	20 Internal	Older People	3150	3150
Manual Handling Loads	58 Train Shetland	Older People	5211	5211
MIDAS TRAINER REFRESHER	29 Internal	Older People	0	0
MIDAS Training	9 Internal	Older People	878	878
Nutrition all cooks	4 Train Shetland	Older People	810	810
Registered Manager	4 Shetland College	Older People	1540	1540
Return to Learn	12 External	Older People	12580	12580
ROSPA Trainer reaccreditation	9 External	Older People	9615	9615
SV2 Induction & Tutorials	40 Shetland College	Older People	42400	42400
SVQ2	40 Shetland College	Older People	70900	70900
Sub Total from Joint Training Plan			127277	127397
<b>Training Budget</b>			<b>£ 924,645</b>	<b>£ 924,765</b>

Course	Max. number participants NHS	Max Number of participants SIC	Number courses	No. participants per course	Duration	Client Group (Majority)	In House/In Shetland/External	Multi-Agency Lead Agency	Facilitator	SIC Costs (inc staff cover)	NHS Costs*	Total Cost
Vulnerable adults	?	12	1	20	1 day	Adults			Williamson/Heather	120	0	120
MS Awareness	0	40	4	10		Adults			Elizabeth Clarke	3600	0	3600
Difficult Conversations	50				1 day	All			Andy Glen		500	500
Staff Appraisals	30				1 day	All			Andy Glen		10	10
Creating Effective Relationships	40				1 day	All			Andy Glen		1000	1000
IT Training (Various clinical- see shet NHS Clinical IT)						All			Various		4614	4614
Admin Development Programme	20				3.5 days	All			Andy Glen		300	300
Crystal Reports	4					All			TBC		4000	4000
Deaf Awareness	45				1 day	All			A Glen/J Haywood		250	250
Domestic Abuse Training	20					All			various		0	0
Driving in Bad Weather	15					All					1125	1125
First Aid	0					All			Train Shetland		0	0
IOSH/NEBOSH	8					All			Shetland/SODEHXO		1000	1000
IT Skills (ECDL)	10					All			College		500	500
Violence and Aggression	50				1 day	All			E Eastham		675	675
Customer Care	20				1 day	All			A Glen		0	0
Managing Dificult Behaviour	0	50	3		1 day	All			TBC	7575	0	7575
Understanding Mental Health & MH Act	?	28	3	10	1 day	All			TBA	4130	0	4130
Visual Impairment	0	50	3	20	1 day	All			TBA	3100	0	3100
Drugs & Alcohol Awareness	0	8				All			Claire Jamieson	2100	0	2100
Epilepsy Awareness	0	36				All			Andrea Holmes	3240	0	3240
Faculty of Family Planning t'ing	40					All			Dr Caroline Hinton		tbc	0
Engaging Communities	20					All		SIC	SIC		tbc	0
SPIRIT Course	7	10	1		?	All		nhs	Alan Murdoch		0	0
Carers	36				1 day	Carers			Michelle Manzie		0	0
1 Day CP Awareness	30	9			1 day	Child			CPTSG	788	1800	2588
3 hr Refresher	20				3 hrs	Child			CPTSG		1000	1000
Train the Trainer	?				1 day	Child			CPTSG			
2.5 Day Foundation	15	11			2.5 days	Child			CPTSG	2406		2406
1 Day Refresher	5	19			1 day	Child			CPTSG	21587	2000	23587
1 day Refresher + Case conf	5				1 day	Child			CPTSG		1000	1000

