Draft Joint Strategic
(Commissioning) Plan 2016-19
Version 3 - November 2015
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Introduction


It is structured around the client groups / services that are included within the delegated authority of the Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

The strategic commissioning plan takes account of other local policy directions as outlined in the Shetland Single Outcome Agreement, Shetland NHS Local Delivery Plan, Shetland Islands Council Housing Strategy, Shetland Community Plan and other local corporate plans.

The Strategic Commissioning Plan is intended to describe how people's lives, health and wellbeing will be improved. This will include decisions about disinvesting in current services in order to reinvest in other services, and redesign of services to meet on-going and changing demand.

In addition, we expect the Joint Strategic (Commissioning) Plan to increasingly reflect the developing engagement with stakeholders and local communities in Shetland, through Locality Planning and links to Community Planning, professional involvement and user and carer fora (through strategic planning on older people and primary care strategy development etc). The Integration Body’s Communication and Engagement Plan sets out more detail of how we will do this.

Guidance sets out the need for Joint Strategic Needs Assessments (JSNAs) to inform the development of the Strategic Plan through the analysis of the needs of local populations. These Needs Assessments will also inform and guide the commissioning of health, wellbeing and social care services. In Shetland the specific strategies that have informed the Strategic Plan (on Carers, Mental Health, Older People, Dementia and Primary Care) include Joint Strategic Needs Assessments, as well as Locality Profiling to inform Locality Planning, and components of Needs Assessments have been included in Service Plans. Again, this will be an area of development in future iterations of the Strategic Plan, taking into account the NHS National Services Scotland (NSS) linked longitudinal health and social care datasets as they become available.

A further area for future development is on performance monitoring, and developing the key performance indicators already in place to show progress towards meeting the national health and wellbeing outcome indicators.

The views and priorities of localities must be taken into account in the development of the Strategic Plan, which means we need to develop localities in Shetland to the point where localities can plan for how the Integration Authority’s resources are to be spent on their local population, and the strategic plan should then consolidate plans agreed in localities.

During 2016/17 we will produce locality plans for Shetland to inform the first year update of this Strategic Commissioning Plan. Each locality plan should include:

- A list of all the services under the management of the Integration Authority of which the locality is a part;
- A note of priorities for each locality under each of the service headings; and
• Planned expenditure under each service heading, using locality budgets.

Financial analysis of service delivery and change will also be developed over the coming year to support analytical processes such as programme budgeting / marginal analysis, and budgeting for locality plans to show how the Integration Authority’s resources are currently used by the locality population. In future this historic share should be set alongside a “fair” share target, based on locality populations weighted to take account of population need and any factors relating to provision of service in the area.

Framework for the Shetland Joint Strategic Commissioning Plan

Principles

The integration delivery principles are:
• that the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users,
• that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:
  o is integrated from the point of view of service-users
  o takes account of the particular needs of different service-users
  o takes account of the particular needs of service-users in different parts of the area in which the service is being provided
  o takes account of the particular characteristics and circumstances of different service-users
  o respects the rights of service-users
  o takes account of the dignity of service-users
  o takes account of the participation by service-users in the community in which service-users live
  o protects and improves the safety of service-users
  o improves the quality of the service
  o is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
  o best anticipates needs and prevents them arising
  o makes the best use of the available facilities, people and other resources

The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.

Integration is designed to bring about fundamental change in the way we deliver services, in order to achieve these outcomes, for instance in shifting the balance of care from institutions to the community, e.g. reducing unplanned hospital admission rates and addressing delayed discharges.
The Plan is written to identify the resources that are being used to help address these challenges, and sets out how service provision will shift over time to support anticipatory and preventative care.

Separate sections of the plan focus on particular sections of the population such as older people and adults with a physical disability, and on specific delegated services such as primary care, mental health services and criminal justice.

The Strategic Plan also sets out the arrangements for carrying out the integration functions in Shetland over the period of the plan including:

- The arrangements for each locality established for locality planning purposes – Appendix 1: Shetland Localities, and Locality Planning process detail included in the briefing on Strategic Planning for Health & Social Care Integration – web-link.
- The operation of the Strategic Planning Group for the purposes of preparing the strategic commissioning plan – see separate paper to IJB – to be added as a web-link subject to agreement by the IJB.
- The date on which functions are to be delegated (to be added, subject to adoption of the 2015/16 plan by the IJB).
- The current CHCP Procurement Strategy will be replaced by an updated Joint Commissioning and Procurement Strategy with the ambition of providing one strategy that will be adopted by the Council, NHS Shetland and Shetland’s Integration Joint Board for health and social care.

Work will be done during 2016/17 to develop an agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions; and to develop a Market Facilitation Plan in line with national guidance as relevant to the Shetland context.
Health & Social Care Integration Plans

Mental Health Service Plan

Policy context

The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in October 2005. The Act contained much more than simply legislation for new forms of compulsory powers and safeguards. Its underpinning principles heralded a new era of rights-based care for people who use mental health services. As well as providing care and treatment, services are now required to promote social inclusion and a wider citizenship agenda.

A number of policy documents have shaped the development of local mental health services: Delivering for Mental Health (2006) set out national policy for the development of Mental Health services and the improvement of mental health in Scotland. This was followed by Better Health Better Care (2007) which established additional improvement objectives and National Targets/Standards. In 2009, Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 outlined the roles and responsibilities of government, local public agencies and third partner agencies in promoting positive mental health.

In August 2012, the Scottish Government published a Mental Health Strategy for Scotland with a renewed emphasis on "prevention, anticipation and supported self management". This focus is central to mental health policy in Scotland and the strategy emphasises a range of improvements and interventions that are in accordance with the best evidence for return against investment over time. The strategy focuses on actions that people can take for themselves and with their communities to maintain and improve their own mental health.

Other strategies closely associated with the 2012 strategy for the delivery of mental health services are Suicide Prevention, Dementia and Substance Misuse.

An updated Mental Health Strategy for Shetland, written in accordance with Scottish Government priorities was agreed by Shetland Islands Council and NHS Shetland in May 2014. The overarching aim of the Shetland Mental Health strategy is to have a single plan that will deliver comprehensive mental health services; use available resources to deliver services in the most effective way and avoid harmful gaps and wasteful overlaps. This will involve health, social care, housing, education, and employment, voluntary and other agencies working jointly in the provision of complementary services across the whole spectrum of mental health support and treatment.

The vision of a 21st century mental health service for the people of Shetland is build upon the principle of person centred partnership with patients, carers and staff. This principle will be at the heart of our service change and improvement initiatives.

Current Services

Adult Mental Health services became part of the Community Health and Social Care Directorate following the decision by the Council and Health Board to jointly appoint a director of Community health and Social Care in February 2014. This was a progression from the previous structure of Clinical Services in the Health Board and the entirety of the Community Care Services in the Council.

The Service comprises a number of regulatory and front-line services and has specific responsibilities in respect of The Mental Health (Care and Treatment) (Scotland) Act 2003 and associated legislation and policy.
Current Mental Health provision encompasses a range of responsibilities and services, all of which can be accessed via a GP by means of an Electronic Single Point of Referral. Our aim is to deliver safe and effective care, with people being seen by the right clinician at the right time.

The Mental Health Service is led by the Service Manager with the support of a 7 person operational team composed of a Clinical Director, 5 Clinical Leads and a Social Care Manager. The seven operational services that make up Shetland’s Mental Health Service are:

- Community Psychiatry Services (CPS)
- Community Psychiatric Nursing Service (CPNS)
- Psychological Therapies Service (PTS)
- Substance Misuse and Recovery Service (SMRS)
- Dementia Service (DS)
- Community Mental Health Support Service (CMHSS)

### Funding and Resources

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<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
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<td>2,743,300</td>
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</table>

### Needs/Unmet needs/Drivers for change

**Needs**

Insert relevant demographics from the Shetland Mental Health Strategy and details of any needs assessment undertaken.

**Unmet Needs**

The 2014 Mental Health Review highlighted a number of unmet needs and service development requirements including; improving access to evidence based psychological therapies and Clinical/Counselling Psychology, support for Adults with ASD, increased availability of OOH psychiatric emergency services and improvements to the facilities available to support those experiencing a psychiatric emergency.

**Drivers for Change**

The key drivers of service change and redesign are the Scottish Patient Safety Program for Mental Health, improved support for Carers, a new emphasis on the importance of Personal Outcomes and growing public pressure for mental health services to match the provision and responsiveness of physical care services. The recent Scottish Government “Responding to Distress” initiative and the associated Distress Brief Intervention (DBI) proposal requires frontline healthcare staff to undertake assessment and signposting of those presenting in distress and, where appropriate, ensure they receive further contact within 24 hours for community problem solving and support for a period of up to 14 days.

**Plans for change**

The changes required to redesign services and address gaps in provision are identified, monitored and reviewed via a number of strategy specific Action Plans (e.g. Mental Health, Dementia, Substance Misuse). The headline objectives are as follows:
<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve local access to evidence based psychological therapies</td>
<td>David Morgan</td>
<td>Ongoing</td>
<td>Outcomes 3, 4 &amp; 5</td>
</tr>
<tr>
<td>Establish a local Clinical/Counselling Psychology service</td>
<td>David Morgan</td>
<td>April 2016</td>
<td>Outcomes 3, 4 &amp; 5</td>
</tr>
<tr>
<td>Develop local capacity to diagnose and support adult ASD</td>
<td>David Morgan</td>
<td>April 2016</td>
<td>Outcomes 1, 3, 4 &amp; 5</td>
</tr>
<tr>
<td>Extend the availability of the Out of Hours response to psychiatric emergencies</td>
<td>David Morgan</td>
<td>Ongoing</td>
<td>Outcomes 3 &amp; 7</td>
</tr>
<tr>
<td>Provide a purpose built room for the management of psychiatric emergencies</td>
<td>Lawson Bissett</td>
<td>June 2016</td>
<td>Outcomes 3 &amp; 7</td>
</tr>
<tr>
<td>Improve support for people who present in distress (DBI Initiative)</td>
<td>David Morgan</td>
<td>September 2016</td>
<td>Outcomes 2, 3, 4 &amp; 7</td>
</tr>
<tr>
<td>Establish a person centred Consultation &amp; Engagement Framework (inc Website)</td>
<td>David Morgan</td>
<td>Ongoing</td>
<td>Outcomes 1, 8 &amp; 9</td>
</tr>
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</table>

**Key Risks to Delivery**

There is a national increase in the demand for, and public expectation of, mental health services. Mainland services are meeting these demands by enhancing community provision and resourcing this change in focus by disinvesting in inpatient facilities. The local service needs additional resource to develop services that meet current standards and expectations and ensure that those services are safe and sustainable. There are significant risks to delivery of the above objectives in the current financial environment. These risks will be managed by the strategic allocation of available resources and partnership working with patients, carers and staff to redesign services to achieve maximum efficiency and effectiveness.

**Performance Targets with links to National Outcomes**

18 Weeks RTT for Psychological Therapies
Substance Misuse HEAT Target
Dementia Standard.

*Insert performance references (e.g. A12 etc)*
Contact Details
Service Manager - Mental Health
Mental Health Manager
Montfield – Upper Floor
Burgh Road
Lerwick
ZE1 0LA
(01595) 743697
david.morgan3@nhs.net

Further Reading
Needs developed with references – to include key documents for each topic referenced above:
E.g.

Mental health Act
“The Matrix” (NES)
Dementia Strategy
SMRS
Responding to Distress
Etc.
Substance Misuse Service Plan

Policy context

External and national drivers for taking a new approach to substance misuse include:

There are a number of national strategic plans for both alcohol and drugs which underpin the aims of the Shetland Alcohol and Drug 2011 – 2015 strategy;

- Changing Scotland’s Relationship with Alcohol a framework for action (2009) Scottish Government,
- The Road to Recovery’ (2008) Scottish Government
- Essential Care’ (2008) Scottish Government
- Quality Alcohol Treatment and Support Report (2011) Scottish Government
- Quality Principles’ for alcohol and drug services (2013) Scottish Government
- Outcomes Framework for Problem Drug Use

The clear focus is on ensuring that services and interventions delivered are of high quality, are effective and cost effective, and focus on supporting people in recovering from substance misuse.

Substance Misuse impacts on individuals, families and communities. A number of local service providers exist to offer treatment and support to both individuals with their own issues and people who are affected by others misuse.

In Shetland, Alcohol and Drug Services are commissioned through Shetland Alcohol and Drug Partnership (SADP). SADP is a multi agency strategic partnership that meets bi-monthly to oversee the design and development of services.

In addition to SADP the Shetland Alcohol and Drug Forum, a multi agency operational group, also meets bi-monthly. Its aim is to provide SADP with information on operational issues and assist with the planning process.

Current Services

In recent years the main services in Shetland providing help and support to a) people with their own substance misuse issues and b) people affected by those who are misusing substances, have been delivered by three distinct agencies; namely NHS Shetland, Shetland Islands Council and Community Alcohol and Drug Services Shetland (CADSS). The new Substance Misuse and Recovery Service is part of the Community Health and Social Care directorate and started operating in April 2015.

There are a range of services in Shetland that provide help and support to people with their own substance misuse issues or have been affected by another person’s substance misuse. Historically, these services have been delivered by a number of providers including NHS Shetland and Shetland Islands Council.

NHS Shetland provides specialist treatment and support through a Substance Misuse Service (Prescribing Clinic) and a Dual Diagnosis service. The Substance Misuse Service offers mediated detox for both alcohol and drugs. The Dual Diagnosis service currently offers support for clients with both alcohol and mental health issues.
These services are provided by:

- Medical Prescriber (Consultant Psychiatrist)
- GP with Specialist Interest (GPwSI)
- Substance Misuse Nurses
- Substance Misuse Support Workers

Referrals to the service are via GP. In addition to the above, Generic treatment and support for people experiencing difficulties with their use of alcohol and drugs can be accessed through A&E, the Mental Health Department and GP surgeries.

Shetland Islands Council employs a Specialist Substance Misuse Social Worker who provides support for people who are not currently accessing treatment or support for their substance misuse. This post holder also undertakes work to support access to residential rehabilitation services on the basis of the person’s assessed needs. In addition, the Local Authority Criminal Justice service works in partnership with CADSS to provide support for those subject to Drug Treatment and Testing Orders (DTTOs) imposed by the Courts.

The statutory services also work in partnership with the following local Voluntary Sector services:

- CADSS who provide early intervention, treatment, support and aftercare of those who misuse drugs and alcohol; young person’s services including input into the Schools programme; working both with individuals who have substance misuse issues and those who are affected by others misuse. Their adult services focus on the psychosocial aspects of substance misuse and work very closely with the Substance Misuse Social Worker. The CADDSS Aftercare Service supports clients with alternative ways of spending leisure time and avoiding relapses.
- SCBP (Shetland Community Bike Project) is an employment based project where all clients must be substance free to participate. A programme of approximately 6 months in length is developed with each individual with the ultimate outcome being further employment. SCBP has a 60% success rate with securing future employment for its participants.
- DAD (Dogs Against Drugs) is a small charitable organisation that is involved in early intervention and enforcement. DAD is involved in the input to the Schools programme. It also works closely with Northern Constabulary on the detection of illegal substances in Shetland.

### Funding and Resources

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<th>Net Budget</th>
<th>Savings target</th>
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<tr>
<td>Substance Misuse</td>
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### Needs/Unmet needs/Drivers for change

The review of Tier 3 Substance Misuse services has been undertaken over the last two years. SADP is now reviewing Tier 1 and 2 services to ensure the same level of effectiveness and cost-effectiveness. A Service Users Group is involved in helping us to understand the needs of
service users, and we continue to develop better ways of collecting, understanding and using the data that is available to us to inform the development of services.

**Plans for change**

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<tr>
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<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
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<tr>
<td>Review of Tier 1 and 2 substance misuse services</td>
<td>Alcohol and Drug Development Officer</td>
<td>October 2015</td>
<td>Links to National Outcomes</td>
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<td></td>
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<td>1. Improving Health &amp; Wellbeing</td>
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<td>5. Reducing health inequalities</td>
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<td>7. Safe from harm</td>
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<td>9. Resource used efficiently</td>
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**Key Risks to Delivery**

Workforce/capacity issues mean that other professional staff don’t have the time they would like in order to undertake preventative work. The main risk is the requirement to achieve savings, which makes it harder to ‘invest to save’ in the way that we would like to do. We are addressing this through the use of volunteers, where at all possible, and think of ways to maximise the contributions of staff that we do have.

**Performance Targets with links to National Outcomes**


a. Shetland Alcohol and Drug Partnership Strategy Outcomes are to:

- Reduce prevalence of alcohol and drug use in adults by 5% by 2020, through early intervention and prevention;
- Reduce alcohol and drugs related harm to children and young people;
- Improve recovery outcomes for Service Users;
- Reduce drug and/or alcohol/suicide related deaths to 2 or less a year by 2020

b. Single Outcome objectives under Outcome B: We live longer healthier lives

- To reduce alcohol consumption as a key risk factor for poor health outcomes; specifically focusing on the most vulnerable and disadvantaged individuals and communities.

c. Public Health Ten Year Plan Targets:
• To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s). The table illustrates Scotland-wide compared to Shetland rates of premature mortality.

• To reduce the number of alcohol related admissions (discharges) from a baseline of 761/100,000 discharges in 2009/10 to a target of 500 / 100,000 discharges by 2014/15, and 300/100,000 by 2021/22. (This target is based on the best performing Boards in Scotland)

Contact Details
Substance Misuse Recovery Service
Lerwick Health Centre
South Road
Lerwick
Shetland, ZE1 0TB
Tel: 01595 743006

Further Reading
• Shetland Alcohol and Drug Partnership Strategy 2016-2020
• Public Health Ten Year Strategy ‘Changing the World’ (2012-2022)
• Outcomes Framework for Problem Drug Use, October 2014, NHS Health Scotland
• CEL 01 (2012) Health Promoting Health Service
Oral Health

Policy context

The Scottish Government expects the overwhelming majority of primary dental care to be provided through independent NHS dental practices, with a Public Dental Service (PDS) meeting any shortfall in provision. A range of specialist dental services is expected to be available to provide treatment that is deemed beyond what would be expected of a primary care dentist, or is not suitable to be provided within a primary care setting.

According to the Scottish Government the remit of the Public Dental Service, is to:

- provide care for people with special needs, including people who would have difficulties accessing general dental practices
- complement the current General Dental Service and specialist services, especially in remote and rural areas
- have a public health role, and oral health promotion targeted both at populations and individuals
- assess and treat people referred for specialised and specialist services, including the use of sedation and general anaesthesia.

Current Services

For the last five years Shetland has had no local independent NHS dental practices, and the PDS has been providing primary dental care to the whole population in addition to its more targeted/specialist remits.

A new independent NHS dental practice is expecting to open in Lerwick during 2015/16 with the capacity to register up to 6000 people for NHS primary dental care. Despite this development the PDS will continue to provide:

**Planned Care** - Routine clinical primary care dental services for people who are registered with the PDS for dental care. Even with a new NHS dental practice due to open in 2015/16, Planned Care will continue to be a major part of current PDS services. Even if several more NHS dental practices were to open, the PDS would continue to provide its remit of planned care for people with special/additional needs.

**Unscheduled Care** - Emergency clinical primary care dental services for the whole population, irrespective of whether they are registered with a local dental service or not.

**Children Services** - The dental input required for Childsmile and the National Dental Inspection Programme, as well as routine clinical dental care for children registered with the PDS.

**Older People** - Providing Dental Screening and oral health promotion in Care Homes, as well as routine dental care for older people, in clinics and in homely settings.

Visiting Consultants from NHS Grampian provide Specialist oral health care services for the whole population – for orthodontics and oral & maxillo-facial surgery in particular.
The Oral Health Promotion team provides a range of dental public health activities for the whole population, including Childsmile activities in clinics, schools, and other community settings and provides Oral Health education to groups and individuals.

**Funding and Resources**

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**Needs/Unmet needs/Drivers for change**

**Plans for change**

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage independent NHS dental practices to open in Shetland</td>
<td>CADO</td>
<td>Ongoing</td>
<td>Outcomes 1, 3, 4, 5, 6, 7, 8, &amp; 9</td>
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<tr>
<td>Develop referral protocols for use by local dental practices</td>
<td>CADO</td>
<td>11/2015</td>
<td>Outcomes 1, 3, 4, 5, 8 &amp; 9</td>
</tr>
<tr>
<td>Review local oral health care for people with Special/ additional needs</td>
<td>CADO</td>
<td>4/2016</td>
<td>Outcomes 1-9</td>
</tr>
<tr>
<td>Review local availability of specialist oral health care</td>
<td>CADO</td>
<td>4/2016</td>
<td>Outcomes 1-9</td>
</tr>
<tr>
<td>Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs</td>
<td>CADO</td>
<td>4/2016</td>
<td>Outcomes 1, 3, 4, 5, 8 &amp; 9</td>
</tr>
</tbody>
</table>
### Key Risks to Delivery

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The shortfall in primary dental care capacity – both the infrastructure (dental surgeries) and the staff - dentists/ other dental care professionals.</td>
<td>The national Scottish Dental Access Initiative is focused to encourage independent NHS dental practices to open in Shetland.</td>
</tr>
<tr>
<td>The geographical isolation of remote, rural and island communities, challenges the cost-efficient provision of oral health care.</td>
<td></td>
</tr>
<tr>
<td>The increasing number of elderly people requiring domiciliary visits for high-maintenance dental care of their own teeth.</td>
<td>By increasing oral health promotion targeted at adults, to improve the oral health of the population prior to people becoming frail.</td>
</tr>
<tr>
<td>The ability to recruit suitably experienced dentists to build sustainable, long-term dental services for Shetland residents.</td>
<td>By building/using managed clinical networks in North of Scotland, to provide specialist clinical leadership and reduce clinical isolation.</td>
</tr>
<tr>
<td>The difficulty in providing post-graduate training opportunities for existing dentists, coupled by a lack of resources for post-qualification opportunities for other Dental Care Professionals</td>
<td></td>
</tr>
</tbody>
</table>

### Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decay experience of children in P1: The mean DMFT (decayed, missing or filled teeth per child) of children aged 5-6 years in P1 attending SIC primary schools</td>
<td>Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
</tr>
<tr>
<td>Number of people with access to Occasional NHS treatment who are waiting to register with PDS for Continuing Care</td>
<td>Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users</td>
</tr>
<tr>
<td>The percentage of the adult and child populations who are registered with Shetland dentists for NHS dental care</td>
<td>Outcome 5 - Health and social care services contribute to reducing health inequalities</td>
</tr>
<tr>
<td>The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland</td>
<td>Outcome 9 - Resources are used effectively in the provision of health and social care services, without waste</td>
</tr>
<tr>
<td>Contact Details</td>
<td>Montfield Clinic</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td>Burgh Road</td>
</tr>
<tr>
<td></td>
<td>Lerwick</td>
</tr>
<tr>
<td></td>
<td>ZE1 0LA</td>
</tr>
<tr>
<td></td>
<td>Tel: 01595 743160</td>
</tr>
</tbody>
</table>
**Pharmacy & Prescribing**

**Policy context**


Over the next few years significant changes will occur in medicine and therapeutics. These changes necessitate the development of new and innovative models of care to enable patients to obtain the maximum benefit. Pharmacists will have a key role in this. Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and reduce the likelihood of adverse events.

These aspirations will result in clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners. An early and key task in Shetland is the review of medicines to ensure that each medicine still provide benefit. This approach is detailed in the national strategy for polypharmacy.

The NHS continues to face increasing workforce pressures. The inclusion of NHS accredited clinical pharmacists into the primary care team is intended to increase the clinical capacity and assist in addressing the growing demands in primary care, particularly as our population in Shetland ages, and the complexity of their care increases.

**Current Services**

The department has been in place since 1998 it has steadily grown since then and for the first time in 2012 has sufficient staffing to provide a service rather than an input. The service is now within the Health and Social Care directorate following the decision by the council and Health Board to jointly appoint a director of Community health and Social Care in February 2014. The Pharmacy service is overseen by the Director of Pharmacy who has joint responsibility for NHS Orkney.

**Pharmacy services**

The pharmacy service is integrated both between Primary and Secondary Care and within Health and Social Care, and is adapting to a locality led service. People are at the heart of pharmacy services and Prescription for Excellence envisages patients linking and registering with a particular pharmacist who will support them in managing their medicines wherever they are, at home, in a care setting or in hospital. The developing service is being designed around the patient’s needs, aspirations and views, and will enable the pharmacist with the patient to draw on help from specialist pharmacists when required. Community pharmacies will increasingly be used as a single point of access to health care.
The pharmacy service will prioritise the national health and wellbeing outcomes through ensuring that people are enabled able to look after and improve their own health and wellbeing and live in good health for longer, through providing better access and tailored support. Pharmacy services are particularly designed for people, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. With medicine management support and polypharmacy reviews being provided wherever people live. And when people use, in particular, social care services the aim is for those have positive experiences of those services, and have their dignity respected through supporting patients in taking their medicines through which are designed around the needs and wishes of patients in a way that preserves their involvement, choices and dignity.

Again, and in line with the national health and wellbeing outcomes the national patient safety programme is being implemented with the aim of ensuring that people being prescribed medicines within health and social care services are safe from harm. (national outcome 7) Part of this is around ensuring that people who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. Ensuring that resources are used effectively and efficiently in the provision of health and social care services is both a national and local priority. (national Outcome 9)

### Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy &amp; Prescribing</td>
<td></td>
<td></td>
<td></td>
<td>6,500,724</td>
<td></td>
</tr>
</tbody>
</table>

### Needs/Unmet needs/Drivers for change

Recent reviews of the Out of Hours primary Care arrangement has identified roles for pharmacists identified in this plan. The need for pharmaceutical care is outlined in Prescription for Excellence. Local need is identified through referral, pharmaceutical care planning and data obtained through PIS and SPPARRA data. There are many patients in Shetland who require support in managing their medicines in their own homes. Of these there are a growing number of patients who require medicine (polypharmacy) reviews.

### Plans for change

Plans continue to develop the role of pharmacy in an incremental way as outlined in the pharmacy work plan; “creating pharmacy capacity” is required to ensure that Prescription for Excellence is delivered locally. Delivery of the plan will involve recruiting a sustainable workforce, this additional staffing commitment will ensure that polypharmacy work will increase, that the GP workforce will operate more efficiently.

Supporting Social Care Workers and patients in their own homes will help to reduce medicine waste, and supporting GP practices in improving repeat prescribing should also help too contain medicine cost. Both these interventions will also reduce the risk to patients of harm from there medicines.

In summary the plans for 2016-17 are to
• Recruit an additional 2-3 pharmacists/technicians to the workforce
• Increase the availability of support to patients in their own homes and in Care homes
• Increase the number of polypharmacy reviews by 20%
• Develop a training and support programme for Remote and Rural pharmacists

Key Risks to Delivery
Recruitment and retention of pharmacists is problematic, and to ensure a sustainable service a remote and rural fellowship is being developed which will encourage pharmacists to train and develop skills locally. Where clinicians are not engaged with the programme then this would also represent a risk to delivery.

Performance Targets with links to National Outcomes
Prescribing Performance reports are produced quarterly and the following Key Performance indicators are in place

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Current Performance 2015/16</th>
<th>Target 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per patient (GP Prescribing) should be less than Scottish average i.e. less than 100% (national outcome 9)</td>
<td>116%</td>
<td>100%</td>
</tr>
<tr>
<td>Number of prescriptions for antibiotics per 1000 patient population should be less than the Scottish average i.e less than 100% (national outcome 7)</td>
<td>101%</td>
<td>95%</td>
</tr>
<tr>
<td>Number of polypharmacy reviews completed per month (national outcome 7)</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Percentage of patients who’s medicines are reconciled by a pharmacist within 72 hours of admission per month (national outcome 7)</td>
<td>77%</td>
<td>75%</td>
</tr>
<tr>
<td>Number of discharge prescriptions dispensed out of hours by nursing staff should be less than 50 per month (national outcome 7)</td>
<td>51</td>
<td>48</td>
</tr>
</tbody>
</table>
Contact Details
The pharmacy department can be contacted on 743370.
Director of Pharmacy is Chris Nicolson at christophernicolson@nhs.net

Further Reading
The pharmacy and prescribing services has pages on the internet. National Polypharmacy guidance describes the national context for planned pharmacy work within the context of the national Pharmacy vision and work plan, Prescription for Excellence
Primary Care

Policy context
- Integration of health and social care and implementation of Health and Wellbeing Outcomes.
- Introduction of a new GP contract in April 2017
- Primary Care strategy (in progress)
- National Out of Hours review

Primary health care services will be required to adapt to meet the health care needs of an ageing population that has rising expectations of health care and treatments. Other factors that affect the development of services include statutory guidance on working hours, rising professional standards and a shortage of health care professionals.

The key drivers for looking at how primary care operates are:
- We want to improve the health of the people in Shetland and ensure healthcare services are meeting public expectation;
- There is greater demand on local health services in part due to an aging population, with greater health needs;
- A hospital setting is not always the answer; more care can be delivered in primary care and community settings than ever before and patients benefit from care provided closer to their home;
- There are workforce challenges (for example recruitment of GPs) which currently affect delivery of the best quality care and optimal patient outcomes;
- We need to adopt new models of care and best practice which can deliver better health outcomes for patients;
- We want to ensure care is safe, effective, efficient and patient centred.

Current Services
Traditionally, the “four pillars” of Primary Care have been GP Services, Pharmacy Services, Dental Services and Ophthalmic Services. There are separate dental and pharmacy departments in Shetland and these are therefore not covered in this section.

For GP Services, there are currently ten Health Centres in Shetland, together with five non-doctor islands which are staffed by Community Nurses and who receive GP services from a local health centre. Of the ten GP Practices, three are directly salaried to NHS Shetland (all staff are employed by NHS Shetland) and the other seven are what is known as independent practices – this means they contract with NHS Shetland to provide core GP services to their practice population, for which they receive funding worked out through a national formula and it is the responsibility of the independent GP practice to decide how to use this funding to provide the contracted services. It should be noted that the NHS in Scotland will see the introduction of a new GP contract in April 2017, although details on the format of this new contract are still to be released. It is expected that substantial work will be required across Scotland to introduce the new contract and Shetland will be no different in this regard; this is referred to in the actions for 16/17 and this service plan will be updated once the detail of the contract has been negotiated.

Within Ophthalmic services, there are three providers of general ophthalmic services in Lerwick, which are open to all Shetland residents. There are also visiting Ophthalmic Consultants who hold clinics in Gilbert Bain Hospital for patients referred to them with complex eye problems. NHS Shetland contracts with NHS Grampian for the provision of an Optometry Advisor role, with the Optometry Advisor undertaking three yearly Ophthalmic Premises inspection visits in conjunction with the local Primary Care Manager, in addition to being a member of the Eyecare Managed Clinical Network. The most recent visits were completed in September 2015.
Funding and Resources

Table of budget and savings targets, including workforce details. Please note that workforce details for the independent practices are not available and any additional income e.g. dispensing income within independent practices will not be shown below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Department (incl. appraiser costs)</td>
<td>2.4</td>
<td>157,637</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lerwick Health Centre</td>
<td>17.83</td>
<td>1,157,124</td>
<td>4,400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yell Health Centre</td>
<td>4.81</td>
<td>314,282</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whalsay Health Centre</td>
<td>3.6</td>
<td>278,559</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unst Health Centre</td>
<td></td>
<td>263,067</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hillswick Health Centre</td>
<td></td>
<td>329,144</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brae Health Centre</td>
<td></td>
<td>358,191</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scalloway Health Centre</td>
<td></td>
<td>395,794</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bixter Health Centre</td>
<td></td>
<td>274,221</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walls Health Centre</td>
<td></td>
<td>223,774</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levenwick Health Centre</td>
<td></td>
<td>377,415</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Hours (including police)</td>
<td>Bank rota</td>
<td>258,400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmic</td>
<td></td>
<td>364,700</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
<td></td>
<td>4,402,320</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

Primary Care has been set a savings target for 2016/17 of £275,000. This will be across all areas of the budget although the actual detail of savings will not be examined until after the publication of the primary care strategy.

Drivers for change:
- There is variation in opening times, different appointment systems and waiting times for appointments between practices;
- There is variation in additional services provided, for example enhanced family planning and minor surgery;
There are current difficulties with balancing the requirements to provide enough appointments to meet demand within waiting times, with the need to spend sufficient time with patients;

There are geographical issues, which may influence ease of access;

There are noticeably different arrangements in hours and out of hours;

Recruitment and retention has proven to be problematic in recent years, across all Practices in Shetland. It is not unusual for there to be several rounds of advertising and it is becoming more difficult to recruit staff who wish to work in a remote and rural location;

A changing workforce profile and changing skills set needed for new models of care;

Changes to secondary care provision in terms of services now being offered through primary care providers rather than the hospital;

Inequity of funding provision across Primary Care in Shetland;

Clinical/medical innovations and improvements such as telehealth.

### Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement 2016/17 GP Contract and QOF amendments</td>
<td>Lisa Watt</td>
<td>April 2016</td>
<td>All Shetland practices to have a contract based on 15/16 contract and QOF amendments once issued by Scottish Government. (H&amp;WO 1, 2, 3, 4, 5, 6, 7, 8, 9)</td>
</tr>
<tr>
<td>Implement agreed actions from Primary Care Strategy (due to report by February 2016). Service Plan will be updated with specific actions once these are agreed</td>
<td>Lisa Watt</td>
<td>April 2016</td>
<td>(H&amp;WO 1, 2, 3, 4, 5, 6, 7, 8, 9)</td>
</tr>
<tr>
<td>Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards. Details of the contract will only be announced in Spring 2016 and there is therefore no further detail to hand at present.</td>
<td>Lisa Watt</td>
<td>April 2016</td>
<td>Smooth implementation for go live date of 1st April 2017, ensuring seamless transition and no disruption to services (H&amp;WO 1, 2, 3, 4, 5, 6, 7, 8, 9)</td>
</tr>
<tr>
<td>Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015</td>
<td>Lisa Watt</td>
<td>April 2016</td>
<td>(H&amp;WO 1, 2, 3, 4, 5, 6, 7, 8, 9)</td>
</tr>
</tbody>
</table>
| **Continue to support the growth of the Scalloway practice** | Lisa Watt | April 2016 | Increasing the practice size in Scalloway will help practice viability, as well as ensuring a more even spread of patient numbers across central Shetland. 
(H&WO 3, 4, 5, 7, 8, 9) |

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### Key Risks to Delivery

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Recruitment across 5 GP Practices in Shetland</td>
<td>Service redesign including use of Advanced Nurse Practitioners in Lerwick Health Centre. Different types of advertising are being used, including Facebook and attendance at the RCGP conference to promote Shetland as a place to work and live.</td>
</tr>
<tr>
<td>Recruitment and retention of staff at all grades</td>
<td>There is low unemployment in Shetland at the moment, which is leading to difficulties in recruitment. Promoting NHS Shetland as a favourable place to work and actively supporting training schemes (such as the GP Training scheme) has benefits to recruiting staff.</td>
</tr>
<tr>
<td>Capacity in small Primary care management team required for day to day management and ongoing service redesign</td>
<td>Under review</td>
</tr>
</tbody>
</table>

### Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Measure</th>
<th>National Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre</td>
<td>Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
</tr>
<tr>
<td>Percentage conversion of OOH GP house visits converting to admission to hospital</td>
<td>Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community</td>
</tr>
</tbody>
</table>
Contact Details
Lisa Watt
Service Manager Primary Care
Directorate of Community Health & Social Care
NHS Board Headquarters
Montfield, Lerwick

e.watt1@nhs.net
693209

Further Reading
Community Nursing Services

Policy context
The Scottish Government’s 2020 vision is “that by 2020 everyone is able to live longer healthier lives at home or in a homely setting”. NHS Scotland notes that they will achieve this vision by delivering a healthcare system which has
- An Integrated Health & social care service
- A focus on prevention, anticipation, and supported self management
- Person-centred care, delivered to the highest standard of quality and safety
- Care provided in community settings unless hospital treatment is required
- People back to their home/community as soon as possible with minimal risk of readmission.

The delivery of the Scottish Government’s vision will be influenced by the demographic challenges posed by the local community, as well as those experienced within the District Nursing workforce which is also an ageing workforce. The ageing population sees people living longer with more complex healthcare needs, and with more longterm conditions.

The District Nursing service assists with the delivery of the following targets
- Reduction in the number of avoidable A&E attendances and admissions;
- Early supported discharge and reduction in delayed discharges from hospital;
- Reduction in emergency in-patient bed day rates for people aged 75 years or over;
- Percentage of time in the last 6 months of life spent at home or in a community setting;
- Shifting the balance of care into an anticipatory model rather than reactive model to support long term conditions management; and
- Proportion of people aged 75 years and over living at home who have an Anticipatory Care plan shared.

A new GP contract is being developed for implementation in April 2017 and a national review of District Nursing services is currently taking place, which is scheduled to report in April 2016. Both of these areas of work will influence the future shape and delivery of nursing services in the Community Setting for the future.

Current Services
The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting.

The District Nursing service is the largest part of Community Nursing services and provides a nursing service to individuals within their own home, or a care home, on a 24 hours a day, seven days a week, 365 days a year basis.

The District Nursing service provides
- Acute care at home;
- Complex care at home;
- End of life care at home.
From April 2012, the District Nursing service has provided a shift based, 24 hours a day, 7 days a week service on mainland Shetland.

The following groups of staff who provide care in a community setting are also provided, and managed, via the Community Nursing service:

- **Practice Nurses** – the Practice Nursing service for all of the Board provided general practices, namely Lerwick, Yell and Whalsay;
- **Advanced Nurse Practitioners** – the Advanced Nurse Practitioner posts based at the Lerwick Health Centre;
- **Specialist Nurses**, eg Continence Nurse Advisor;
- **Non-Doctor Island/Out of Hours Nursing** – there are resident nurses on the non-doctor islands of Fair Isle, Foula, Fetlar, Skerries and Bressay. Some of these postholders, along with their relief colleagues, provide the overnight nursing service on mainland Shetland; and
- **Intermediate Care Team** – this multi-disciplinary, partnership team provide additional support at home for individuals to prevent unnecessary admission to hospital or provide additional support to increase independence on discharge home from hospital. This additional support is provided on a time limited basis of up to 6 weeks. The team are based at the Independent Living Centre, Gremista, Lerwick.

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

All of the component services within Community Nursing services work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.

### Funding and Resources

The overall Community Nursing Services has approx 48.1 full time equivalent staff and an annual revenue expenditure of £2.3 million. The staffing establishment is as detailed below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Nursing services</td>
<td>48.1</td>
<td></td>
<td></td>
<td>£2,398,437</td>
<td></td>
</tr>
</tbody>
</table>

### Needs/Unmet needs/Drivers for change

<table>
<thead>
<tr>
<th>Service Aims/Priorities</th>
<th>Objectives/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>There will be a demonstrably healthier local population who are able to remain in their own</td>
<td>All community based nurses will promote healthy lifestyles to all individuals on the caseload.</td>
</tr>
</tbody>
</table>
### Service Aims/Priorities

<table>
<thead>
<tr>
<th>homes or in a homely environment for as long as they so wish.</th>
<th>Anticipatory care plans will be developed with individuals in order to support them to remain in their own homes for as long as possible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so</td>
<td>District Nurses/Community Nursing service will work as part of a locality service delivery model, influencing and leading care for individuals with a health need.</td>
</tr>
<tr>
<td>Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to “tell their story once”.</td>
<td>District Nurses will actively adopt the case manager role for individuals with complex health needs.</td>
</tr>
</tbody>
</table>

### Plans for change

#### New Planned Actions Due to Start in 2016/17

<table>
<thead>
<tr>
<th>Title/Heading</th>
<th>Team</th>
<th>Start</th>
<th>End</th>
<th>Output</th>
<th>Expected Outcome/Supported Aims/Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further develop sustainable Intermediate Care Team with integral overnight nursing/care service</td>
<td>Intermediate Care Team</td>
<td>April 2016</td>
<td>July 2016</td>
<td>Sustainable service in place</td>
<td>Provides a 24hour nursing and care service at home thus supporting early supported discharge from hospital as well as avoiding unnecessary admissions</td>
</tr>
<tr>
<td>Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care</td>
<td>Chief Nurse</td>
<td>April 2016</td>
<td>March 2017</td>
<td>Electronic record keeping/management system in place</td>
<td>Enhance communication across multidisciplinary, interagency teams thus supporting improved seamless care for individuals</td>
</tr>
<tr>
<td>Further develop model of case management</td>
<td>Chief Nurse</td>
<td>Ongoing</td>
<td></td>
<td>District Nurses undertake case management role</td>
<td>Better co-ordinated care for individuals with complex health needs</td>
</tr>
</tbody>
</table>
### New Planned Actions Due to Start in 2016/17

<table>
<thead>
<tr>
<th>Title/Heading</th>
<th>Team</th>
<th>Start</th>
<th>End</th>
<th>Output</th>
<th>Expected Outcome/Supported Aims/Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>within Community Nursing services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue to support implementation of eKIS Anticipatory Care Planning across the services</td>
<td>Chief Nurse/ Clinical Team Leaders</td>
<td>Ongoing</td>
<td></td>
<td>Increase in eKIS plans in place across all General Practices in Shetland</td>
<td>Enhance anticipatory approach to care for individuals with complex health needs.</td>
</tr>
<tr>
<td>Conduct review of local District Nursing services in line with national “Transforming Nursing Roles” project</td>
<td>Chief Nurse</td>
<td>April 2016</td>
<td>September 2016</td>
<td>Ensure that District Nursing workforce locally continues to develop with national direction</td>
<td>District Nursing workforce is fit for purpose for 21st century</td>
</tr>
<tr>
<td>Develop Nursing in Community Strategy</td>
<td>Chief Nurse</td>
<td>September 2016</td>
<td>March 2017</td>
<td>Set strategic direction for nursing in community settings</td>
<td>Strategy developed to support careers in nursing in a community setting which provides a career framework from initial registration to Advanced Practice. Nursing service supports implementation of new GP contract from April 2017</td>
</tr>
</tbody>
</table>

### Key Risks to Delivery
During 2015-2016 the Community Nursing service has continued to experience significant difficulty with recruitment in the service, the effects of this in terms of service provision being
further compounded by a number of staff who have had a period of longterm sickness absence whilst awaiting or recovering from surgical interventions.