<b>IAF</b>						<b>Child</b>							0
2 day training	58	20			2 days	<b>Child</b>			Kirstie Anderson	0	0		0
0.5 day training	352	50			0.5 day	<b>Child</b>			Kirstie Anderson	0	0		0
Paediatrics	0					Child			Kirstie Anderson		0		0
In Service Days Education	0					Child			Various		200		200
Sexual Health in Young People	0	31	3	10	1 day	Child			Jane Gilbey	3504	0		3504
Learning Disabilities	10				1 day	LD			Andrea Holmes		0		0
Huntingdons disease course	7		1	?		NHS		nhs	Alan Murdoch		0		0
Care Management Training & Single Shared Assessment	22	12			2.5 days	<b>Older</b>			Ian Sandilands/Ann williamson	3545	0		3545
Continence Care	100	100	10		1 day	Older			Sue Peaker	6500	0		6500
Stroke Awareness	60				1 day	Older			Dorothy Stroey		0		0
Infection Control	12	217	22		1 day	Older			NES?	11286	0		11286
Dementia	0	60	3		1 day	Older			TBC	6000	0		6000
Medication	0	350	35	10	0.5 day	Older			TBC	8750	0		8750
Moving and Handling (Refresher)	216	350	43	8	1 day	Older			e Eastham/SIC	21000	0		21000
Moving and Handling 2 day	72	23			2 days	Older			E Eastham/SIC	5775	0		5775
Moving and Handling Trainer	0	4			2 days	Older			ROSPA	1216	0		1216
Arthritis awareness	0	50	3	20	1 day	Older			Occ Health??	3300	0		3300
Palliative Care	4	50	3	20	3 day	Older			Bruce Clemiston	7875	0		7875

**Sub Total**

**127277 19974.0763 147251**

**\* Please note that the NHS does not add backfill costs to the costs of training and it does not add the costs of Staff Development training to the plan.**

**Section 9:**

**Communications and Consultation**

The Joint Future Communication Strategy was produced in October 2002. The strategy was revised in March 2005 to take account of changes being implemented as part of the establishment of the Community Health Partnership (CHP) in Shetland.

The Joint Future framework draws on a number of stakeholder forums set up either on a locality basis or to focus on specific issues/topics e.g. disability, mental health, training. Some have a clear staff focus, others directly involve service user and carer representatives.

# *“Communication Strategy”*

Revised May 2007

## **Joint Future Communication Strategy**

### **1. Aim**

“To listen and respond to community needs and aspirations; to share knowledge and information appropriately with all Joint Future stakeholders.”

*Stakeholders include:*

- service users;
- carers;
- staff employed by the Council and NHS Shetland;
- Members of SIC and Shetland NHS Board;
- service providers;
- partner agencies;
- voluntary organisations;
- the public;
- the Scottish Executive.

### **2. Objectives**

- To provide clear, comprehensive information to the public about the services available and how to get them.
- To provide information about service standards and how well agencies and service providers in Shetland are performing against national care standards.
- To share information and knowledge on a need to know basis; avoiding duplication while respecting confidentiality at all times.
- To listen to service users, carers and the public and respond to their views on current service provision and future needs.
- To undertake research in partnership with other agencies, service users, carers and the public.
- To involve all stakeholders in service planning and redesign.
- To ensure effective communication and consultation in each locality through the Public Partnership Forum (PPF) network established within the Community Health Partnership (CHP).
- To use new technology to promote efficient information sharing and create links with stakeholders in all parts of Shetland.

## Shetland's Joint Future Joint Future Communication Framework

Stakeholder Type	Who are the Stakeholders	Focus of Communication	Method
SERVICE USERS (DIRECT)	Clients / Patients Carers	Service Levels Service Quality Information on Services How will a Joint Future make a difference to them?	Patient surveys/questionnaires; Focus Groups; Public Meetings; Individually through Single Shared Assessment process; Inspection Reports.
SERVICE USERS (INDIRECT)	Independent/Voluntary Organisations Community Groups  NHS 100 Patient Focus Public Involvement (PFPI) Steering Group; Public Partnership Forum	How will a Joint Future make a difference to the services provided?  How will that impact on the service which they provide?	Briefings and Newsletters
STAFF (DIRECT)	SIC Education & Social Care NHS Shetland Joint Future Joint Staff Forum Union Representatives	The Change Process and what it means to them: Service Levels Service Quality Changing Terms and Conditions Security of Employment Career Plans Roles and Responsibilities	Staff Meetings Joint Future Joint Staff Forum; Local Partnership Forum; Employees JCC meetings; Focus Groups; Workshops; Staff surveys; Staff Newsletters; Team Briefings; Intranet sites; Inspection Reports.