It is hoped that a number of these issues will be resolved before we enter 2016-2017. The impact of these issues has been to limit service development in 2015-2016 as staff have had to focus on meeting the current clinical needs of patients on the active caseload.

Performance Targets with links to National Outcomes

The overall aims and objectives of all the constituent parts of the Community Nursing services are to:

• Support and maximise the health potential of individuals, as well as address the health and care needs of various client groups and/or their carers within the wider community; and
• Utilise a holistic approach to providing safe, effective, person-centred care in a variety of community settings.

These aims and objectives contribute to the delivery of the National Health and Wellbeing Outcomes, in particular:

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

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

<table>
<thead>
<tr>
<th>Service Aims/Priorities</th>
<th>Objectives/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish.</td>
<td>All community based nurses will promote healthy lifestyles to all individuals on the caseload. Anticipatory care plans will be developed with individuals in order to support them to remain in their own homes for as long as possible.</td>
</tr>
<tr>
<td>The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so</td>
<td>District Nurses/Community Nursing service will work as part of a locality service delivery model, influencing and leading care for individuals with a health need.</td>
</tr>
<tr>
<td>Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to “tell their story once”.</td>
<td>District Nurses will actively adopt the case manager role for individuals with complex health needs.</td>
</tr>
<tr>
<td>Performance Measure</td>
<td>Performance 2015/16</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Number of Early Supported Discharges</td>
<td></td>
</tr>
<tr>
<td>Number of Admissions Avoided through involvement of Intermediate Care Team</td>
<td></td>
</tr>
<tr>
<td>Number of individuals with complex health needs whose care is case managed by a District Nurse</td>
<td></td>
</tr>
<tr>
<td>Number of Anticipatory Care Plans in place and shared across services</td>
<td></td>
</tr>
<tr>
<td>Number of early supported discharges with no re-admission in 30 days</td>
<td></td>
</tr>
<tr>
<td>Number of people supported to die in preferred place of care</td>
<td></td>
</tr>
<tr>
<td>Number of people supported to have a solution to their continence problem which is not a containment solution</td>
<td></td>
</tr>
<tr>
<td>Number of individuals seen by an Advanced Nurse Practitioner as first point of access to healthcare</td>
<td></td>
</tr>
<tr>
<td>Number of individuals seen by an Advanced Nurse Practitioner who subsequently referred to another practitioner for a “second opinion”</td>
<td></td>
</tr>
<tr>
<td>Patient Satisfaction survey of patients seen by Advanced Nurse Practitioners</td>
<td></td>
</tr>
</tbody>
</table>

**Contact Details**

Edna Mary Watson  
Chief Nurse  
Directorate of Community Health & Social Care  
NHS Board Headquarters  
Montfield  
Lerwick  
Email edna.watson@nhs.net  
Phone Number – 01595 743377
Intermediate Care

Policy context

The background to the implementation of intermediate care is detailed in the Scottish Government’s Reshaping Care for Older People strategy:


and in the Intermediate Care Framework for Scotland:


The Reshaping Older Peoples Care Agenda aims to reduce unplanned admissions to hospital or long term care, enhance discharge planning, recovery and self-management.

Some of the key drivers behind this agenda are:

- HEAT Targets – the delayed discharge target is for no person to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015.

- AHP National Delivery Plan (Scottish Government, 2012)
  - Action 2.3 AHP directors will work with directors of social work and their NHS boards to maximise the AHP contribution to achieving delayed discharge targets and reduce overall length of stay in hospital, which will support the delivery of the legal treatment time guarantee.
  - Action 2.4 AHP directors will work with directors of social work to support older people and those with disability and complex needs to live independently in their own home/homely setting for as long as possible, delaying or reducing admissions into institutional care.
  - Action 2.5 AHP directors will work with directors of social work to reconfigure “enabling” services, such as rehabilitation and reablement, to deliver best value and enhance care experiences for people who use services and their families and carers.

Current Services

Intermediate care will deliver the following.

- Individuals will be supported to remain at home, thus avoiding unnecessary admissions to the hospital;
- Individuals will be supported home from hospital and can receive 24 hour care at home for the first 5-7 days thus providing time to undertake further assessment of need once at home and within familiar surroundings;
- Enhanced care to palliative care patients who can receive additional nursing care and support on a 24/7 basis;
- Provision of support and advice to care centre staff on the management of clients with nursing, healthcare and therapy needs;
- Enhanced therapy input to ensure functional abilities are maximised.
- Additional “enabling” and “reabling” input through therapy assistant input.
- Assessment of individual patient needs on a 24/7 basis by Registered Nursing staff.
• First point of access to healthcare for patients with care needs via support/advice/assessment provided by District Nurses/Nurse Practitioners contacted directly by care staff.

The Intermediate care team has to deliver the following outcomes:

• Reduction in numbers of individuals admitted to the Gilbert Bain Hospital or residential setting with primarily a social or nursing care need;
• Reduction in emergency admissions to the GBH and residential care.
• Increase in the number of people successfully returned to a home/residential care setting post GBH admission;
• Increase in number of people who could be considered to be cared for primarily in a community setting due to support being available from the overnight nursing and care team.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care</td>
<td>5.8 WTE employed by SIC</td>
<td></td>
<td></td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>1.3 WTE Availability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

Service redesign is based on the availability of funding for the next financial year. The service is currently expanding to meet the needs of an elderly population. The growth of their service will expand across the whole of Shetland mainland.

Plans for change

Currently the service has been developing for the past 12 months. Service evaluation is currently being taken place. At this time there are no plans for change.

Key Risks to Delivery

Funding cute are a viable risk. Audit is being conducted on a regular basis to show the cost saving of patients in the community setting vs hospital settings. This will show over the next financial year a trajectory of service delivery thus meeting the needs of the national outcomes measures.
Performance Targets with links to National Outcomes

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

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

Contact Details

Christopher Rice
Intermediate Care Team Lead
Tel: 07795 370 112
e-mail: christopher.rice@nhs.net
Sexual Health

Policy context

Current Services

Strategic planning and co-ordination of services is led by a local multi-agency Sexual Health and Blood Borne Virus Strategy group. It oversees the co-ordination of this area of work in Shetland, including developing the Strategy and workplans and monitoring progress.

There are two main elements to sexual health services: the Sexual health and wellbeing clinic and primary care services. However sexual health work is also incorporated into a number of other services including school nursing and health visiting; secondary care (particularly gynaecology); public health and health improvement; sexual health and relationships education in schools and the voluntary sector (OPEN Peer Education project).

The Sexual Health and Wellbeing (SHWB) Clinic runs once a week in the out-patients department of the Gilbert Bain Hospital and provides both family planning and genitourinary medicine services with health promotion as a key element. It is primarily nurse led with some GP clinics. The service has recently undertaken a project with NHS Grampian to develop telemedicine facilities for patients diagnosed with HIV, including consultant and psychologist appointments supported by the sexual health clinic staff in the hospital outpatient department, reducing the need for patients to travel off island for care and support. During 2015 the service was amalgamated with maternity, early pregnancy, and some gynaecology services to establish a more robust Reproductive Health Service. This new service is managed by the Senior Charge Midwife for Reproductive Health.

Primary Care: There are ten general practices in Shetland. Each offers access to some contraceptive services for their patients and a number also see non-registered patients for contraceptive services. Not all practices currently offer long acting reversible contraception (LARC) but those that do not have arrangements with other practices to ensure the service is provided. All the practices can offer screening for STIs via the local laboratory services and those in Grampian. Emergency contraception is available out of hours: five of the GP practices provide their own out of hours services, the other practices use NHS24. There is also a walk-in primary care service at weekends in the Gilbert Bain Hospital. The five Community Pharmacies in Shetland can all provide emergency hormonal contraception free of charge to the patient.

Funding and Resources
It is not currently possible to identify the total costs for Sexual Health Services. There is dedicated income, but this does not cover all the costs. The budget specifically for the Sexual Health and Wellbeing Clinic is outlined below. The funding and resources in other services and organisations that are used to provide sexual health services can not currently be separated out from their overall budget allocations and work force.
The Sexual Health and Wellbeing Clinic has an annual budget of £40,000. Staff are rotated to the clinic from the maternity service and supported by other sessional nurses. In addition, there is a GP and a healthcare support worker at the clinic every other week.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health Clinic</td>
<td>Sexual Health Clinic (staffing includes one GP, nurses, HCSWs and admin staff on a sessional basis; managerial support)</td>
<td>£40,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Needs/Unmet needs/Drivers for change**

- As there is more local and national activity on awareness raising and health promotion, then more people are coming forward to access services.
- Demand for the sexual health clinic is increasing; including more people presenting who are at risk but currently asymptomatic; more men attending; and potentially people now coming to the local clinic who previously went to clinics on the mainland (although this is hard to quantify).
- There is also increased demand for long-acting reversible contraception as this is being actively promoted: insertion of coils and implants requires specific additional training for staff, which will not be met within current resources.
- It is recognised that access to the Sexual Health and Wellbeing Clinic is limited, especially for people who live out with Lerwick and those that cannot get there in the evening. The development of the reproductive health team should allow greater flexibility in the provision of services out with the clinic.
- There is scope for more work on understanding and addressing the needs of the local LGBT (lesbian, gay, bisexual, transgender) community, and specifically MSM ('men who have sex with men').
- There is scope for more work on understanding and addressing the needs of people locally who may be affected by Gender Based Violence (including rape and sexual assault; childhood sexual abuse; human trafficking & sexual exploitation): this links with the work on Domestic Abuse.
- There is scope to improve the pathways for women who require a termination of pregnancy (who currently have to go to Aberdeen) and other services currently provided in Aberdeen utilising telemedicine to provide a satellite service linked to NHS Grampian.
### Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for nurses / midwives to fit LARC implants</td>
<td>Elaine McCover</td>
<td>December 2015</td>
<td>Reduction in unplanned pregnancy</td>
</tr>
<tr>
<td>Training for nurses / midwives to fit contraceptive coils</td>
<td>Elaine McCover</td>
<td>December 2016</td>
<td>Reduction in unplanned pregnancy</td>
</tr>
<tr>
<td>Implementation of electronic patient record system (NaSH)</td>
<td>Elaine McCover/Andrew Carlisle</td>
<td>December 2016</td>
<td>ENMAHP health agenda</td>
</tr>
<tr>
<td>Look at improving termination pathway to reach 9 weeks target including looking at what elements of the service could be carried out on Shetland</td>
<td>Elaine McCover</td>
<td>December 2016</td>
<td>Reduction in unplanned pregnancy</td>
</tr>
<tr>
<td>All pregnant women to have antenatal discussion re contraception, and be discharged from maternity services postnatal with an effective method of contraception, with an emphasis on LARC</td>
<td>Elaine McCover</td>
<td>complete</td>
<td>Reduction in unplanned pregnancy</td>
</tr>
<tr>
<td>24/7 provision of emergency contraception through reproductive health service rather than A&amp;E</td>
<td>Elaine McCover</td>
<td>April 2016</td>
<td>Reduction in unplanned pregnancy</td>
</tr>
</tbody>
</table>

### Key Risks to Delivery

**Training for staff and maintaining competencies**

Whilst many courses can be accessed on-line, there is still the need for clinical training and experience which can require time spent ‘off island’. The expense of travelling to mainland Scotland and often needing to spend one or more nights away from Shetland can be prohibitive. This is also particularly difficult for nurses in the sexual health clinic who might only work two sessions a month, again this should be improved by the newly established reproductive health team and greater ability to provide some training locally. Where possible, we endeavour to bring trainers to Shetland where this is more cost effective and practical, although sometimes this is not possible because of the relatively small number of people here who require the particular training being offered.
Sustainability of the sexual health clinic

There have been previous attempts at running a clinic in the past, which had been unsustainable largely due to lack of funding, trained staff and managerial support. However, we now have a good structure in place with the clinic integrated into the Reproductive Health Team, and also aim to have sustained clinical leadership through the new consultant post. We also have a team of sessional staff who have undergone training. However, a proportion of funding for the clinic is provided through the prevention Bundle allocation for the Scottish Government, and if this were to stop the service would be under threat.

Performance Targets with links to National Outcomes

National Sexual Health and BBV Outcomes:

Outcome 1: Fewer newly acquired BBVs and STIs; fewer unintended pregnancies.
Outcome 2: A reduction in the health inequalities gap in sexual health and BBVs.
Outcome 3: People affected by blood borne viruses lead longer, healthier lives.
Outcome 4: Sexual relationships are free from coercion and harm.
Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive.

National Key Performance Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>TARGET 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>The proportion of women of reproductive age with intrauterine and implantable contraceptives (LARC):</td>
<td>108.8 per 1000 women</td>
<td>Not yet available</td>
<td>60 per 1000 women</td>
<td></td>
</tr>
<tr>
<td>Teenage pregnancy (rate per 1000) for &lt;16 year olds</td>
<td>Not yet available</td>
<td>Not yet available</td>
<td>Maintain at &lt;2 per 1000 (Local target)</td>
<td></td>
</tr>
<tr>
<td>Teenage pregnancy (rate per 1000) for &lt;20 year olds</td>
<td>Not yet available</td>
<td>Not yet available</td>
<td>No target</td>
<td></td>
</tr>
<tr>
<td>Percentage of termination of pregnancy procedures taking place at less than or equal to 9 weeks gestation per NHS Board.</td>
<td>60.9% (for all 3 island boards)</td>
<td>Not yet available</td>
<td>TARGET 70%</td>
<td></td>
</tr>
<tr>
<td>Proportion of women who have had a termination, who leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants).</td>
<td>Not measured</td>
<td>Not yet available</td>
<td>TARGET 60%</td>
<td></td>
</tr>
</tbody>
</table>

There are currently no national HEAT targets or local SOA indicators relating specifically to sexual health.
Contact Details
Reproductive Health Service: Elaine McCover

Further Reading
Healthy Shetland Website: Sexual Health Information, including information and a video and the clinic.
www.healthyshetland.com/health-topics/sexual-health
Adult Services

Adult Learning Disability and Autism Spectrum Disorder Service

Policy context

There are a wide range of legislative provisions which impose powers and duties on the local authority with regard to the care and support of people with learning disabilities. The main statutory duties are contained in Sections 25 and 26 of the Mental Health Care and Treatment (Scotland) Act 2003. For the purposes of this Act a mental disorder includes learning disabilities and autistic spectrum disorders. Section 25 provides that a local authority is obliged to provide or arrange the provision of care and support to people who have or have had a mental disorder and are in need of services. Section 25 states that the care and support services provided shall be designed to minimise the effect of the mental disorder on such persons; and give such persons the opportunity to lead lives which are as normal as possible. This can include accommodation and care at home to support both quality of life and safety.

Section 26 provides that the local authority shall provide services which promote the social development and well being of persons with a mental disorder. This includes services which provide the following:

- Social, cultural and recreational activities;
- Training for such of those persons as are over school age;
- Assistance for such of those persons as are over school age in obtaining and in undertaking employment

Other legislation which shapes service delivery for people with learning disabilities and autistic spectrum disorders includes; Social Work (Scotland) Act 1968; NHS and Community Care Act 1990; Adults with Incapacity (Scotland) Act 2000; Regulation of Care (Scotland) Act 2001; Mental Health (Care and Treatment) (Scotland) Act 2003; Adult Support & Protection (Scotland) Act 2007; Social Care (Self-directed Support) (Scotland) Act 2013; Public Bodies (Joint Working) (Scotland) Act 2014; Carers (Scotland) Bill 2015.

Current Services

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

Supported Living and Outreach Service (SL&O) provides Supported Tenancies for adults with learning disability, autism spectrum disorder and complex needs. Outreach support for people living in their own or family home may also be available. Each person will is supported to develop a person centred plan that assists them to achieve goals and outcomes and manages welfare and financial risks.

Supported Vocational Activity Service includes the Eric Gray Resource Centre (EGRC) which provides a range of educational, recreational and social activities to meet the assessed need of adults with a learning disability, autism spectrum disorder and complex needs in line with EGRC criteria.

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

A Short Break and Respite Service is provided from Newcraigielea service which offers 8 en-suite bedrooms and 1 self-contained bedsit for short breaks and respite to meet the assessed need of adults with a learning disability, autism spectrum disorder and complex needs and that of any unpaid carer in line with eligibility criteria. Newcraigielea also offers a day care services through the GOLD Group for older people with learning disability to meet the level of assessed need in line with eligibility criteria.

Learning Disability Nurse is a single handed, community nursing service offered throughout Shetland for people aged 5 - 75 with a learning disability in addition to a health need. The nurse works with a range of services such as Education, Social Work, Supported Employment, Day and Voluntary Sector Services. There is a consultative and liaison service with Secondary Health Care, Adult Mental Health, CAMHS, Community and Children’s Nursing.

Specialist Psychiatry and Clinical Psychology are provided by a visiting Consultant Psychiatrist and a visiting Clinical Psychologist offer outpatient appointments or home visits as appropriate.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Services</td>
<td></td>
<td></td>
<td></td>
<td>5,330,617</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

The number of people in Shetland with learning disability, autistic spectrum disorder, profound and multiple complex needs known to the Local Authority is slightly above the national average with just over 8 people per 1000 compared to the Scottish average of 6 people per 1000. At October 2015, this translates into 197 adults with either Learning Disability or Autism Spectrum Disorder and a further 51 under 16’s year olds in Shetland.

Advances in medical and social care have led to a significant increase in the survival rate and life expectancy of the population as a whole, including people with learning disabilities and autistic spectrum disorder.

As the population of people with a learning disability and autism spectrum disorder grows larger and are reaching older age, experiencing the issues associated with older age such as arthritis, the menopause and dementia, it is increasingly important to consider what enables people to remain in their own homes and have meaningful lives in their communities. Additionally, it is recognised that 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:

- Growing public expectations that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
- Demographic change with increasing birth survival rates and life expectancy,
- Rise in prevalence of people with autism spectrum disorder
- Increased risk for people with learning disabilities to experience age related issues, e.g. dementia;

---

- Reductions in public funding due to the recession and current ongoing difficult economic climate;
- Persisting inequalities in health;
- The need to demonstrate outcomes not just process;
- The need to consider the sustainability of services.

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

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

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

### Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target end date</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
</table>
| Progression of the Day Services New Build (EGRC) | Clare Scott | Started July 2014. Ongoing April 2016 | • Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.  
• People who use health and social care services have a positive experience of those services, and have their dignity respected. |
| Holistic review of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the review. | Clare Scott | April 2016 | • People with LD/ASD are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community,  
• Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.  
• People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.  
• Ensuring that resources are used effectively and efficiently in the provision of health and social care services. |
### Key Risks to Delivery

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| Staff Numbers/Skill Shortage/                                        | Maximise retention of staff, develop flexibility and resilience within teams and across service area  
We will do this by; ensuring that staff across all service areas are engaged in the work they do and are supported to continuously improve the information, support, care and treatment they provide; ensuring that Maximising Attendance Policy is strictly adhered to; maintaining good working relations between staff and line managers; ensuring recruitment processes are LEAN and that any barriers to recruitment are dealt with promptly; continuation of Modern Apprenticeship scheme and Traineeship in collaboration with Shetland College to attract new staff; ensuring succession planning and CPD opportunities are central to review cycles. |
| Business Continuity Plans Inadequate                                  | Business continuity plans are in place for each service strand in Ad.Svs - LD&ASD with contingencies plans in place to address key business failures that could impact on service delivery. Plans are monitored and reviewed a minimum of annually or as and when required.                                                                                      |
| Contractual Liabilities and Failure Of Key Supplier                   | Service Level Agreements (SLA) and/or Grant Condition Agreements are in place for all services purchased from local voluntary and not for profit organisations. Procedures set out in clear document available to all. Each SLA has a nominated Lead to oversee functioning of provision.                                                                                                                              |
| Managing Expectations of the Community                                | Develop user friendly, public information resources and ensure availability in a number of formats (e.g. electronic; easy read; paper; etc). Set clear criteria for services. Eligibility criteria for community care services are in place and in line with revised national guidance. This forms an integral part of the revised SSA process With You, For You.                                                                                      |

### Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Measure</th>
<th>Aim</th>
<th>National Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills</td>
<td>Adults with learning disability, autistic spectrum disorder and/or complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted</td>
<td>Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users</td>
</tr>
<tr>
<td>Number of emergency respite nights provided for adults with LD/ASD.</td>
<td>Advance Care Plans will be developed with people, those close to them and service providers to make decisions with respect to their future health, personal and practical aspects of care and support. The risk of unscheduled care will be reduced.</td>
<td>Outcome 6 - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing</td>
</tr>
<tr>
<td>An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Social Care staff trained to implement Positive Behaviour Support.</td>
<td>Staff will have the knowledge and theory of Positive Behaviour Support and be able to put into practice in the support they provide.</td>
<td>Outcome 8 - People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do</td>
</tr>
</tbody>
</table>
### Contact Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare Scott</td>
<td>Executive Manager Adult</td>
<td>Upper Floor Montfield Burgh Road Lerwick Shetland ZE1 0LA</td>
<td>e-mail; <a href="mailto:clare.scott@shetland.gov.uk">clare.scott@shetland.gov.uk</a> Phone 01595 744330</td>
</tr>
<tr>
<td>Connie Russell</td>
<td>Team Leader</td>
<td>Kantersted Road Lerwick Shetland ZE1 0RJ</td>
<td>e-mail; <a href="mailto:connie.russell@shetland.gov.uk">connie.russell@shetland.gov.uk</a> Phone 01595 745560</td>
</tr>
<tr>
<td>Robbie Simpson</td>
<td>Team Leader</td>
<td>Seafield Road Lerwick Shetland ZE1 0WZ</td>
<td>e-mail; <a href="mailto:robbie.simpson@shetland.gov.uk">robbie.simpson@shetland.gov.uk</a> Phone 01595 744463</td>
</tr>
<tr>
<td>Jordan Sutherland</td>
<td>Team Leader Supported Living and Outreach Community Health and Social Care Grantfield Lerwick Shetland ZE1 0NT</td>
<td>e-mail; <a href="mailto:jordan.sutherland@shetland.gov.uk">jordan.sutherland@shetland.gov.uk</a> Phone 01595 74 4306</td>
<td></td>
</tr>
<tr>
<td>Andrea Holmes</td>
<td>Learning Disability Nurse</td>
<td>Grantfield Lerwick Shetland ZE1 0NT</td>
<td>e-mail; <a href="mailto:andrea.holmes@nhs.net">andrea.holmes@nhs.net</a> Phone 01595 807487</td>
</tr>
</tbody>
</table>

### Further Reading

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

Comprehensive information on the provisions of the relevant legislation is available from the Scottish Government website [http://www.gov.scot/Home](http://www.gov.scot/Home)
Adult Social Work

Policy context
- Integration of health and social care and implementation of Health and Wellbeing Outcomes
- Self directed support
- Carer’s legislation
- Inspection regime

Current Services
The Service comprises a team of professionally qualified social workers, support workers and administration support staff who undertake a range of statutory social work functions, primarily in three areas:

Community Care Assessments and Care Management - Screening referrals to establish whether or not a social work response is required. This area of work may result in no further action, offer of advice, signposting or referral to other service areas, referral to social work assessment. Assessment of social need and care management – assess whether or not an adult (aged 18 or over) requires support. For complex cases the team will manage the case, this is called care management.

Adult Support and Protection – receive and assess adult protection referrals which involves working with police and health services, investigate whether or not an adult is in need of protection from abuse. If this is the case a protection plan will be put in place to support the individual. This will be care managed by a social worker. Additionally working with adults who are subject to protection plans to reduce risk of abuse and to provide them with support.

Mental Health Officer functions - Mental Health assessment, support and intervention – assess whether or not an individual requires support due to a mental health disorder. There are a number of specific functions only a Mental Health Officer can perform.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Social Work</td>
<td></td>
<td></td>
<td></td>
<td>1,530,881</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change
The Adult Social Work Team provides a service to any adult who requests or requires an assessment under the legislation listed above. Customers include adults with dementia, mental health difficulties, brain injuries, lifelong conditions, learning disabilities, physical disabilities, older and frail people, carers and those at risk of abuse.

The amount of people supported by this service through care management is typically around 180 at any one time. The number of people supported on a short term basis, either through screening or assessment will be higher than this and can fluctuate.

Population projections for our customer base show the following:

Adults
The population of adults (18-64) is predicted to decrease by 6.6% (13,691 to 12,791) between 2013 and 2023 and by 15% by 2033 (to 11,641).
Over 65’s
The population of over 65’s is predicted to increase by 32% (4,200 to 5,544) between 2013 and 2023 and by 65% by 2033 (to 6,924).

Over 85’s
The population of over 85’s is predicted to increase by 44% (533 to 769) between 2013 and 2023 and by 143% by 2033 (to 1,294).

The drivers for change for Adult Social Work are:
1) To ensure appropriate involvement in the integration agenda through locality working.
2) Through Self-directed Support continue to enable people to achieve better outcomes through enhanced choice.
3) Implement the recommendations from the recent inspection of services to older people, including improvements to risk assessment and risk management.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
</table>

Key Risks to Delivery

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment of staff</td>
<td></td>
</tr>
</tbody>
</table>

Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Performance Statement</th>
<th>National Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and percentage of assessments completed on time</td>
<td>Ensure all assessments are completed on time</td>
<td>Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected</td>
</tr>
<tr>
<td>Number and percentage of reviews completed on time</td>
<td>Ensure all reviews are completed on time</td>
<td>Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected</td>
</tr>
<tr>
<td>Number and percentage of outcomes for individuals are met</td>
<td>Outcomes are improved for individuals</td>
<td>Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
</tr>
</tbody>
</table>

Contact Details
Stephen Morgan – Interim Executive Manager of Adult Social Work
Grantfield Offices
Lerwick
Community Care Resources

Policy context
In March 2010, Reshaping Care for Older People: A Programme for Change 2011-2021 set out the Scottish Government’s vision and immediate actions for reshaping the care and support of older people in Scotland.

The programme provides a framework, built on consensus across all sectors and interests, to address the challenges of supporting and caring for Scotland’s growing older population into the next decade and beyond. It aims to improve the quality and outcomes of current models of care, whilst developing services in a sustainable way that address current demographic and funding pressures.

New legislation, in the form of the Public Bodies (Joint Working) (Scotland) Act 2014 came into force on 1 April 2014. The Act requires Health Boards and Local Authorities to integrate their health and social care services. Integration is focused on person-centred care, health, planning and delivery so people get the right advice and support in the right place and at the right time.

Current Services
The Community Care Resources provides services to adults in need across Shetland. Our purpose is to enable people to remain within their own homes and communities by providing person centred care to increase levels of independence, self-care and self-managed care. We reduce unplanned, emergency and inappropriate admissions to hospital and facilitate early discharge from hospital wherever possible through the use of Care at Home and Care Centre resources. The service has the following elements, delivered from a number of localities around Shetland:

- Residential care used for long term care or short breaks (respite)
- Day services
- Care at home
- Domestic
- Meals on Wheels

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Resources</td>
<td></td>
<td></td>
<td></td>
<td>10,111,603</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

- Our population is ageing fast. In Shetland it is anticipated that by 2016, the number of people aged 65 or over will be 38% greater than in 2006 and 92% greater by 2031. This is higher than the national average and the fourth highest rate of change across Scotland’s 32 local authorities. The 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
- Growing public expectations that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
• Difficulty in recruiting social care staff;
• Demographic change with increasing life expectancy, a larger older population, greater social mobility of the population and a rise in the number of people living alone;
• Increasing prevalence of long term conditions and increasing multiple morbidity;
• Reductions in public and Shetland Charitable Trust funding and difficulties in recruiting will challenge the way care is delivered in Shetland. The sustainability of services needs to be addressed in order to ensure that the model of care delivered is fit for purpose.

### Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review current models of care in Shetland to ensure sustainability of service.</td>
<td>Director of CH&amp;SC</td>
<td>Sept 16</td>
<td>Outcome 9 - Resources are used effectively. Outcome 2 - People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.</td>
</tr>
<tr>
<td>To work with locality partnerships to plan / deliver local services.</td>
<td>Team Leaders</td>
<td>May 16</td>
<td>Outcome 3 - People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.</td>
</tr>
<tr>
<td>Review roles and responsibilities within the care sector.</td>
<td>Executive Manager</td>
<td>April 16</td>
<td>Outcome 8 - People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.</td>
</tr>
<tr>
<td>Sector review of procedures and processes</td>
<td>Executive Manager TLs</td>
<td>June 16</td>
<td>Outcome 9 – Effective use of resources, avoiding waste and unnecessary variation.</td>
</tr>
</tbody>
</table>

### Key Risks to Delivery

- During 2014-2015 the Community Care Resource service has experienced significant difficulty with recruitment, particularly with regards to community based social care
workers. A recruitment campaign was commenced and contracted hours and rota patterns were remodelled. This remains a high risk area.

- Reductions in public funding and Shetland Charitable Trust funding will impact on the way we deliver services if the status quo continues. The way care is delivered in Shetland and the sustainability of services needs to be addressed in order to ensure that the model of care delivered is fit for purpose.

**Performance Targets with links to National Outcomes**

HEAT, Single Outcome Agreement or any other performance targets and outcome measures. **To be added in later**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people over 65 being supported in a non institutionalised setting</td>
<td>Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community</td>
</tr>
<tr>
<td>Percentage of people receiving intensive care at home</td>
<td>As above</td>
</tr>
<tr>
<td>Number of over 65's receiving Personal Care at Home.</td>
<td>As above</td>
</tr>
<tr>
<td>Delayed discharge from Hospital - no delays exceeding 14 days</td>
<td>Outcome 7 - People who use health and social care services are safe from harm</td>
</tr>
<tr>
<td>Delayed discharge from care centres - no delays exceeding four weeks</td>
<td>As above</td>
</tr>
<tr>
<td>Number of individuals identified as having unmet need</td>
<td>As above</td>
</tr>
<tr>
<td>Risk and need assessment and support plans in place within 7 weeks.</td>
<td>As above</td>
</tr>
<tr>
<td>Occupancy of care homes</td>
<td>Outcome 9 - Resources are used effectively in the provision of health and social care services, without waste</td>
</tr>
</tbody>
</table>

**Contact Details**

Community Care Resources  
Montfield Offices  
Burgh Road  
Lerwick  
Shetland ZE1 0LA

**Further Reading**

- Social Work Services, Care Homes, Respite Providers and Care At Home Services are subject to inspection by the Care Inspectorate [www.careinspectorate.com](http://www.careinspectorate.com)
- The manager of each service area must be registered with the Care Inspectorate as a Registered Manager. Each service is inspected at least annually by the Care Inspectorate and is measured against the National Care Standards. All social care staff must be registered with Scottish Social Services Council in order to practice and must abide by the Codes of Practice. [www.sssc.uk.com](http://www.sssc.uk.com)
Criminal Justice

Policy context
The Strategy for Justice in Scotland sets out the Government’s approach to make the Scottish justice system fit for the 21st century. The second phase of the Reducing Reoffending Programme which began in 2012 is focused on making sure that the right services and support are provided so that prolific offenders can address their reoffending and its causes.

Criminal justice social work services are statutory partners in ensuring effective community justice in local communities. Community Justice is currently the responsibility of Community Justice Authorities; however, following a redesign as set out in the draft Community Justice (Scotland) Bill, CJA’s will be disbanded on 31 March 2017. From the 1 April 2017 responsibility for community justice will be transferred to ‘community justice partners’, with oversight and assurance to Ministers being given by a new national body, Community Justice Scotland. In Shetland, a local Community Justice Partnership will be established and will report to the Shetland Partnership. The Partnership will be responsible for producing a strategic plan that will address local and national priorities. A transition plan is being formed and will be submitted to the Scottish Government in 2016.

Current Services
The Service comprises of a small team of professionally qualified social workers and support workers who undertake a range of statutory social work functions that ensures all people who commit offences are appropriately assessed, supervised and risk managed. The service is responsible for the delivery and development of all criminal justice social work services throughout Shetland. This includes the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences.

Funding and Resources
Funding for Criminal Justice Social Work Services is ring fenced and allocated by the Northern Community Justice Authority on an annual basis. The funding covers the meeting of statutory duties. The service works collaboratively with other statutory and third sector partners in Shetland to ensure that receive the assistant and support their need to stop their offending behaviour.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.49</td>
<td>340,654</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change
The main driver for change is the redesign of community justice which evolved from the Commission on Women Offenders Report and Audit Scotland’s evaluation of Community Justice Authorities. The service also takes account of relevant evidence as summarised in the 2011 report “What Works to Reduce Reoffending: A Summary of the Evidence”.
Women who offend
http://www.scotland.gov.uk/News/Releases/2012/04/womenoffenders17042012

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in the transition phase of the Redesign of Community Justice at a local and national level.</td>
<td>Executive Manager</td>
<td>April 16</td>
<td>Reduce reoffending / Safer Communities.</td>
</tr>
<tr>
<td>To work with local partners and partnerships to plan / deliver local services.</td>
<td>Executive Manager/ Senior Social Worker</td>
<td>May 16</td>
<td>Offenders within Shetland have the best opportunities to make positive changes to their lives.</td>
</tr>
<tr>
<td>To contribute to the National outcomes, performance and improvement framework.</td>
<td>Executive Manager</td>
<td>Oct 16</td>
<td>An outcome focussed approach to the planning and delivery of community justice services.</td>
</tr>
<tr>
<td>Review of processes and procedures to ensure they remain fit for purpose</td>
<td>Executive Manager</td>
<td>June 16</td>
<td>The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.</td>
</tr>
<tr>
<td>Continue to promote increased use of fiscal and police direct measures.</td>
<td>Senior Social Worker</td>
<td>April 16</td>
<td>Fewer people appearing in Court.</td>
</tr>
</tbody>
</table>

Key Risks to Delivery

- The future funding formulae for criminal justice social work has not been decided. Any reduction in annual funding will have a significant impact on the delivery of service and the service’s ability to meet statutory duties and contribute to community safety.
Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Measure</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people commencing supervision within 7 working days of being sentenced.</td>
<td>People have access to swift justice.</td>
</tr>
<tr>
<td>Percentage of court reports submitted on time.</td>
<td>People have access to swift justice.</td>
</tr>
<tr>
<td>Percentage of risk and need assessment completed within 20 days.</td>
<td>Reduce reoffending.</td>
</tr>
<tr>
<td>Percentage of individuals showing a decrease in assessed risk and need at end of order</td>
<td>Reduce reoffending.</td>
</tr>
<tr>
<td>Percentage of Unpaid work commenced within 7 working days.</td>
<td>Reduce reoffending.</td>
</tr>
</tbody>
</table>

Contact Details

Denise Morgan
Executive Manager Criminal Justice
Grantfield Offices
Lerwick
Shetland

Email: denise.morgan@shetland.gov.uk
Housing Support Services
Adult's Speech and Language Therapy

Policy context
Nationally agreed 9 Health and Wellbeing Outcomes as put in place following the Public Bodies (joint working) (Scotland) Act 2014 and Royal College of Speech and Language Therapy clinical guidelines.

Current Services
Speech and language therapy in Shetland provides life-changing treatment, support and care for adults who have difficulties with communication, or with eating, drinking and swallowing. Speech and language therapists (SLTs) work closely with families, carers and other professionals such as nurses and occupational therapists. SLTs work in the Gilbert Bain Hospital, Care Homes, the SLT base at the Independent Living Centre, people’s own homes and at Supported Living and Outreach settings. They work with adults with:

- Communication or eating and swallowing problems following neurological impairments and degenerative conditions, including stroke, head injury, MS, Parkinson’s disease and dementia.
- Head, neck or throat cancer
- Voice problems
- Learning difficulties
- Physical disabilities
- Stammering

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech &amp; Language Therapy</td>
<td></td>
<td></td>
<td></td>
<td>88,135</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change
20% of population will have speech, language and communication needs at some time in their life affecting their ability to sustain family and social relationships, income levels, education, employment, health, social care and justice services. Communication and/or eating and drinking difficulties are part of life for many, if not all, people with the following long-term conditions—stroke, head and neck cancers, dementia, autistic spectrum disorder, brain injury, cerebral palsy and motor neurone disease, multiple sclerosis, Parkinson’s disease and learning disability. The current Speech and Language Therapy adult caseload is 94 adults, of these, 34 are adults with learning disability. The majority of the Speech and Language service is funded by the SIC Children’s service. There has been a steady growth in referrals for adults over the past 5 years and this is expected to continue. The current capacity does not allow for development of the service to groups such those with dementia where the service is restricted to providing support to those with dysphagia (swallowing difficulties).

Plans for change
The service is trialling a communication group with the support of the Shetland Stroke Support Group for those with Aphasia (language difficulties following stroke), in order to support those individuals who have moved on from regular therapy and are benefitting from the peer support.
from the group. SLT was involved in the multiagency communication skills training programme supporting those involved with Adult Learning Disabilities accessing health care. Further communication training programmes to support those working with and living with people with barriers to communication will be developed if capacity allows.

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target end date</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of fast track referral to facilitate discharge</td>
<td>Shona Hughson</td>
<td>November 2015</td>
<td>For Adult LD email/phone named clinician for advice Outcome 5</td>
</tr>
<tr>
<td>Implementation of designated phone-in advice and information sessions to</td>
<td>Clare Burke</td>
<td>February 2016</td>
<td>Reduction in travel time for therapists and users Outcome 9 and 5</td>
</tr>
<tr>
<td>ensure more efficient use of qualified Speech and Language therapy resources.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of monthly drop-in sessions at Independent Living Centre</td>
<td>Clare Burke</td>
<td>February 2016</td>
<td>More efficient use of time and resources, and meeting needs at an earlier stage. Outcome 9 and 5</td>
</tr>
<tr>
<td>for patients/parents with SLT related concern</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participate in Skype/VC telehealth project as part of a research project</td>
<td>Shona Hughson</td>
<td>January 2016</td>
<td>To ensure most effective use of scarce professional resource. Outcome 5 and 9</td>
</tr>
<tr>
<td>aiming to use technology to meet Speech and Language needs more efficiently.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement recommendations from research project findings if results are</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive/effective.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key Risks to Delivery**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in staffing levels, leading to service loss to inpatients</td>
<td>Staff retention and maintaining clinical competencies.</td>
</tr>
<tr>
<td>with dysphagia and associated life threatening aspiration risk.</td>
<td>Dysphagia screening training provided to ward nurses.</td>
</tr>
<tr>
<td>High caseload numbers mean limited capacity to provide universal</td>
<td>Regular monthly monitoring</td>
</tr>
<tr>
<td>services such as communication skills training to families and carers</td>
<td></td>
</tr>
<tr>
<td>Removal or reduction of funding from SIC Children’s Service to NHS</td>
<td>Ensure both NHS and SIC are aware of risks and consequences around</td>
</tr>
<tr>
<td>(SIC currently funds 55% of SLT service)</td>
<td>withdrawal of funding to service</td>
</tr>
</tbody>
</table>
Performance Targets with links to National Outcomes

HEAT, Single Outcome Agreement or any other performance targets and outcome measures.