## Shetland's Joint Future

Stakeholder Type	Who are the Stakeholders	Focus of Consultation	Method
STAFF (INDIRECT)	SIC Executive Management Team SIC Education & Social Care – rest NHS Shetland - rest SIC Corporate Services SIC Infrastructure Services	Changing Roles and Responsibilities and their impact	“All Staff” Bulletins; Team briefings; Local Partnership Forums; Employees’ JCC; Training Forum
MEMBERS / SCOTTISH EXECUTIVE	SIC Social Forum; SIC Social Care Spokesperson; Employees JCC; SIC Adult Services Board; Services Committee; SIC and NHS Board Community Councils; CHP; Community Planning Board	Service Outcomes – quality, equality, performance. Value for Money / Best Value Links to other Corporate Strategies	Briefings; Presentations; Seminars; Formal Reports; Progress Reports / Audits; Inspection Reports
OTHERS	Shetland public	Service Outcomes – quality, equality, performance. Value for Money / Best Value	Public Meetings; Web Sites; Press Releases; Radio publicity through SIBC and Radio Shetland; Radio Shetland’s - Speak Easy; Local papers – articles, advertising and Pull Out Supplements; Inspection Reports

**Section 10:**

**Information Sharing**

- The principle of information sharing is an integral part of Shetland's Joint Future Single Shared Assessment (SSA). The SSA is used for all community care client groups.
- Information is shared with service users' consent. This is recorded in the SSA and any care plans.
- Data sharing is manual for the most part, however, work is on-going to establish secure e-mail links between the Council and NHS Shetland.
- The long-term aim of the local NHS IM&T strategy is to move to electronic patient records and electronic healthcare records, with single data entry at the point of data capture, and with data then shared by all healthcare system users. All new and existing clinical information systems are being integrated in one central information store. Joint planning and implementation arrangements for IM & T are being established with the local authority and voluntary organisations. Work on eCare and the implementation locally of an eCare store will be taken forward during the lifetime of this plan in line with the national eCare initiative. A Local Data Sharing Partnership has been established chaired by the Council's Executive Director of Education and Social Care. Electronic data sharing of the SSA is a first priority for the Data Sharing Partnership.
- The SSA procedures are updated on a regular basis, usually annually, with input from partner agencies, fieldwork staff, independent sector providers, service users and carers.
- There is a Joint Information Sharing Protocol which is being updated by the Data Sharing Partnership and will be included in the SSA procedures.
- Training for all staff expected to use the SSA procedures is part of on-going joint training and induction programmes. Training in care management has been revised in light of the national guidance published in August 2004. A comprehensive training programme in SSA and Care Management has been delivered locally based on the toolkit developed nationally for this purpose. The training has been included in future training plans as a rolling programme.

## Shetland's Joint Future

- Care files for people receiving care in their own homes are shared by staff involved in the care plan. The care file is kept in the person's home.

## **Section 11:**

### **Single Shared Assessment**

Shetland Islands Council and Shetland NHS Board have had joint procedures in place for all community care assessments since 1992/93. The procedures have been updated on a regular basis over the years and following a major revision in 2003/2004 were issued in April 2004 as Shetland's Single Shared Assessment Procedures (SSA).

The SSA includes the Indicator of Relative Need (IoRN) developed by the Scottish Executive. The IoRN is used routinely as part of the assessment of need for anyone aged 65 or over. It has also been used in residential care settings to assist in reviews of dependency and staffing levels.