<table>
<thead>
<tr>
<th>Target</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with swallowing difficulties in GBH – respond within 48 hours</td>
<td>1</td>
</tr>
<tr>
<td>6 weeks to first appointment</td>
<td>1</td>
</tr>
</tbody>
</table>

Contact Details
Speech and Language Therapy Department
The Independent Living Centre
Gremista
Lerwick
Shetland
ZE1 0XY

Telephone: 01595 744242
Email: shet-hb.SpeechDepartment@nhs.net

Further Reading

www.nowhearne.co.uk

www.rcslt.org (for policy position papers on e.g. dementia, learning disabilities.)
Children’s Speech and Language Therapy

Current Service
Speech and language therapy in Shetland provides life-changing treatment, support and care for children who have difficulties with communication, or with eating, drinking and swallowing. Speech and language therapists (SLTs) work closely with parents and other professionals such as teachers, psychologists and other AHPs. SLTs work in schools, early years settings, the SLT base at ILC and in peoples own homes. They work with babies with feeding and swallowing difficulties and children with

- Mild, moderate or severe learning difficulties
- Physical disabilities
- Language delay
- Specific language impairment
- Hearing impairment
- Specific difficulties in producing sounds
- Cleft palate
- Stammering
- Autism/social interaction difficulties
- Voice disorders
- Selective mutism

Needs/Unmet needs/Drivers for Change
The current SLT children’s caseload is 267 children, 2 wte SLTs funded through the SIC children’s service. Service demand exceeds capacity. Nationally a move towards greater SLT involvement in universal rather than targeted input is expected and a move away from what is considered more “traditional “therapy models advocated.

Plans for change
Locally the service is considering alternative therapy options including

- phone in advice and information sessions
- monthly drop-ins,
- parent groups,
- as well as ongoing trials of “5 minute therapy”,
- outcome measures and some
- joint group work with early years providers.
- looking into involvement into a research project on use of VC/Skype and SLT provision

Key Risks to Delivery
The key risks to delivery involve any reduction in staffing levels as demand already exceeds capacity. Staff retention and maintenance of clinical competencies are essential in order to at least maintain current levels of service delivery. Monthly caseload monitoring is in place. Work life balance treated with consideration and links established and maintained with local SLT students and graduates. We have struggled in the past to fill vacancies both temporary and permanent.
Performance targets
Waiting times for new referrals, SLTs aim to offer a first appointment within 6 weeks and this is usually achieved. Open referral policy is in operation and self referral is available.

Contact details
Speech and Language Therapy are now based at the Independent Living Centre in Gremista. You will find us on the right hand side of the road, past the Shetland College junction.

Speech and Language Therapy Department
The Independent Living Centre
Gremista
Lerwick
Shetland
ZE1 0XY
Telephone: 01595 744242
Email: shet-hb.SpeechDepartment@nhs.net
Nutrition and Dietetics Services

Policy context
SIGN, NICE, British Dietetic Association, HPC, BAPEN, NHS Shetland Guidelines and Policies, Diabetes UK.
To be added in next draft.

Current Services
The main areas of practice are Diabetes, Gastro Intestinal and Weight Management. The dietetic service also has a responsibility to ensure MUST and other nutrition training is in place for care home and care at home staff and to deliver staff and patient education on all the areas listed above.

Dietetic services are provided at 3 in-patient wards in the Gilbert Bain Hospital, out-patient clinics at the Gilbert Bain Hospital, Care Homes, through telephone appointments and domiciliary visits where there is assessed need.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition and dietetic service</td>
<td>2.8 WTE</td>
<td></td>
<td></td>
<td>118,839</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change
The dietetic service is in a vulnerable position having had a high turnover of staff in the last few years. It is currently undergoing significant development to ensure it is meeting the needs of the population of Shetland, however this development is challenged by a current vacancy.

The particular areas requiring further development and consolidation are described in the plans for change section.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target end date</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Development and implementation of bariatric pathway</td>
<td>Lead dietician</td>
<td>Underway</td>
<td>People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
</tr>
<tr>
<td>Complete development of and implement general Weight Management plan, and roll out sessions in specific Health Centres</td>
<td>Lead dietician</td>
<td>Underway</td>
<td>People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
</tr>
<tr>
<td>Complete development of diabetes pathway and roll out as appropriate</td>
<td>Lead dietician</td>
<td>Underway</td>
<td>People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
</tr>
</tbody>
</table>
Complete and evaluate pilot training programme to care homes and roll out across care home estate

Design web page on the Dietetic service including referral criteria and pathways for all referring clinicians.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in dietetic time will mean that only urgent cases will be seen meaning that less preventative work is undertaken</td>
<td>Cases will be prioritised, however risk remains that a single dietician will be unable to manage even high priority cases</td>
</tr>
<tr>
<td>Unable to obtain approval to recruit to vacant dietetic post</td>
<td>Case will be made to EMT to recruit to vacant positions</td>
</tr>
<tr>
<td>Positions prove unattractive to potential applicants due to fragility of service meaning posts remain unfilled.</td>
<td>Attempts will be made to ensure stability of service</td>
</tr>
</tbody>
</table>

Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Performance target</th>
<th>National outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 WRTT</td>
<td>Resources are used effectively and efficiently in the provision of health and social care services</td>
</tr>
<tr>
<td>To be added in next draft</td>
<td></td>
</tr>
</tbody>
</table>
Podiatry Services

Policy context
Public Bodies (joint working) (Scotland) Act 2014; National Health and Wellbeing Outcomes; National Delivery Plan for AHPs in Scotland (2012); NHS Shetland Workforce plan 2014-17; Localities Planning; 18/52 RTT; 4/52 MSK RTT; AHP MSK Minimum pathway standards; SIGN; HCPC; Older People Health and Wellbeing Strategy; Scotland’s Dementia Strategy 2013-16; Shetland NHS Intermediate Care Operational Plan; Prevention and Management of Falls; GIRFEC.

Current Services
Podiatry Services provide a comprehensive range of treatment, advice and education to the population of Shetland. Services provided include: routine podiatry, nail surgery, nail management, vascular and neurological assessment and screening; MSK assessment and orthoses prescription; footwear advice; falls prevention advice; diabetic foot assessment and screening; wound care.

Podiatry services have successfully implemented and continue to promote both open and self referral (AHP NDP target), as well as introducing, implementing and enforcing the Personal Footcare guidelines (AHP NDP target).

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry</td>
<td>4.4</td>
<td></td>
<td></td>
<td>224,917</td>
<td>2%</td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change
Podiatry services will continue to have to provide to frail and elderly. It is clear that the number of elderly in Shetland will increase. This will have demand implications for Podiatry. Existing patients will continue to be provided with scheduled care where assessed and appropriate. The increasing number of elderly patients who are not currently registered with Podiatry will be a potential unmet need and could have unscheduled care requirements.

Podiatry will continue to provide current range of services, but in addition unmet need in falls prevention, vascular assessment, orthopaedic triage, dementia care, wound management, health education and telehealth will need to be addressed.

Children’s services continue to develop both as Podiatry only input and as part of greater multi-disciplinary workstreams.

Greater joint working with Physiotherapy has commenced and will continue to develop. Joint working with non-NHS teams, such as falls prevention and care at home will change workload demands. Podiatry has commenced Orthopaedic triage which will continue to increase in frequency. Podiatry team have plans to commence direct referral to Medical Imaging, Orthopaedics, Pain clinics and Rheumatology.
## Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.</td>
<td>Chris Hamer</td>
<td>October 2015</td>
<td>Maintaining foot health, enabling patients to remain mobile. NHWO’s 1,2,3,4,9.</td>
</tr>
<tr>
<td>Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.</td>
<td>Chris Hamer</td>
<td>October 2015</td>
<td>Recognising and acting upon early signs of dementia assists in diagnosis and treatment. NHWO’s 1,2,4,9.</td>
</tr>
<tr>
<td>Implement podiatric aspects into falls prevention strategy.</td>
<td>Chris Hamer</td>
<td>October 2015</td>
<td>Expert and evidenced based interventions for those patients at risk from falls. NHWO’s 1,2,3,4,5,7,9.</td>
</tr>
<tr>
<td>Contribute to savings targets by triaging orthopaedic referrals.</td>
<td>Chris Hamer</td>
<td>October 2015</td>
<td>Ensuring referrals are directed to the appropriate clinical service. NHWO’s 2,3,4,5,7,9.</td>
</tr>
<tr>
<td>Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.</td>
<td>Chris Hamer</td>
<td>October 2015</td>
<td>Working across primary and secondary care to produce an effective and efficient vascular care pathway. NHWO’s 2,3,4,5,7,8,9.</td>
</tr>
</tbody>
</table>

## Key Risks to Delivery

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff absences (sick and annual leave)</td>
<td>Continual engagement with staff, rapid onward referral to OH when necessary. Monitoring of safe work practices. Flexible leave arrangements.</td>
</tr>
<tr>
<td>Staff retention and recruitment</td>
<td>Engagement with staff. Staff able to input into service changes and improvements.</td>
</tr>
<tr>
<td>Continued savings</td>
<td>Efficient use of service resources. Use of PECOS and national contracts. Investigation of potential efficiencies.</td>
</tr>
<tr>
<td>Clinical facility availability</td>
<td>Efficient use of clinical rooms, sharing use where practicable. Use of alternative clinical facilities.</td>
</tr>
</tbody>
</table>
Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Performance Target</th>
<th>National Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHP MSK 4wRTT</td>
<td>NHWO 1</td>
</tr>
<tr>
<td>18w RTT</td>
<td>NHWO 9</td>
</tr>
<tr>
<td>Reduce DNA rate to 5%</td>
<td>NHWO 9</td>
</tr>
</tbody>
</table>

Contact Details

Mr Chris Hamer, Podiatry Manager,
01595 743021 or c.hamer@nhs.net
Orthotic Service Plan

Policy context

The main policy context for Orthotics is the Allied Health Profession’s National Delivery Plan. This emphasises the requirement for people with musculoskeletal problems to be treated within four weeks of receipt of referral. In addition, the works within the integration framework and therefore aims to achieve the nine Health and Wellbeing Outcomes and national indicators.

Current Services

The Orthotic Department provides Orthotic services to NHS Shetland and the local community. The Orthotic service is multifunctional with diagnostic and treatment services for people with Musculoskeletal (MSK) issues. It is aimed at, avoiding pain, returning function, preventing deformity and protect “at risk” body parts. This is achieved using Orthotic devices and/or advice on self help. The department’s aim is to keep patient’s mobile and pain free. This can be achieved by working closely with community services to keep patients in their home environment for as long as possible or to help patients return to work earlier via appropriate interventions. The service also holds the budget for Breast prostheses services, Wig services and is involved in the wheelchair services in Shetland.

With integration embedding itself, it is planned that Orthotic Services technical side will be able to prevent wastage by servicing and repairing community seating equipment.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORTHOTIC SERVICE</td>
<td>2</td>
<td></td>
<td></td>
<td>143,363</td>
<td>4212</td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

There will be an increasing need for Orthotic services with an aging population requiring increased support for mobility to keep them safe (e.g. avoiding falls) and in their home environment. With this comes a need for further protection to prevent pressure injuries which are expensive to heal both in nursing time and dressings.

There is currently an Orthotic service redesign plan submitted to move the service to the Independent Living Centre. This move is part of the Ambulatory Care Service changes being developed with acute services at the Gilbert Bain Hospital. This will include a move to new clinical and technical technology which will release time to improve the service (improving the patient experience) and also to be close to and responsive to community services so that equipment can be serviced rather than disposed off as is currently the case.

In addition, reducing employment cost is a driver for change. If either the Orthotist or technician were to leave then a reorganisation of staff could be carried out. Such things as administration support being brought into the service could mean a part time Orthotist or technician being employed in future, reducing the wages expenditure.
<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target end date</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overseeing the departments move to the Independent Living Centre (ILC), as part of the Ambulatory service redesign. Introduction of new technologies which will improve service delivery times and release time for service improvement.</td>
<td>Laurence Hughes</td>
<td>July 2016</td>
<td>Improved service integration between Orthotic services and community services. H&amp;WB 3 improving patient experience. H&amp;WB9. Resources are used effectively and efficiently.</td>
</tr>
<tr>
<td>Increase speed of treatment by moving to modern treatment techniques. This will allow patients from outer lying islands to be treated on the same day and avoid a return visit.</td>
<td>Laurence Hughes</td>
<td>July 2016</td>
<td>H&amp;WB5. Reducing inequality. H&amp;WB 2. Keeping at risk patients independently at home.</td>
</tr>
<tr>
<td>Review service and implement actions to reduce the rate of non-attendees (DNAs) to below 5%, thereby making better use of professional resource</td>
<td>Laurence Hughes</td>
<td>July 2016</td>
<td>H&amp;WB3. Improved patient experience</td>
</tr>
<tr>
<td>Continue to review and revise technician’s activity to release time to service community equipment, thereby reducing spend on community equipment</td>
<td>Laurence Hughes</td>
<td>October 2015-16</td>
<td>H&amp;WB 9. Resources are used effectively and efficiently.</td>
</tr>
<tr>
<td>Development of referral criteria and introduction of self referral in line with the Allied Health Professional National Delivery Plan.</td>
<td>Laurence Hughes in conjunction with Scottish Orthotic Clinical Lead (ScOL) group.</td>
<td>April 2016</td>
<td>H&amp;WB 1 and 9</td>
</tr>
<tr>
<td>Implement appropriate appointment booking procedure to ensure equity of access to service.</td>
<td>Laurence Hughes</td>
<td>July 2016</td>
<td>H&amp;WB5. Reducing health inequalities.</td>
</tr>
<tr>
<td>Ensure access to service operates in line with other services in Scotland by adopting consensus documents under development by ScOL</td>
<td>Laurence Hughes</td>
<td>July 2016</td>
<td>H&amp;WB5. Reducing inequalities. And 9 Effective and efficient services</td>
</tr>
</tbody>
</table>
Key Risks to Delivery

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of key staff in single handed department</td>
<td>Business Continuity Plan in place which is reviewed on a yearly basis</td>
</tr>
<tr>
<td>Insufficient budget to respond to demand</td>
<td>Budget is carefully monitored. Access to service criteria under review</td>
</tr>
<tr>
<td>Continuity of service whilst move to new building takes place</td>
<td>Suitable plans in place to ensure service continuity</td>
</tr>
<tr>
<td>Unable to meet 4 week referral to first contact target due to lack of staff availability (sickness, annual leave etc)</td>
<td>Discussion has taken place with national AHP directors group about achievability of target in very small services.</td>
</tr>
</tbody>
</table>

Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Target</th>
<th>NHWO</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHP MSK 4wRTT</td>
<td>1, 3</td>
</tr>
<tr>
<td>18w RTT</td>
<td>3, 9</td>
</tr>
<tr>
<td>Reduce DNA rate to 5%</td>
<td>9</td>
</tr>
</tbody>
</table>

Contact Details

Orthotic service is situated in the Gilbert Bain Hospital, South Road Lerwick, Shetland. Contact Laurence Hughes 01595743023. Email laurencehughes@nhs.net

Further Reading

- Ambulatory Care Services redesign plan
- Orthotic dept Business case
Physiotherapy

Policy context

National:
AHP NDP – particularly 4 week wait for MSK conditions, 18 week wait for others, self-referral, work status, falls prevention
AHP Musculoskeletal pathway minimum standards
Integration of Health and Social Care

Local:

Current Services

Physiotherapy helps restore movement and function when someone is affected by injury, illness or disability. Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice.

The NHS Shetland physiotherapy team covers a wide range of specialties: musculoskeletal, neurology, respiratory, elderly, adults with learning disability, chronic pain, paediatrics and inpatients (medical, surgical, rehabilitation and maternity). The service is based at the Gilbert Bain Hospital, where the majority of patients are seen; but patients are also seen at home, or in care centres, schools and leisure centres if appropriate.

Unscheduled Care:
Physiotherapists work on all wards at the Gilbert Bain Hospital and, with the exception of the rehabilitation ward, the majority of the work is related to unscheduled care. Physiotherapists are available for A&E during the working day to assess/advise as required. There is physiotherapist availability for patients receiving Intermediate Care input who have a physiotherapy need. Our core hours are 0830-1700 Monday to Friday and respiratory on-call cover is provided 0900-1700 at weekends and Public Holidays.

Planned Care:
This covers all other aspects of physiotherapy.

Older people:
There is an older people’s specialist within the physiotherapy team, however she has a broad caseload which, although predominantly elderly, includes all age groups. There are no elements of the physiotherapy service exclusive to older people; with the exception of paediatrics all physiotherapists have a high proportion of older people on their caseloads.

Workload and caseload are defined by specialty, area or individual practitioner – there is no split between planned and unplanned care or older people.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy</td>
<td></td>
<td></td>
<td></td>
<td>602,664</td>
<td></td>
</tr>
</tbody>
</table>
Needs/Unmet needs/Drivers for change

From August 2014 to July 2015 the physiotherapy service received 2553 referrals (11.6% of the population). Referral rates continue to increase year-on-year – since 2011 referrals have increased by 31%. The increase in referral is proportional from all sources; i.e. self, GP, secondary care and community and across specialties. This increase in referral rates has been absorbed into existing staffing levels. Additional staffing resources allocated have been for specific service developments, e.g. chronic pain and telehealth.

Self-referral is considered best practice and is a target within the AHP NDP. From August 2014 to July 2015 self-referral accounted for 46% of all referrals. Self-referral has, in part, replaced GP referral. In the MSK service where throughput is highest this has given additional challenges – particularly around time taken to triage referrals, seeking additional information and dealing with people presenting with multiple or complex problems.

As a result of high demand with unchanged staffing levels waiting times have increased. Projects are underway in musculoskeletal (MSK) and neurology looking at all aspects of the service, with a view to reducing the workload by referral management and promoting self-management.

Due to the small numbers of staff and range of specialties covered it is not possible to cover absence within current resources. Waiting times rise during periods of absence, particularly unplanned or long-term absence. The current savings targets and financial climate may cause difficulty recruiting to vacancies, which would have a negative impact on appointment availability and waiting times.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of neurophysiotherapy service (PID attached)</td>
<td>Fiona Smith, Margaret Gear</td>
<td>Underway: completion August 2016</td>
<td>See PID</td>
</tr>
<tr>
<td>Review of physiotherapy musculoskeletal outpatients service</td>
<td>Paula Wishart</td>
<td>Underway: ongoing</td>
<td>Self management, Referral management, Reduce waiting times (links to AHP NDP and MSK pathway minimum standards)</td>
</tr>
<tr>
<td>Multi-disciplinary Falls Pilot (within current resources)</td>
<td>Elaine Campbell</td>
<td></td>
<td>Evaluation of results and recommendation regarding future falls programmes (links to AHP NDP)</td>
</tr>
</tbody>
</table>

Key Risks to Delivery

- High referral rates: The risk of rising waiting times if we are not able to keep up demand. This is being addressed through the projects detailed above.
- Complex conditions: Across all specialties we are seeing an increasing number of people with complex conditions. This requires an increased amount of therapist time, clinically and administratively (including liaising with other health professionals or other agencies)
- Staffing:
Performance Targets with links to National Outcomes

AHP NDP
AHP MSK minimum standards

Contact Details
Address: Gilbert Bain Hospital, Lerwick, ZE1 0TB
Phone: 01595 743323
Email: shet-hb.physiotherapy@nhs.net

Further Reading
Chartered Society of Physiotherapy: www.csp.org.uk
Health and Care Professions Council: www.hcpc-uk.co.uk
NHS Inform MSK zone (self-management): www.nhsinform.co.uk/MSK/
Adult Occupational Therapy

Policy context

 Occupational Therapy service development is informed by a number of national and local strategies which includes but is not limited to these. Integration and the National Health and Wellbeing Outcomes are particular drivers. Scotland’s National Dementia Strategy 2013-16 is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. Maximising Recovery & Promoting Independence describes the provision of intermediate care service whilst the Rehabilitation framework promotes reablement and rehabilitation strategy and Realising Potential describes OT input into mental health services. The See Hear Strategy guides the development of sensory impairment services. The AHP National delivery plan is currently under review but once published will contain actions that need to be implemented.

Specific areas of legislation are described below:
• The Social Work (Scotland) Act 1968 places a general duty on local authorities to promote social welfare (Section 12 of the 1968 Act) by making available advice, guidance and assistance. There are also specific duties to assess needs and decide whether those needs call for the provision of services, which essentially means services under part II of the 1968 Act. There is a duty under the National Assistance Act, Section 2 of the Chronically Sick & Disabled Persons Act 1972, Social Work Act to assess need including that of support or instruction within the home. Occupational therapists particularly have a key role in carrying out these assessments of need and prescribing appropriate advice, treatment programmes, equipment or adaptations.
• Local authorities have specific duties under the Health and Safety at Work etc. Act 1974; Manual Handling Operations Regulations 1992, the Management of Health and Safety at Work regulations 1999 - Occupational Therapists are qualified to carry out moving and handling risk assessments, assess for and provide suitable equipment to meet the employer's responsibilities.
• The local authority has duties under the Disability Discrimination Act 2005 to ensure disabled people have equal access to opportunities, which Occupational Therapists assist in achievement through treatment, advice, adaptations and equipment provision. This includes the needs of people with sensory impairment.
• The Housing (Scotland) Act 2006 describes an obligation to provide financial assistance with a range of structural adaptations attracting a mandatory grant. The guidance notes that applications for assistance should be referred to a suitable specialist, usually an occupational therapist employed by the local authority Guidance on this is found in the Implementing the Housing (Scotland) Act 2006, Parts 1 and 2: Statutory Guidance for Local Authorities: Volume 6 Work to Meet the Needs of Disabled People.

Current Services

GBH: Adult inpatient and outpatient occupational therapy service with a focus on rehabilitation, reablement and adaption to impairment thereby supporting a timely return home and their community, and to people’s occupations

SIC: Community based service primarily for adults with impairments, including sensory loss, with a focus on rehabilitation and enablement enabling them to remain at home and engaged in their occupations. Home adaptations and specialised equipment support the process.

SIC Telecare: Uses technology to enable older and more vulnerable people to live independently and securely in their home through a range of electronic monitoring equipment
SIC Independent Living Centre: Community resource with information and a range of equipment for people to view and trial. The Bluer Badge Clinic is run from this facility

SIC Equipment Store: Manages, maintains, delivers, installs and collects, maintains and repairs all occupational therapy equipment used in the community and in hospital. The Community Nursing store is also held here

Funding and Resources

To be finalised once budgets are approved

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy (not broken down by adult/children)</td>
<td></td>
<td></td>
<td></td>
<td>1,644,149</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

Identified need includes:
- Mental health occupational therapy services, both inpatient and community. The Mental Health Strategy for Scotland identifies that mental illness is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety.
- Neurological outpatient service to provide treatment to maximise people’s potential once discharged
- Provision of rapid response to A&E to facilitate discharge directly home wherever possible

Drivers for change include Government strategies especially Integration, responding to internal and external pressures and seeking further efficiencies within the services. Telecare advancements provide greater opportunity for people to stay at home, but require constant updating of knowledge. Health and safety requirements and considerations must be adhered to with regard to very large quantities of equipment deployed.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target end date</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore need for dedicated Mental Health aspect of OT service and implement as appropriate</td>
<td>Jane Pembroke</td>
<td>April 2016 onwards</td>
<td>1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 effective resource utilisation</td>
</tr>
<tr>
<td>Explore need for specialisation in Dementia services and implement as appropriate</td>
<td>Jane Pembroke</td>
<td>April 2016 onwards</td>
<td>1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 effective resource utilisation</td>
</tr>
<tr>
<td>Increase number of people in receipt of technology enabled care</td>
<td>Jane Pembroke</td>
<td>April 2016 onwards</td>
<td>1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 effective resource utilisation</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provide rapid response to A&amp;E in order to facilitate discharge straight home</td>
<td>Jane Pembroke</td>
<td>April 2016 onwards</td>
<td>2- people able to live at home 4 -quality of life 8- staff are supported to feel engaged and continuously improve their service 9- use resources effectively and efficiently</td>
</tr>
<tr>
<td>Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community</td>
<td>Jane Pembroke with Jo Robinson</td>
<td>Commenced April 2015, ongoing development</td>
<td>1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 -resource are used effectively</td>
</tr>
<tr>
<td>ILC Equipment Store- review, and refresh all procedures and protocol that ensure the supply of appropriately maintained equipment. Integrate district nursing equipment into establish integrated system.</td>
<td>Jane Pembroke/ Ian Sandilands</td>
<td>October 2015 and ongoing</td>
<td>3- people have positive experience of our service 7 -people who use our service are safe from harm 9- resources are used effectively</td>
</tr>
</tbody>
</table>

### Key Risks to Delivery

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of staff resource to implement and maintain quality initiatives</td>
<td>Self assessment and self management techniques are implemented wherever possible to do so safely</td>
</tr>
<tr>
<td>Recruitment to hospital posts continues to present challenges</td>
<td>Continued redesign to ensure posts are varied and satisfying</td>
</tr>
<tr>
<td>Poor management and deployment of equipment due to competing pressures</td>
<td>Ensure risks assessments, protocols and procedures are in place and implementation monitored</td>
</tr>
<tr>
<td>Large geographical area and increasing need to provide wider range of services, to respond to a wide variety of government and professional initiatives</td>
<td>Continued redesign of services to ensure most effective and efficient use of resources</td>
</tr>
<tr>
<td>Potential conflict between needs of health board and statutory responsibilities of local authority within limited resources</td>
<td>Ensure prioritisation of needs of both services and potential conflicts are raised with managers</td>
</tr>
<tr>
<td>Need for staff to have wide ranging generalist and specialist skills</td>
<td>Ensure personal development plans are up to date and CPD opportunities are taken. Ensure quality control mechanisms are in place</td>
</tr>
</tbody>
</table>
### Performance Targets with links to National Outcomes

<table>
<thead>
<tr>
<th>Performance target</th>
<th>National Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Eligibility Criteria timescales</td>
<td>NHWO 2</td>
</tr>
<tr>
<td>Increasing number of people are supported by technology enabled care</td>
<td>NHWO 1,2, 7</td>
</tr>
</tbody>
</table>

### Contact Details

- Occupational Therapy Service, Independent Living Centre, Gremista 01595 744319
- Occupational Therapy Service, Gilbert Bain Hospital 01595 743022

### Further Reading

- Principles for Planning and Delivering Integrated Health and Social Care
- Draft Older People Health and Wellbeing Strategy
- **Scotland's National Dementia** Strategy 2013-2016
- National Health and Wellbeing Outcomes Framework
Child Occupational Therapy

Policy context

Current Services

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td>.8 OT .53 OTA</td>
<td>Budget for 2106 just been set- , can include in next document?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (not broken down by adult/children)</td>
<td></td>
<td></td>
<td></td>
<td>1,644,149</td>
<td></td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

- Increasing focus on early intervention (under 5’s) in line with government policy. Presents risk to over 5’s in system who have not had this start and require ongoing OT input to maximise their potential and lessen potential reliance on funded services
- Paediatrician shortage has meant some work is being transferred to OT eg routine developmental screening of babies with onward referral

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal plan under way to review service, check for relevance to current environment and facilitate change</td>
<td>Marc Beswick</td>
<td>Under way</td>
<td>1. people improve their health and well being</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. people are able to live at home</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. quality of life</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. reduce health inequalities</td>
</tr>
</tbody>
</table>
Key Risks to Delivery

- Band 7 OT has expressed that he is beginning to think about a change. Based on experience recruitment will be problematical. Fostering interest in existing staff to build skills and confidence and a move to Paediatrics

Performance Targets with links to National Outcomes

Assessment completed within 14 days

Contact Details

Jane Pembroke Team Lead  744319
Marc Beswick 743022

Further Reading

National Health and Wellbeing Outcomes Framework

AHP National Delivery Plan:

Core Suite of Integration Indicators:

Shetland NHS Autism Strategy and Action Plan
Support Services Plans

Information & Communication Technology

To follow
Finance

Policy context
The organisation has a statutory duty to break even and the directorate role is to ensure efficient stewardship of resources and delivery of the government best value programme for public funds.

Current Services
The Finance Directorate includes the Board Finance Department, the Finance Department, the Patient Travel Department and the Central Stores Department.

Board Finance – This department represents the Board’s Director of Finance and central corporate expenditure such as insurance costs, legal expenses and audit fees.

Finance Department – Responsible for the financial stewardship of the Board and has a statutory obligation to produce annual accounts and associated reports. The department provides timely, accurate financial information to heads of departments to aid them in their organisational decision making. Through service level agreements with NHS Grampian provides the Board’s Payroll Service and Accounts Payable/Receivable functions.

Patient Travel – Responsible for the booking of all patient travel to and from various mainland health Boards particularly NHS Grampian. The department manages the Highlands & Islands Travel Scheme (HITS) and all relevant reimbursements to patients.

Central Stores Department – Responsible for the five rights of procurement to ensure goods/equipment/services are available of the right quality, in the right quantity, in the right place, at the right time, at the right price. Being an Island Board the department must ensure there are adequate stock levels across the Board to deal with adverse weather conditions frequently experienced in Shetland.

Funding and Resources
Table of budget and savings targets, including workforce details

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Finance</td>
<td>1.0</td>
<td></td>
<td></td>
<td>£384,483</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>6.8</td>
<td></td>
<td></td>
<td>£349,548</td>
<td></td>
</tr>
<tr>
<td>Patient Travel</td>
<td>3.0</td>
<td></td>
<td></td>
<td>£2,827,823</td>
<td></td>
</tr>
<tr>
<td>Central Stores</td>
<td>5.50</td>
<td></td>
<td></td>
<td>£181,658</td>
<td></td>
</tr>
<tr>
<td>Directorate Savings Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£25,200</td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change
Drivers for change include reducing budgets combined with a greater appetite for financial information in the current climate. With demand increasing on the department it will be very difficult to maintain the level of service whilst continuing to find additional savings year on year.
There is also a shared services initiative under way where Finance/Stores may be merged with other Boards or nationally into central hubs.

**Plans for change**

With demand for financial information increasing ideally the Finance Department would like to recruit a band 4 Finance Officer to assist with the monthly closedown process. This would allow us to achieve an 8 working day closedown which corresponds to best practice in the NHS. To fund this additional recurring savings will be found within the directorate.

Service levels in Shetland have now been reduced to a minimum with Payroll, Accounts Payable & Receivable outsourced to NHS Grampian through a Service Level Agreement.

As a result of outsourcing these services, the Finance Directorate has achieved all of its savings target up to and including the financial year 2016/17.

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit a B4 Finance Officer</td>
<td>Head of Finance &amp; Procurement</td>
<td>Oct 2015</td>
<td></td>
</tr>
</tbody>
</table>

**Key Risks to Delivery**

Budget constraints may result in a lower level of service and there is ongoing difficulty in recruiting and retaining staff.

**Performance Targets with links to National Outcomes**

No performance targets as such but regular scrutiny by External & Internal Audit which results in continuous improvement of the service.

**Contact Details**

NHS Switchboard 01595 74 3000
Human Resources and Support Services

Policy context
Service changes are currently being driven by the introduction of a National IT platform EESS. NHS Shetland commenced implementing the system in 2012 at Phase 2 of the National programme. There have been numerous setbacks and delays, involving developments to the system in order for it to be fit for purpose. Successful implementation will support the National HR Shared Service (HRSS) Agenda.

Current Services
The department provide the following services:
- Job Evaluation
- Recruitment planning and advertising
- Coordination of recruitment interviews
- On Boarding Administration for new starts
- Pre-employment checks
- Relocation monitoring
- Exit interviews
- Professional Registration monitoring
- Issue of ID badges
- Absence monitoring / promoting attendance
- Employment law / employee relations / case management advise, conduct, capability, grievances, whistle blowing, bullying and harassment
- From informal to formal investigation / hearing / appeal / tribunal
- TUPE guidance and due diligence administration
- Consultation on change
- Workforce data monitoring / returns (vacancy, WTE/turnover/FOI's/ Junior Doctor)
- Workforce planning – projections and reports
- Redeployment
- Policy and procedure development
- Training delivery
- Equality and Diversity – policy, monitoring, action plans

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target across directorate / contribution 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel: Pay</td>
<td>5.5 WTE</td>
<td>214,078</td>
<td>0</td>
<td></td>
<td>3000</td>
</tr>
<tr>
<td>Personnel: Non Pay</td>
<td></td>
<td>189,838</td>
<td>0</td>
<td></td>
<td>7000</td>
</tr>
<tr>
<td>Human Resources overall</td>
<td></td>
<td></td>
<td></td>
<td>689,685</td>
<td></td>
</tr>
</tbody>
</table>

We have been carrying a 0.5 wte band 4 vacancy, that we have filled on a temporary basis through bank to support the delivery of workloads. We anticipate £3k recurring saving by using Band 2/3 with additional responsibilities distributed across substantive staff.
Needs/Unmet needs/Drivers for change

Following the implementation of EESS in 2013, a 1wte Band 3 vacancy was released to savings. Reduction in 1 wte was planned following successful implementation. National delays in advancing the initial implementation of EESS and the lack of clarity regarding the impact of HRSS locally have resulted in staff increasing responsibilities to cover workload demands. The current substantive admin staff Job descriptions will need to be reviewed to reflect changes in responsibilities. Following the review / evaluation of Job Descriptions any remaining budget outstanding from the current vacancy 0.5 wte band 4 will go to savings.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National HR Shared Services for Recruitment and Medical staffing</td>
<td>HRSM</td>
<td>Likely to proceed in the next 2-5 years</td>
<td>Redeployment of HR Recruitment staff as applicable - still to be identified</td>
</tr>
</tbody>
</table>

Key Risks to Delivery

HRSS is nationally driven, Recruitment administration is likely to be centralised in the next 2-5 years. There is likely to be some discretion to determine what staff are required locally to support service delivery. Staff and Manager’s will require training on the EESS system to enable them to self administer current HR recruitment administration activities within the system, including vacancy and candidate administration / coordination of short listing, interview and on boarding. If the demand for administration support across clinical services increases, the savings anticipated nationally will not be achieved and local pay costs will likely increase and local expertise reduce.

Performance Targets with links to National Outcomes

Reduction in administration demands will enable remaining HR resource to refocus responsibilities on supporting resource planning, redesign, integration of services, effective performance management and management of change, policy development and training delivery. This will include monitoring and reporting of absence / attendance against the 4% HEAT target.

Contact Details
Lorraine Allinson, HR Services Manager 01595 743071, Lorraine.allinson@nhs.net.

Further Reading
HRSS project Initiation document
http://www.qihub.scot.nhs.uk/media/611088/hrss%20-%20pid%20-%20may%202014.pdf
Quality Improvement Hub
**Occupational Health**

**Policy context**
Service changes are currently being driven by external / NHS local demand for services, and nationally with the introduction of the Fit for Work Service Scotland and requirement for accreditation via SEQOHS.

**Current Services**
The department provides a range of services including:
- Management referrals for absence / performance case management
- Self Referral -NHS Staff
- CBT relating to personal or workplace issues / change
- Health Surveillance
- Immunisations
- Pre-employment screening
- Health Checks
- Work related Vaccinations
- Workplace/ workstation assessments
- Night Worker assessments
- Needle stick Injury response
- Stress management
- Medicals
- Ill Health Retirement
- Staff Training

In addition to local OH service- the department are set up to support the delivery of the Fit for Work Service Scotland as this is rolled out.

**Funding and Resources**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target across directorate / contribution 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>OH: Pay</td>
<td>3 WTE</td>
<td>144,042</td>
<td></td>
<td></td>
<td>£4000</td>
</tr>
<tr>
<td>OH: Non Pay</td>
<td></td>
<td>17,300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OH Income</td>
<td></td>
<td></td>
<td>57,430</td>
<td>99,912</td>
<td></td>
</tr>
</tbody>
</table>

Pay budget includes Visiting Consultant from NHS Highland. 4K recurring saving has been agreed from pay budget for 2016/17. Line management and business management including SLA with NHS Highland is via the HRSM for which costs are included in Personnel plan & not included in above.
Key Drivers for change

- Legislation: Equality Act provides an increasing need for assessment and supportive adjustments in the workplace
- Demographics - Ageing workforce - complex health needs
- Increase in stress & MSK related absence
- Need to work more efficiently within reduced budgets
- Local business demand for services has increased following the retirement of an alternative provider. This has also enabled our consultant to become an approved Doctor for the MCA, so we can offer ENG1 medicals to our customers
- Requirement for SEQOHS national accreditation for which the department are working towards
- National Fit For Work Service implementation programme – Local participation in national implementation plan

Plans for change

The introduction of the FFWS in Scotland, funded through the Department of Working Pensions (DWP) may reshape external customer service demands as this service will focus on referral from the GP / employer into a national service, for those with 4 or more week sickness absence from work. NHS Shetland will participate in this service delivery but allocation of referrals will be via call a central call centre for the service (NHS 24). The service level will be managed separately via a defined SLA.

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction for Fit for Work Service</td>
<td>Senior OH Nurse</td>
<td>2015/16</td>
<td>23, 500 income</td>
</tr>
</tbody>
</table>

Key Risks to Delivery

- The FFWS set up costs to be recovered from DWP January 2016 – awaiting confirmation of ongoing funding / service demand. Service Level Agreement is in place for FFWS for 0.5 wte Band 6, £23,500. Current lead nurse Band 7 with additional Bank support Band 5 have been utilised for set up and readiness for commencement of service. Local start delayed, awaiting training from NHS Lanarkshire, FFWS lead.

- There is a risk that we may lose 70% of income if Shetland Island Council participate in a collective procurement process for a regional OH service provider with Highlands Local Authority – tender to cover service for Highlands and Islands. NHS Shetland occupational health is not resourced to bid for the work in its entirety and process may not permit us to bid for the Shetland work in isolation. Due to location we may be able to subcontract the work required to be delivered locally in Shetland. TUPE is unlikely to apply as service is not delivered by a defined resource. Failure to generate replacement income would result in a reduction in staffing required to deliver remaining demands.

- The department are set up to participate in the delivery of the Fit for Work Service Scotland. Reimbursement from DWP is outstanding for set up arrangements / training costs. Service
level agreement is for £23,500 to provide 0.5wte Band 6. No funding has been received and unlikely until January 2016.

- Increasing demand from local businesses provides potential to increase current income generation; this is without any marketing due to the retirement of an alternative local provider.

- Retention of skilled staff will be key to maintain service delivery levels – local availability of skill is very limited therefore national recruitment or specialist agency would be required to fill any turnover or any increase in resource requirements.

**Performance Targets with links to National Outcomes**

In the event there was a reduction in income and OH staff, service would continue to support NHS staff in maintaining health, wellbeing and fitness for work. Service would continue to support achievement of the 4% HEAT target for absence and reduce risk in relation to the Equality Act 2010 and the requirement for adjustments. Without a local service we would unlikely achieve 4% absence target or national average.

**Contact Details**

Lorraine Allinson, HR Services Manager  
Telephone: 01595 743071,  
Email: Lorraine.allinson@nhs.net.

**Further Reading**

- FFW: [http://www.fitforworkscotland.scot/](http://www.fitforworkscotland.scot/)
- NICE Guidelines [https://www.nice.org.uk/guidance/ng13](https://www.nice.org.uk/guidance/ng13)
- Procurement Highland local authority [http://www.google.co.uk/url?url=http://www.highland.gov.uk/download/meetings/id/40290/item20res7710pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBQQFjAAahUKEwi9geTamMLIAhXCPxQKHTxaAlw&usg=AFQjCNHoPUDGtqKdggY1JgymN0NA7RSdOw](http://www.google.co.uk/url?url=http://www.highland.gov.uk/download/meetings/id/40290/item20res7710pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBQQFjAAahUKEwi9geTamMLIAhXCPxQKHTxaAlw&usg=AFQjCNHoPUDGtqKdggY1JgymN0NA7RSdOw)
- Previous OH tender [http://www.publictenders.net/tender/349150](http://www.publictenders.net/tender/349150)
Staff Development

Policy context

- Joint Development Review (JDR) and Personal Development Planning (PDP)
- Staff Development Policy
- Fire Safety Policy
- Manual Handling Policy
- Policy and Guidelines for the Prevention and Non-Physical Management of Aggression and Violence (PMAV) in the Workplace
- Volunteering Policy

Current Services

- **The Staff and Organisational Development Team** is responsible for: the delivery and the co-ordination of key personal and professional training to enable employees across the workforce including those in training to deliver safe and effective care. The department also has a service improvement lead that provides training and project support across Health and Social Care. The Staff and Organisational Development Team are responsible for offering wide range of training covering all areas required by the Board ensuring compliance with statutory requirements. The staff and Organisational Development Team are also responsible for assisting teams achieve targets and objects through specific interventions and for supporting staff with the KSF and JDR programme.

- **The Clinical Education Team** is responsible for creating and maintaining a clinical learning environment for all students. The team also delivers and coordinates a range of clinical training events and programmes to support the aim of appropriately trained staff.

- **The Service Improvement Team** is responsible for providing training and project support across the organisation. The team utilises a range of tools and techniques that are fundamental to getting to grips with the challenges of everyday service delivery and trialling and measuring ideas for change.