The SSA includes a joint NHS and Council procedure for staff on independent advocacy and the Joint Information Sharing Protocol. Full copies of the SSA and IoRN are available separately.

The SSA is for people with community care needs seeking help from Social Care, Health or Housing services and who may require the services of more than one professional discipline or agency.

It is used for the individual assessment of people in the community who are vulnerable by means of frailty, disability or illness.

The SSA uses a person-centred approach, led by a single professional, with other specialist involvement as appropriate. The lead worker should be the most appropriate professional in each case e.g. a social worker, community nurse or occupational therapist.

The Joint Future SSA and Care Management Team is responsible for the on-going development and review of the SSA and care management procedures.

The remit of the Team is included below. Priorities for the team during the lifetime of this plan include:

- complete implementation of the first full revision of SSA procedures;
- implementation of a quality assurance framework for the SSA process;
- development of an action plan to ensure targets on SSA included in the LITs are met.

## Shetland's Joint Future

### Care Management in Shetland

#### Background

The original guidance on care management was issued by the Scottish Office in June 1991, in which the general principles were outlined.

It stated that local arrangements for care management should

- Enable people to live as normal a life as possible in their own homes or in a homely environment in the local community.
- Provide the right amount of care and support to help people achieve maximum possible independence, and by acquiring or reacquiring basic living skills, help them achieve their full potential.
- Give people a greater individual say in how they live their lives and the services they need to help them do so
- Promote partnership between users, carers and service providers in all sectors
- Ensure that the resources available are used in the most effective way to meet individual user care needs.

These principles were not new, they were, and still are, seen as underpinning good social work practice

Care management was defined as the process of relating services to individual need and was seen to be founded on a needs led approach to the provision of services.

Care management was seen to include the following tasks

- Identification of persons who appear to have community care needs
- Assessment of care needs for the individual
- Planning and arranging the delivery of care
- Monitoring the quality of care provided
- Review of individual care needs

Care management was clearly seen as a process which was separate to service delivery.

#### Update

In August 2004, the Scottish Executive issued updated guidance on Care Management in Community Care. This was in response to a report by the Joint Future Group and a major study commissioned by the Executive, which recognised that practice in care management had drifted from the original concept.

This guidance is seen as bringing care management up to date in terms of context and application.

## Shetland's Joint Future

The main aim is to re focus care management on people with complex or changing needs and to extend the range of care managers to include more professionals, in the context of partnership working.

Care management is seen as a key part of the agenda under Joint Futures to deliver better outcomes through better joint services.

### **Care Management should:**

- Empower people who use services by giving them greater choice in how their support and care are tailored to meet their needs.
- Ensure greater continuity and speedier delivery of care
- Enable care managers to reach key decisions and determine service outcomes quickly and effectively
- Shape the development of more integration and more responsive services, with better results for people who use them.

The guidance distinguishes between 'care management' and 'care coordination'.

Care coordination is defined as being required by those individuals with straightforward and/or stable needs who do not require complex care management.

Care management is required for people who have complex needs or rapidly or frequently changing needs.

(It is, however, recognised that an individual's needs may be such that they may move between the two).

### **Eligibility Criteria**

#### **Background**

It is worthwhile noting that the needs of any individual will have depth (severity of need) and breadth (range of need). It is envisaged that one or more of the eligibility criteria can indicate that a care manager is required. The concern is, that by being too prescriptive, these will become a tool for exclusion as opposed to inclusion for those with complex needs.

Complex need is seen as a term to describe the interconnected nature of an individual's needs where there are multiple interlinked problems and the total is more than the sum of the interlinking parts.

This would include areas where:-

- there is a high level of social/medical need;
- input from more than one agency is required; and
- help with more than one activity is needed.