Funding and Resources

Updated workforce plan below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Gross Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Capital Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>2.2</td>
<td>2.2 Band 7</td>
<td>.2 Ext</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff and Organisational</td>
<td>2.1</td>
<td>1 Band 3</td>
<td>.24 Band 3</td>
<td>Ext</td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td>1.1 Band 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Improvement and AHPs</td>
<td>.7</td>
<td>.3 Band 6</td>
<td>.4 Band 7</td>
<td>0.4 Band 7</td>
<td>Ext</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Education</td>
<td>1.5</td>
<td>.4 Band 3</td>
<td>.5 Band 6 Ext</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1 Band 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Staff and Organisational Development Department receives external funding for a range of posts including the Clinical Development Facilitator and Staff Development Administrator by Robert Gordon University. The Practice Education Facilitator for Nursing, Practice Education Lead for AHPs, Post-Graduate Medical Administrator is all or partially funded by NHS Education for Scotland.
### Needs/Unmet needs/Drivers for change
The Organisational and Staff Development Department delivers high quality education, organisational development and continuous service improvement across NHS Shetland supporting the Board achieving its Corporate Objectives.

<table>
<thead>
<tr>
<th>Service Aims/Priorities</th>
<th>Objectives/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>To support the continued mainstreaming and embedding of the NHS Knowledge and Skills Framework (KSF) and Personal Development Review (PDR) process</td>
<td>Update Learning materials to support the continued use of e-KSF and effective JDR processes.</td>
</tr>
<tr>
<td>Corporate Induction and Compulsory Refresher Training.</td>
<td>Monitor attendance rates and ensure quality and currency of induction and refresher training.</td>
</tr>
<tr>
<td>Support the delivery of Service Improvement within the Board.</td>
<td>Provide support for projects as requested by the Senior Management Team e.g. localities and pathways projects. Establish a Service Improvement Forum where staff can share knowledge, skills and experiences in a safe learning environment.</td>
</tr>
<tr>
<td>iMatter Staff Experience Tool Implementation</td>
<td>Support the implementation of the programme with Cohort 1 staff in line with SGHD plan. This includes: Finance, Human Resources and Support Services, Public Health and Performance.</td>
</tr>
</tbody>
</table>

**Previous Actions Completed in 2014/15**

<table>
<thead>
<tr>
<th>Description</th>
<th>Delivered Early/on-time/late</th>
<th>Achieved original intention?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restructure of the Staff and Organisational Development Team.</td>
<td>On time</td>
<td>Savings were made based on change in structure which now does not include and overall service lead (3 team leads).</td>
</tr>
</tbody>
</table>
Support and embed service improvement delivery within the Board.

On time

Provide 3 internal secondment opportunities within the Board which will enable staff to deliver improvement methods via work based projects.

New Planned Actions Due to Start in 2015/16

<table>
<thead>
<tr>
<th>Description</th>
<th>PRINCE</th>
<th>Start</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move to Eess learning management system</td>
<td>No</td>
<td>Due to start in Jan 2016</td>
<td>Completed 2016</td>
</tr>
</tbody>
</table>

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

**Risks to Delivery**

The team is small and carries out a diverse range of actions across the organisation. Risks associated with the outcomes of these actions are,

- Leave
- Vacancies not being filled
- Posts not being renewed
- Capacity

**Performance Indicators**
## Contact Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Hospital</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Hall</td>
<td>Staff and Organisational...</td>
<td>Montfield (Lower) Hospital</td>
<td>Burgh Road</td>
<td>01595-743-081</td>
</tr>
<tr>
<td></td>
<td>Development Manager</td>
<td></td>
<td>Lerwick</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ZE1OLA</td>
<td></td>
</tr>
<tr>
<td>Mhairi Roberts</td>
<td>Clinical Education</td>
<td>Montfield (Lower) Hospital</td>
<td>Burgh Road</td>
<td>01595-743-204</td>
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<tr>
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<td>ZE1OLA</td>
<td></td>
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<tr>
<td>Bruce McCulloch</td>
<td>Service Improvement</td>
<td>Montfield (Lower) Hospital</td>
<td>Burgh Road</td>
<td>01595-743-202</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
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<td>ZE1OLA</td>
<td></td>
</tr>
</tbody>
</table>
Medical Records

Policy context

Current Services
The Medical Records Department provides various functions within NHS Shetland. Our purpose is to provide, secretarial cover for local and visiting consultants, ward clerks, patient focus booking with outpatient receptionist, clinical coding, and main hospital reception cover. We do this by booking patient appointments, inpatient and outpatient in a timely fashion in accordance with the rules set down by the Scottish Government, ensuring that clinic letters, discharge letters are processed in a timely fashion. Procedures are coded correctly and within the time scales provided so that statistics can be provided on a monthly basis to the Scottish Government on the performance of NHS Shetland. The main hospital reception is the centre for greeting the general public coming into the Gilbert Bain, it also the main point for internal and external mail, Telephone exchange for the Gilbert Bain. It also acts as the first point of contact for emergency services in the hospital.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretarial Administration</td>
<td>27.99</td>
<td>420,186 first 6 months 2015</td>
<td>819,956</td>
<td></td>
<td>2%</td>
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</table>

Needs/Unmet needs/Drivers for change

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Succession Planning for Health Records Manager</td>
<td>Kathleen Carolan</td>
<td>October 2015</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Key Risks to Delivery
Health Records Manager, retiring at end of 2015, succession planning currently being discussed with staff. The Reception supervisor will be going off long term sick, cover is in place but this could be fragile and lead to additional spend on the budget.
Performance Targets with links to National Outcomes
N/A

Contact Details
Health Records Manager 01595 743033
Health Records Supervisor 01595 743015
Clinical Coder & PFB Team Leader 01595 743223
Reception Supervisor 01595 743000
Spiritual Care

To follow
Estates and Facilities

Policy context
The Estate & Facilities service is designed to support the overall vision of NHS Shetland. It therefore aspires to provide and maintain sustainable, high quality properties and facilities services that allow the effective delivery and continuous improvement of healthcare across Shetland.

Current Services
A detailed summary of the physical assets supported by the Estates department are included in the PAMS (see link). These include the Gilbert Bain Hospital, the Montfield site including Dental services, Staff development and Board HQ and 10 Health centres and 4 clinics spread across the Shetland mainland and outer isles. There are also a number of other small owned properties (i.e. St Olaf Dental practice) and privately owned premises from which NHS contractor services are provided (i.e. Pharmacies and Opticians).
All the NHS Shetland owned buildings, Health centres and Medical equipment assets are supported by an Estates function that carries out planned and reactive maintenance, capital planning, minor repairs and schemes and a Medical Physics function.
The facilities services provided by the Directorate include Domestics, Catering, Porters and Laundry and Linen services.
The service is obliged to maintain compliance with a range of indicators. A number of these are national KPIs and others link to legislative requirements (e.g. Legionella, Hospital Gases, Building regulations, Fire safety, etc, etc.)

Funding and Resources
The total budgets and workforce for the department are:
Estates: Revenue - £1.99M, Capital - £1.1M; Staffing – 15.5 WTE
Facilities: Revenue - £1.66M Staffing – 71.12 WTE

The savings target for 2014/15 was £202k
The savings target for 2015/16 is a further target of £122k and outline plans have been identified to achieve this.
The savings target for 2016/17 is a further target of £177k and outline plans have been submitted to achieve this.
Future year on year targets are anticipated to be 3%

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates &amp; Facilities</td>
<td></td>
<td></td>
<td></td>
<td>1,681,400</td>
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</table>

Needs/Unmet needs/Drivers for change
The savings target for 2014/15 was £202k
The savings target for 2015/16 is a further target of £122k and outline plans have been identified to achieve this.
The savings target for 2016/17 is a further target of £177k and outline plans have been submitted to achieve this.
Future year on year targets are anticipated to be 3%
**Plans for change**

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property and Asset Management Strategy 2015 (PAMS) sets out the list of</td>
<td>Lawson Bisset</td>
<td>2015</td>
<td>Refer to PAMS</td>
</tr>
<tr>
<td>priorities over next year, five years and 10 years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key Risks to Delivery**
The key risks, as identified above are the availability of adequate resources to support the services required. This includes both staffing, linked to recruitment and retention and finances (revenue and capital budget). Along with other support services the E&F directorate is currently working to deliver a 25% efficiency target over a 5 year period. Agreement has already been reached to provide recruitment & retention “premia”, linked to Agenda for Change T&C’s for key trades staff and this has been agreed for a period of 3 years until March 2017. In addition work a joint project is also underway to maximise opportunities from joint working with Shetland Island Council.

**Performance Targets with links to National Outcomes**
The PAMS sets out a range of KPIs and mechanisms for performance monitoring. This includes indicators on:

- Energy Efficiency (HEAT)
- Property : SCART (quality indicators); Backlog maintenance etc
- Facilities: Patient Satisfaction (IP survey); Cleanliness Audits;
- Within the SAFR all Estates & Facilities services across Scotland are also measured for efficiency and comparative cost

**Contact Details**
Lawson Bisset
Head of Estates and Facilities
lawson.bisset@nhs.net
01595 743029
HEALTH IMPROVEMENT

Policy context
External and national drivers for taking a new approach to health improvement include:

- Increasingly challenging national targets (e.g. HEAT target for smoking cessation which is now focussing on the hardest to reach groups)
- Increasing emphasis on doing things ‘with’ people rather than ‘for’ them, including using co-production\(^2\), enablement, and asset based\(^3\) approaches
- Fewer public sector resources to meet increased demand due to factors such as changing demographics (the aging population) and global economics. This was the focus of the recent Christie Commission
- Changes in lifestyle and culture (for example more sedentary work and leisure pursuits, and the use of games consoles and portable devices)
- Changes in diet (for example increased consumption of processed and convenience food, and larger portion sizes)
- A persisting, and possibly worsening, inequality gap between the most advantaged and the most disadvantaged in our society

Current Services
There are a range of health improvement services and resources available for people and communities in Shetland, most of which are open access. There are also a number of training programmes, usually for staff and volunteers, but some are also open to members of the public. Many of the services listed below are delivered by the Health Improvement Team, but there are other providers including the voluntary sector, primary care and other NHS departments. Services include:

- ‘Help Yourself to Health’ information and resources based in the Shetland public library
- **Keep Well** Health Checks workplaces and primary care
- **Smoking Cessation** Services in primary care; community pharmacies; and drop in sessions
- **Weight Management** including Counterweight in primary care (for adults) and a range of Child and Family healthy weight interventions
- **Drug and Alcohol** services delivered by Community Alcohol & Drug Services Shetland and the NHS prescribing Clinic
- **Sexual Health and Wellbeing** Clinic; a Monday evening drop-in clinic at the Gilbert Bain Hospital
- **A pre-conceptual care** service for people planning pregnancy, which is provided through the maternity department by a specialist midwife.
- **Exercise on referral** as part of cardiac rehabilitation programme (with Shetland Recreational Trust)
- **Falls prevention work** including Chair-Based Exercise
- **Healthy Working Lives**: includes advice, resources and training for employers and workplaces
- **ASIST (Suicide Prevention)** and **Mental Health First Aid training**

\(^2\) Co-production is a new vision for public services based on recognising the resources that citizens already have, and delivering services with rather than for service users, their families and their neighbours.

\(^3\) Asset based approaches are based on the principles of appreciating and mobilising individual and community talents, skills and assets, rather than focussing on problems and needs
• **Improving Health: Developing Effective Practice** Training for healthcare and other workers

**Other health improvement activities** often delivered in partnership: including awareness raising and campaigns; preventative work (often with children and young people); other training events.

**Funding and Resources**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Improvement</td>
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<td></td>
<td></td>
<td>353,794</td>
<td></td>
</tr>
</tbody>
</table>

**Needs/Unmet needs/Drivers for change**

Needs assessment undertaken through locality profiling, and analysis of current service delivery. There is a more detailed assessment of need within the overarching health improvement strategy and within each of the individual health improvement strategies. Key statistics for Shetland include:

- There are still approximately 3000 people who smoke
- According to GP figures, smoking rates are higher in the practices covering the more disadvantaged areas of Shetland
  - In 2011 10% of pregnant women were smoking at booking
  - In 2011/12 23.4% of primary 1 children in Shetland were overweight or obese (Body Mass Index - BMI on 85th centile or above)
  - 220 people were discharged from hospital with alcohol related diagnoses in 2011-12
  - Seven people died through suicide or deaths of undetermined intent in 2011

Whilst there is a wide range of health improvement services and activities available in Shetland, many of these are still centred in Lerwick (e.g. the drop in clinics, community pharmacy services and many of the training events) and people in the more remote and rural areas need better access to the same opportunities.

As well as geographical limitations, there are other restrictions on the services that can be provided because of our very small scale. This can result in widening the health inequalities gap by excluding some of the most vulnerable and disadvantaged groups from being able to access services. There is therefore an unmet need in making health improvement services and activities more accessible to all communities and groups that need them.

There are some specific areas of unmet need that have been identified, and these have not changed in the past year, including:

- Exercise on prescription for more groups (currently just for cardiac rehabilitation patients).
- Greater range of weight management interventions, particularly for those needing a more intensive intervention than Counterweight.
- Psychological interventions and support for individuals with complex needs struggling with behaviour change.
Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increasing capability, capacity and the contribution of non specialist staff: including work with the wider workforce through the Health Promoting Health Service programme to embed health improvement in routine practice; increasing community based work and the use of volunteers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ‘invest to save’ to support accelerated health improvement programmes tackling key risk factors and positive lifestyles with a focus on physical activity, reductions in smoking and alcohol misuse; utilising the increased capacity and capability as above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community capacity building and work in partnership with voluntary sector partners.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key Risks to Delivery
Workforce/capacity issues mean that other professional staff don’t have the time they would like in order to undertake preventative work.

The main risk is the requirement to achieve savings, which makes it harder to ‘invest to save’ in the way that we would like to do. We are addressing this through the use of volunteers, where at all possible, and think of ways to maximise the contributions of staff that we do have.

Performance Targets with links to National Outcomes
Single Outcome objectives under Outcome B: We live longer healthier lives.
Objective 1: To reduce alcohol consumption as a key risk factor for poor health outcomes; specifically focusing on the most vulnerable and disadvantaged individuals and communities.
Objective 2: To reduce smoking as a key risk factor for poor health outcomes; specifically focusing on the most vulnerable and disadvantaged individuals and communities

Objective 3: To increase physical activity, focussing on those who are currently inactive and the most vulnerable and disadvantaged individuals and communities

Objective 4: To reduce the suicide rate by identifying and tackling key risk factors at a local level

Objective 5: To support reducing health inequalities by increasing access to a healthy diet

Public Health Ten Year Plan Targets:

- To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s). The table illustrates Scotland-wide compared to Shetland rates of premature mortality.

- To reduce the percentage of adults who smoke from 15% in 2010 (as measured by Scottish Household Survey) to 10% by 2015, and 5% by 2022

- To reduce the percentage of adults who smoke in the two most deprived SIMD quintiles in Shetland to match the overall smoking rate for Shetland by 2015. Historical data based on GP practice shows that the practices that cover the most deprived areas in Shetland (as measured by SIMD) have higher smoking rates than other practices. However we need to determine the current baseline for this indicator, and set a trajectory to reach the target.

- To achieve the HEAT target of 104 inequalities related smoking cessation successful quits at 4 weeks by end March 2014 (35 achieved by March 2012)

- To reduce the number of alcohol related admissions (discharges) from a baseline of 761/100,000 discharges in 2009/10 to a target of 500 / 100,000 discharges by 2014/15, and 300/100,000 by 2021/22. (This target is based on the best performing Boards in Scotland)

- To increase the proportion of people aged over 65 who live in a housing rather than hospital or care setting: This is currently high at 974.7/1000 but needs to be maintained despite an increasing elderly population. The data presented in the table below illustrates how, working jointly, services are enabling more people to stay in their own homes with 36.3 per 1000 population living in a care or hospital setting in 2009 dropping to 23.6 for 2014.

Contact Details
Health Improvement are based at Grantfield, Lerwick, Shetland ZE1 0NT
Phone: 01595 807484
Email: shet-hb.healthimprovementdepartment@nhs.net

Further Reading
- Public Health Ten Year Strategy ‘Changing the World’ (2012-2022)
- Mental Health Strategy
- Obesity Strategy
- Active Lives Strategy
- Shetland Sports Strategy
- Choose Life Action Plan
- Older People’s Strategy
- CEL 01 (2012) Health Promoting Health Service
Public Health Service Plan

- **Policy context**
  Public Health covers the three domains of health improvement, health protection and population health in service planning and delivery.
  Further detail on Health Improvement is included in that separate section of the Strategic Plan. This section focuses on the core Public Health Team, and policy and service change etc in core public health, health protection and population health.
  However, financial targets for savings for public health come from the whole departmental budget, so the likely impact of these is included here.
  The Public Health team work to deliver the requirements of the Public Health Etc (Scotland) Act 2008, which governs the requirements and arrangements for public health in Scotland.
  There is currently a national review of public health in Scotland, and the service will need to take account of any change that results from that review (due to report later in 2015/16).

- **Current Services**
  The Public Health Department provides public health services to NHS Shetland and the local community. Our purpose is to promote, improve and protect the health and wellbeing of the people of Shetland, to prevent ill-health, and to reduce health inequalities.
  We do this by surveillance and response to communicable disease and environmental health threats, and oversight of immunisation and screening programmes; health improvement programmes targeted at lifestyle factors, working with individuals and communities on prevention and tackling inequalities; and technical support on population health through health intelligence work, needs assessment, health impact assessment and service evaluation.
  The team also provides support for the Strategic Planning function to the Board, and supports the Board’s performance monitoring system.
  We consist of:
  - Director of Public Health (F/T)
  - Consultant in Public Health Medicine (P/T)
  - Public Health specialist (P/T)
  - Senior Planning & Information Officer (F/T)
  - Information Analyst Public Health Intelligence (P/T)
  - Public Health secretary & admin support (shared with Director of Pharmacy)

- **Funding and Resources**
  Table of budget and savings targets, including workforce details

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>14.6\textsuperscript{i} 3.1\textsuperscript{ii}</td>
<td>£548,214\textsuperscript{i}</td>
<td>£194,420\textsuperscript{ii}</td>
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<td></td>
</tr>
</tbody>
</table>

\textsuperscript{i} Includes Health Improvement staff
\textsuperscript{ii} Core Public Health Team

- **Needs/Unmet needs/Drivers for change**
  Population health needs are changing with an increasing elderly population, and increasing demands on health and care services. Public health intervention offers the potential to change the pattern of demand, through prevention, early intervention and
health improvement for which a case can be made for ‘Invest to Save’ in Health Improvement activity. The challenge is to do this whilst meeting departmental savings targets by reducing budgets.

In addition the DPH is retiring at end March 2106, which gives both a challenge around sustainability and resilience within the team, and a potential efficiency / savings opportunity around team skill mix. The decision on this rests with the CE and the Board.

- **Plans for change**

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement of DPH and succession planning</td>
<td>CE</td>
<td>June 2015 / end March 2016</td>
<td>Efficiency savings achieved with minimal loss of service delivery. Links to National Outcomes</td>
</tr>
</tbody>
</table>
| Team staffing restructure to achieve savings targets | DPH          | Sept 2015 / March 2017      | 1. Improving Health & Wellbeing  
5. Reducing health inequalities  
7. Safe from harm  
9. Resources used efficiently |

The Public Health Team has achieved its savings targets to date consistently through savings in non-pay and staff turnover. In 2016/17 for the first time this will not be possible. The team is therefore planning redesign with any future staff leaving - to not replace or replace with budget savings to achieve the savings targets for 16/17 and 17/18.

We can achieve our future savings targets if we have staff turnover and our workforce plan for 2016/17 will set out how we might achieve that. Without natural turnover we can only achieve savings by a restructuring that would displace staff to achieve the savings. The workforce plan for 16/17 will therefore also show the plan for restructuring the dept to achieve savings through staff redeployment.

- **Key Risks to Delivery**

Increasingly we use national programme budgets to fund core staff which brings two risks: around achieving savings - some programmes require performance monitoring to government which needs to show spend in programme areas, this limits our flexibility to make savings or reduce services in these programme areas; if national programme funding ends, unless it is replaced with new programme funding we reduce staffing to remain in budget. This has been managed to date through the use of short term contracts and natural staff turnover. These opportunities have now all come to an end, so future reductions in programme budgets will result in loss of staff, and the dept budget will need to absorb any associated costs.

If we are faced with restructuring and staff redeployment, we will need a lead-in time to achieve savings, and we will need to add to our savings targets with any associated costs unless the Board reaches Board-wide agreement on supported funding. The workforce plan will detail our management of this risk.

There is a risk of reduced service delivery with reduced staffing levels, which we will aim to minimise through reducing unnecessary activity, best use of skill mix, and focus on effective practice.
This includes failure or delays in re-recruitment to the DPH role, or reduced staffing resource in any replacement redesign.