**Criteria**

- a) Individuals who may require, or at risk of requiring, permanent care in a residential setting.
- b) Individuals who are returning home following a period of residential care or of acute hospital care and require intensive support for their rehabilitation into the community.
- c) Individuals who are experiencing severe mental or physical incapacity with a resultant loss of independence and fluctuating levels of need. This would include -
  - post hospital discharge
  - recurrent episodes of ill health e.g. UTI, TIA, Bi Polar Disorder
- d) Individuals who are terminally ill and require intensive support from health such as palliative care. This would include -
  - those who are in the end stage of life as defined by the Palliative Care Strategy
  - require intensive support to allow them to die at home.
- e) Individuals who have a high level of physical need or are experiencing loss of independence.
  - This would include those who require assistance with getting up/going to bed, all aspects of personal care and food preparation.
  - Assistance could take the form of prompting, enabling, emotional support as well as supervision and assistance with daily living tasks and maintaining routines.
- f) Individuals who have a high level of risk and require services for their safety or protection. This would include -
  - those who are experiencing difficulties with daily routine
  - prone to falls
  - at risk of abuse from a partner/carer/family member
  - prone to wander outside
  - are unable to comply with medication
  - suffering malnourishment/dehydration due to inability to prepare adequate dietary requirements
  - unable to identify risks for themselves
- g) Individuals who have complex needs or challenging behaviour where a high level of support is necessary. This would include -
  - brain injury
  - people with dementia
- h) Individuals with rapidly or frequently changing needs which cannot be met out-with a stable environment. This would include situations where
  - levels of need oscillate from care co-ordination to care management.
  - levels of need are changing with such frequency that ongoing assessment is required.

- i) Individuals who are highly dependent on the support of a carer where there is a risk of this breaking down. This would include situations where –
- care needs have increased to the point where the carer is no longer comfortable with providing care;
  - the responsibility of providing care is no longer tenable;
  - the contribution of the carer has not been recognised by external agencies
- j) Individuals who are carers of people with complex needs, and have care needs of their own, which mean they require services in their own right and are unable to maintain their caring role.

*All Direct Payment packages of care will have an allocated Care Manager.*

### **Care Managers**

It has been established practice that social workers within the Community Care Fieldwork Team are the main source for care managers. However, in the context of the guidance, it is recognised that other workers with an appropriate professional qualification, and relevant training, could take on the role of care manager.

It is proposed that the following be designated as potential care managers:

- Social Workers
- Occupational Therapists
- Community Nurses
- Specialist Nurses
  - CPNs
  - Macmillan Nurse
  - MS Nurse
  - Stoke Nurse
  - Discharge Liaison Nurse
  - Health Visitor – Elderly
  - Learning Disabilities Nurse

### **Assessment**

Assessment is a key element in the process of care management and Shetland has had a joint process for assessment of need for vulnerable people from all community care client groups in place since 1992. The process has been revised several times over the years and in April 2004 was re-issued as Shetland's Single Shared Assessment.

Assessments are undertaken through the SSA process, which leads into individual care planning, monitoring and reviewing of the care plan. All of these are established practice in community care within the islands.

While it should be said that the worker who completes the SSA may not always assume the role of the care manager, assessment remains a key responsibility of the care manager.

The role of care manager is decided either by the Service Manager - Fieldwork, on the receipt of the completed SSA, or agreed at the multi agency case conference.

### **Role of the Care Manager**

- To ensure that the SSA is updated to reflect the individual's needs.
- To agree the current care plan with the service users.
- To take the lead in coordinating the services identified in the care plan.
- To ensure that arrangements are in place for monitoring and reviewing the care plan.
- To respond to the review findings to ensure that the service users' changing needs continue to be met.
- To assess the ongoing need for care management.
- To ensure that the service user and their carers are included in the process.
- To liaise with service providers in response to changing demands for services.
- To identify and record unmet needs.
- To arrange case conference/review meetings as the need for multi agency discussions are indicated by the service users' changing needs.
- At minimum, the recommended timescales for reviews as set out in the SSA procedures should be followed.

### **What can we expect from Care Management?**

Care Management should:

- Identify service users whose needs require allocation of a care manager
- Allocate a named care manager, who must work with the individual
- Ensure that a comprehensive assessment has been undertaken, in consultation with the individual and their carer.
- Identify a care package, based on the agreed assessment of need.
- Commission the elements of the care package, as agreed in the care plan.
- Discuss the options for care, including the choice of Direct Payments
- Ensure that a Carer's assessment, where indicated, is carried out
- Ensure levels of risk are monitored
- Adjust the care package to reflect any change in needs, through the monitoring and review process
- Ensure the update of the SSA

### **Training**

The National Training Framework for Care Management was launched by the Scottish Executive in May 2006.

This was seen as a means of supporting the practice initiatives, which were outlined in the August 2004 guidance on Care Management.

The expectation was that this framework was to be implemented regionally and would shape the delivery of training across Scotland.

The 7 modular course is designed as a "tool kit" which can be adapted to suit local provision.

All Local Authorities were required to submit an Action Plan outlining timescales for the delivery of the Training.

For Shetland it was decided that the modules would be delivered 2 ½ days to multi agency groups and would be led by Senior Practitioners/Managers from Health and Social Care.

The first training was held in January 2007 with a second scheduled for April and a third in June. Thereafter, it is envisaged the training will be offered on a twice yearly basis.

Although assessment is an integral part of Care Management, it is anticipated that additional ½ / 1 day sessions on the revised SSA and CM procedures will be held, to allow professionals to familiarise themselves with the new procedures.

### **Devolved Budgets**

Budgets for care services delivered at home are set by locality and are accessible to care managers and care co-ordinators. Overall responsibility for monitoring the level of resources available by locality is shared by the joint management team responsible for the promotion of Shetland's SSA and Care Management framework.

Full details are included in Shetland's Extended Local Partnership Agreement.

## Shetland's Joint Future

### Single Shared Assessment and Care Management Team Terms of Reference

#### Purpose

To oversee the practical application of Single Shared Assessment (SSA) locally and perform a quality assurance (QA) and monitoring role for assessment and care management practice.

#### Remit

- To keep Shetland's SSA procedures under review and issue updated versions and guidance on SSA; the Indicator of Relative Need (IoRN) and care management issues.
- To monitor implementation of SSA including performance against targets for referral, assessment, service provision and review.
- To take actions to ensure Local Improvement Targets (LITs) relating to SSA and care management are met.
- To report on LITs as part of the Joint Performance Information and Assessment Framework (JPIAF) via JFJMT.
- To fulfil a quality assurance role on SSA, care planning and care management, to ensure equitable service provision across all localities.
- To anticipate future needs and advise JFJMT of resource implications.
- To link with locality based Health and Care Teams established within the framework of the CHP to assist in the co-ordination of health and care services in each locality.
- To implement Phase 3 of the Care at Home Service Redesign project.

#### Membership

Service Manager Community Care Fieldwork (chair)  
CHP Lead Nurse  
Senior Social Worker, Community Care Team  
Service Manager Community Care Resources, SIC  
Evaluation, Research & Development Officer, SIC  
Assistant Director Patient Services – Nursing  
Discharge Liaison Nurse

#### Meetings

Meetings will be held every 6 weeks.

All meetings will be minuted. Minutes will be available to staff and to the public under the provisions of the Freedom of Information (Scotland) Act 2002.

## Shetland's Joint Future

The minutes will be reviewed by the Joint Future Joint Management Team (JFJMT).

The agenda will cover the following:

- SSA procedures: updates and guidance
- Care Management: criteria and guidance
- Performance targets: LITs
- Care @ Home
  - current service provision
  - future needs
  - resource issues: budgets and staffing
- Locality Health and Care Teams
- Discharge Liaison
- Information Sharing