- **Performance Targets with links to National Outcomes**
  Health Improvement HEAT targets are detailed in the Health Improvement section. Public Health also leads and supports delivery against the Single Outcome Agreement objectives on Living Longer, Healthier Lives (with targets on alcohol, physical activity, smoking and suicide prevention); Reducing Inequalities; and Being the best place for children and young people to grow up.

- **Contact Details**
  The Public Health team are based in Upper Floor Montfield in Board HQ, Burgh Road, Lerwick ZE1 0LA.
  Contact via the department secretary on 01595 743340 or on email to shet-hb.publichealthshetland@nhs.net

- **Further Reading**
  Public Health Annual Report 2014/15 including Appendices on progress against the Work Programme and the Public Health Ten Year Plan - add in web link
Child & Family Health

Policy context
The Scottish Government’s ambition is that Scotland should be the best place in the world for children and young people to grow up. There are a number of national policies and local strategies that we link with to help achieve this ambition and ensure that children and young people who live in Shetland will have the best possible start in life and achieve the best outcomes.

The Refreshed Maternity Framework (2011) has been designed to address all care from conception, throughout pregnancy and during the postnatal period. This document clearly outlines the strategic direction for maternity services in Scotland and NHS Shetland is delivering on this Framework. It has been well recognised that maternal health and wellbeing has a significant impact on future child development and resilience.

The Children and Young People (Scotland) Act 2014, which was passed by the Scottish Parliament in February 2014 combines proposals to improve the delivery of children’s rights and services for children and young people. It is wide-ranging in its focus, building on the foundations of Getting it Right for Every Child (GIRFEC) particularly with the responsibilities outlined for the Named Person/Lead Professional.

GIRFEC is more than the framework supporting inter-agency assessment and planning. It provides the overarching principles and values for everything we do for our children and young people. In order to further embed these into our thinking and practice, we have formulated our practice around the GIRFEC National Practice Model SHANARRI outcomes. All our partner services have adopted this principle. The aim is to bring a common language and framework to all children and young people’s services planning.

The Early Years Framework published in December 2008, signified an important milestone in encouraging partnership working to deliver a shared commitment to giving children the best start in life and to improving the life chances of children, young people and families at risk.

The objective of the Early Years Collaborative (EYC) is to accelerate the conversion of the high level principles set out in GIRFEC and the Early Years Framework into practical action. The aim is to:
- Deliver tangible improvement in outcomes and reduce inequalities for Scotland’s vulnerable children
- Put Shetland squarely on course to shifting the balance of public services towards early intervention and prevention by 2016
- Sustain this change to 2018 and beyond

The EYC is premised on the fact that we know there is strong evidence about costs and outcomes of current and desired practice, but much of this is not being used in daily work. Where we have taken on board the evidence, practice does not always reliably recreate what the evidence tells us, and there is inconsistency and patchy implementation. The EYC will help us close that gap by:
- Creating a structure in which partners can easily learn from each other and from recognised experts in areas where they want to make improvements.
- Supporting the application of improvement methodology to bridge the gap between what we know works and what we do.

There are key change areas identified and the Shetland EYC Group are working with individual teams to deliver improved outcomes for children as described in SOA and Integrated Children’s
Plan. These include addressing child poverty, family engagement and parenting skills amongst others.

**Current Services**

The Child Health Team was created in 2012 as a result of bringing together child health services across the community, hospital and specialist settings. The team includes: 1 GPwSi (Paediatrics), 1 team leader, 5.3 Health Visitors, 2 Children's Nurses, 1 School Nurse and a Public Health Staff Nurse who work across Shetland. They are supported by 2 support staff. There are a number of staff who support and work alongside this core team.

- **Health Visitors**
  Health visitors (HVs) support and educate families from pregnancy through to a child's fifth birthday or entering school. Health visitors are trained to recognise the risk factors, triggers of concern, and signs of abuse and neglect in children. HVs also maintain contact with families while formal safeguarding arrangements are in place; ensuring families receive the best possible support during this time.

- **Children's' Nurses**
  Children's nurses have a broad casemix from caring for a neonate to supporting a child following trauma e.g. accident or bereavement. Children’s nurses also play a key role in the care and support needed by the wider-family, including the parents. The team includes two Registered Children’s Nurses – one with a focus on hospital care and the other is based in the community and provides holistic child centred care to children and young people up to the age of 18 years of age for a wide range of health issues and conditions. The Community Children's nurse may be the Lead professional for children and young people who are identified as needing a Child's Plan as defined by Getting Right for Every Child.

- **Out-Patient Services**
  Our Children's Outpatient Department operates as required and enables children to be seen within Shetland by General Practitioner with Special Interest in Paediatrics and by visiting paediatricians and visiting specialists. Our healthcare support worker works within this department half time and in the school nursing service the rest of her time.

- **School Nurses**
  School nurses are public health nurses who work within a variety of settings but principally within schools. A child-centred public health approach enables the school nurse to work at community level with public health programmes, with whole schools, with group work within schools and with individual children, young people and their families.

- **Children's Physiotherapy**
  The paediatric physiotherapy service is based at the Gilbert Bain Hospital and served by 1.6 WTE staff (made up of 1 WTE Band 7, 0.5 Paediatric band 6, and 0.1 Outpatient Band 6). It provides a service to children and young people aged 0-16 (19 if additional needs) in a variety of settings including: inpatients, outpatients, community and schools. The service takes referrals from health, education and also from parents and children themselves via self-referral. It provides advice, assessment and treatment in all areas of paediatric physiotherapy such as development, orthopaedics and musculoskeletal problems, respiratory illness and neurology. It is also able to refer directly into paediatric and orthopaedic clinics for children on the caseload which minimises the impact on GP’s.

- **Speech and Language Therapy Service**
This service provides assessment, diagnosis and treatment for children and adults with
speech, language and communication needs, and those with eating, drinking swallowing
problems (dysphagia). Children are seen with a range of speech, language and
communication needs, including language delay and disorder, difficulties with speech
production, voice problems, dysfluency and social communication difficulties. There are
2.56 speech and language therapist and 0.7 support worker. There is currently 243
children on the caseload with 104 referrals in 2013.

- **Child and Adolescent Mental Health Service**
  This multi disciplinary team provides a CAMH service to the population of Shetland. The
team consists of 1 WTE Psychiatric Nurse, 1 WTE Primary Mental Health Worker, 0.7
WTE Clinical Associate in Applied Psychology and two visiting specialists – a Consultant
Psychologist and a Consultant Psychiatrist – who hold monthly clinics over 4 sessions. It
provides consultations, assessments and interventions; treatment can include different
types of individual therapy: behavioural; cognitive; systemic; psychodynamic, family work
of various kinds, and where needed prescribed medication. Referral for 2014 has seen a
30% increase in numbers from the same time period in 2013.

- **Children’s Occupational Therapist (OT)**
  This service is involved in the assessment and development of the practical skills
necessary for children’s everyday life. An OT will aim to enable a child to be as
independent as possible by analysing the following areas functional abilities, school skills,
play skills sensory abilities fine motor gross motor, movement abilities and behavioural
responses during your child’s day. The staff consist of a specialist children’s OT (0.8)
Assistant Practitioner (0.5).

- **Medical Care**
  Medical services on island are provided by a local GP with Special Interest in paediatrics
and sessional paediatrician providing a community child health clinic, and joint clinics with
visiting paediatricians offering a combination of general paediatric sessions and specialist
clinics e.g. cardiac, respiratory. Most in-patient children’s services are provided through
NHS Grampian or to more specialist regional or national paediatric services.
Children, who are acutely ill, will present through Accident and Emergency, be assessed
and given initial treatment by the medical or surgical teams, in consultation with specialist
paediatric services in Grampian as appropriate. Children may stay overnight in GBH but if
they need longer term inpatient care they will be transferred to a specialist Children’s
Hospital. There is also a paediatric retrieval service for transporting seriously ill children to
specialist units off island.

### Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>16.02</td>
<td></td>
<td></td>
<td>£777,938</td>
<td>£4,538</td>
</tr>
<tr>
<td>Child Health &amp; Health Visiting</td>
<td>11.98</td>
<td></td>
<td></td>
<td>£581,731</td>
<td>£17,452</td>
</tr>
</tbody>
</table>

4 Establishment is taken from 2015/16 workforce plans
5 Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas
<table>
<thead>
<tr>
<th>Service Description</th>
<th>WTE</th>
<th>Staffing Costs 2015/16</th>
<th>Management Costs 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health</td>
<td>NA</td>
<td>£38,137</td>
<td>£1,144</td>
</tr>
<tr>
<td>CAMHS</td>
<td>2.5</td>
<td>£181,995</td>
<td>£5,460</td>
</tr>
<tr>
<td>Medical Staffing - Child Health Consultants</td>
<td>NA</td>
<td>£250,049</td>
<td>£7,501</td>
</tr>
<tr>
<td>Medical Staffing - Consultant Gynaecologist/Obstetrician &amp; GPwSI</td>
<td>1.66</td>
<td>£324,446</td>
<td>£4,155</td>
</tr>
<tr>
<td>Management Costs</td>
<td>1</td>
<td>£74,000</td>
<td>£2,220</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29.66</td>
<td><strong>£2,228,296</strong></td>
<td><strong>£42,470</strong></td>
</tr>
</tbody>
</table>

The indicative savings target for planned care services in 2016-17 is **£42,470**. This is equivalent in staffing costs to a reduction of WTE 1.3 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- review skill mix including advanced practice NMAHP role development and other skill mix changes
- Repatriating services e.g. obstetrics and gynaecology to reduce patient travel and the cost of off island services

**Needs/Unmet needs/Drivers for change**

- Due to the changes in medical training recruiting medical consultants who have the expertise to care for children may be problematic in the future.
- A national shortage of Health Visiting staff and the implementation of the Children and Young Peoples Act have led to a government-led initiative to increase the number of health visiting posts Scotland wide with a new training programme starting and an increase in the number of Health Visiting posts rising over the coming years.
- In terms of the Shetland workforce, 60% of Health Visitors in post are due for retirement in the 3-5 years
- Modernisation of the school nursing role is at an early stage and the outcome of that consultation may have an impact on the service we provide in the future
- CAMHS require redesign options discussed to ensure the service can accommodate the increase and diversity of the children being supported by the staff
- Advance Practice models for AHP is being discussed nationally. We need to look at the potential of advanced practice NMAHP roles to support children’s services locally

**Plans for change**

- The impact of the Children and Young Person’s Act 2014 and the new HV pathway needs to be quantified and evaluated over the next few years – including the workforce needed to deliver the legal requirements of the act
- Redesign of the CAHMS team and links to specialist services is a key priority
- On-island paediatric outpatient care is fragile. A review of the options available to sustain input from medical specialist team will be required over the next 1-2 years

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6 Increasing to 3.5 in 16-17
• Joint commissioning and joint budgeting discussions are being tabled at the Integrated Children and Young Person’s Strategic Planning group (ICYPSPG). We will be engaging with this work over the coming years
• The move to an electronic child’s record will allow the secure sharing of information between services when required under the Children and Young Person’s Act (2014)

### Key Service Indicators - HEAT and other Local Targets

<table>
<thead>
<tr>
<th>ID Code</th>
<th>Target Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.9</td>
<td>3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year (percentage)</td>
</tr>
<tr>
<td>H.10</td>
<td>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours. (percentage)</td>
</tr>
<tr>
<td>BSC4</td>
<td>Immunisation Uptake - MMR1 at 2 yrs (percentage)</td>
</tr>
<tr>
<td>BSC7</td>
<td>Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter) (percentage)</td>
</tr>
<tr>
<td>HI.3</td>
<td>Percentage of mothers smoking during pregnancy</td>
</tr>
<tr>
<td>HI.4</td>
<td>Reduce the proportion of children with their Body Mass Index outwith a healthy range (&gt;=85th centile) (percentage)</td>
</tr>
<tr>
<td>HI.6</td>
<td>Reduce teenage pregnancy rate (13-15 year olds) Rate per 1,000 population (3 year rolling average) (rate)</td>
</tr>
</tbody>
</table>

### Service Performance Measures from the Shetland Single Outcome Agreement

Single Outcome Agreement objectives:

• Effective early intervention and prevention to enable all our children and young people to have the best start in live.
• Effective early intervention and prevention to get it right for every child.

### Other Performance indicators

National Performance Framework strategic objectives:

• Our children have the best start in life and are ready to succeed.
• We have improved the life chances for children, young people and families at risk.
• Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

**EYC aims are:**

• To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1000 births in 2010, to 4.3 per 1000 births in 2015) and infant mortality (from 3.7 per 1000 live births in 2010, to 3.1 per 1000 live births in 2015). This objective has been achieved and a review is underway to establish further aims in this area.
• To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child’s 27-30 month child health review, by end-2016.
• To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.

Local outcomes (as agreed by the Integrated Children and Young Peoples Strategic Planning Group in the Multiagency Children’s Plan):

• Shift from crisis intervention to prevention and early intervention.
• Promote resilience and wellbeing of children, young people, families and communities.
• Timely engagement with children and young people to ensure their views shape current and future planning.
• Continue development of our workforce in delivering the best outcomes for children and young people through their multi-agency working.

Contact Details
Kate Kenmure – kate.kenmure@nhs.net

Further Reading
GIRFEC website: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp
EYC website: http://www.scotland.gov.uk/Topics/People/Young-People/early-years
Shetland Integrated Children and Young People Plan
Acute & Specialist Services

Planned Care

Policy Context

Planned care is an umbrella term used to describe services which are planned and pre-booked by appointment. This includes access to elective procedures in Day Case and Ambulatory Care settings, access to diagnostic tests and outpatient consultations.

The overarching aim of services aligned to planned care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services for pre-booked assessments, tests, care and procedures. Planned care takes place across community, hospital and specialist settings.

The national policy context is very broad and includes: the Public Bodies (Joint Working) (Scotland) Act (2014); 20:20 Vision (2011) and the Patients Rights Act (2011).

Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The importance of planned care services is described in local strategies and plans e.g. the older people’s strategy (2015), dementia strategy (2015), mental health strategy (2013), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of planned care services, which are also aligned to local policy context, include:

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

Current Services Provided

The majority of healthcare services have a planned care pathway, but the main ones can be defined7 as:

- Day Surgery Services
- Out Patient Services (local and visiting)
- Pre-Operative Assessment Services
- Chemotherapy Services
- Renal Services
- Elective Inpatient Medical Services
- Elective Inpatient Surgical Services
- Elective Rehabilitation Services
- Planned Critical Care Services (e.g. pre-operative optimisation and post operative care)

---

7 The services shown in bold are part of the joint service planning arrangements set out in the Integration Scheme – known as part B ‘set aside’ services.
- Elective Theatre Services
- Elective Obstetric Services e.g. pre and post natal care, planned c-sections
- Elective Service provision at NHS Grampian for patients requiring specialist interventions
- Allied Health Professionals - AHPs (planned clinics are in place across all seven AHP disciplines)
- Diagnostic Services (e.g. Medical Imaging, Laboratory Services, Audiology, Physiological Measurements etc)

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of planned care, including the provision of tele-health services to support long term conditions and self management as well as transporting patients between health and social care settings.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery. Child and Family Health Services and specialist off island services are also shown in separate plans.

**Funding & Resources**

**Jointly Commissioned Services (that include a planned care component)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Ward (Ward 3)</td>
<td>26.62</td>
<td></td>
<td></td>
<td>£910,654</td>
<td>£27,320</td>
</tr>
<tr>
<td>Rehabilitation Unit (Ronas)</td>
<td>12.89</td>
<td></td>
<td></td>
<td>£524,671</td>
<td>£15,740</td>
</tr>
<tr>
<td>Medical Staffing - Consultant Physicians &amp; Junior Doctors in Training</td>
<td>8</td>
<td></td>
<td></td>
<td>£1,007,037</td>
<td>£30,211</td>
</tr>
<tr>
<td>Renal</td>
<td>3.57</td>
<td></td>
<td></td>
<td>£144,699</td>
<td>£4,341</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51.08</strong></td>
<td></td>
<td></td>
<td><strong>£2,587,061</strong></td>
<td><strong>£77,612</strong></td>
</tr>
</tbody>
</table>

**Other Planned Care Services & Support Functions in the Acute & Specialist Services Directorate**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Services (Surgical Ward, DSU &amp; HDU)</td>
<td>27.38</td>
<td></td>
<td></td>
<td>£1,066,022</td>
<td>£21,320</td>
</tr>
<tr>
<td>Theatre Services</td>
<td>15.19</td>
<td></td>
<td></td>
<td>£929,032</td>
<td>£18,581</td>
</tr>
<tr>
<td>Decontamination Services</td>
<td>4.64</td>
<td></td>
<td></td>
<td>£166,759</td>
<td>£3,335</td>
</tr>
<tr>
<td>Out Patient Services</td>
<td>7.42</td>
<td></td>
<td></td>
<td>£283,942</td>
<td>£5,679</td>
</tr>
</tbody>
</table>

---

8 Establishment is taken from 2015/16 workforce plans
9 Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas
<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting Services (NHS Grampian and other providers)</td>
<td>Not Applicable</td>
<td></td>
<td>£267,632</td>
<td>£31,981</td>
<td></td>
</tr>
<tr>
<td>Pre- Assessment</td>
<td>2.2</td>
<td>£103,669</td>
<td></td>
<td>£27,871</td>
<td></td>
</tr>
<tr>
<td>Oncology/Chemotherapy</td>
<td>3</td>
<td>£151,259</td>
<td></td>
<td>£5,003</td>
<td></td>
</tr>
<tr>
<td>Specialist Nurses</td>
<td>2.73</td>
<td>£138,499</td>
<td></td>
<td>£8,518</td>
<td></td>
</tr>
<tr>
<td>Medical Staffing - Consultant Surgeons &amp; Junior Doctors in Training</td>
<td>7</td>
<td>£883,751</td>
<td>£10</td>
<td>£8,029</td>
<td></td>
</tr>
<tr>
<td>Medical Staffing - Consultant Anaesthetists</td>
<td>4</td>
<td>£666,556</td>
<td></td>
<td>£3,110</td>
<td></td>
</tr>
<tr>
<td>Maternity Services</td>
<td>16.02</td>
<td>£777,938</td>
<td></td>
<td>£4,538</td>
<td></td>
</tr>
<tr>
<td>Medical Staffing - Consultant Gynaecologist/Obstetrician &amp; GPwSI</td>
<td>1.66</td>
<td>£324,446</td>
<td></td>
<td>£4,155</td>
<td></td>
</tr>
<tr>
<td>Medical Imaging</td>
<td>8.96</td>
<td>£663,449</td>
<td></td>
<td>£26,513</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>9.62</td>
<td>£761,461</td>
<td></td>
<td>£19,997</td>
<td></td>
</tr>
<tr>
<td>Physiological Measurements</td>
<td>1</td>
<td>£66,616</td>
<td></td>
<td>£23,338</td>
<td></td>
</tr>
<tr>
<td>Audiology</td>
<td>1.6</td>
<td>£132,659</td>
<td></td>
<td>£9,733</td>
<td></td>
</tr>
<tr>
<td>Health Records &amp; Reception</td>
<td>27.99</td>
<td>£896,660</td>
<td></td>
<td>£19,903</td>
<td></td>
</tr>
<tr>
<td>Hospital Management</td>
<td>3</td>
<td>£239,559</td>
<td></td>
<td>£22,844</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>143.41</strong></td>
<td><strong>£8,519,909</strong></td>
<td></td>
<td><strong>£255,597</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Drivers for Change**

Over recent years, services that provide planned care have been under increasing pressure. There are a number of factors which are associated with the increase in planned care activity including:

- A response to demands associated with demographic changes and patterns of ill health
- Increased public expectation of equity of access to health and social care services
- Advancement in technology, diagnostic capabilities and surgical techniques has made many interventions safer and less invasive resulting in an increase in the number of patients eligible for treatment
- Progressive shift towards the delivery of day case surgery, interventions and diagnostic tests in ambulatory care units and out with the hospital setting
- Successful delivery of services within the national waiting times treatment guarantee (TTG) and other access targets
Another important factor impacting on planned care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways.

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies
- Managed Clinical Networks (MCNs) to support people with long term conditions e.g. diabetes, cancer, neurological conditions, sensory impairment
- Promoting personal and community level resilience and accountability for health and wellbeing
- Effective health and care pathway design across primary, secondary and specialist care
- Delivering Outpatient Integration Together (DO IT)
- The Patients Rights Act – Treatment Time Guarantee (TTG)
- Making ambulatory care and day care services the norm
- Effective models of unscheduled care delivery

Plans for Change

The indicative savings target for planned care services in 2016-17 is £333,209. This is equivalent in staffing costs to a reduction of WTE 10.5 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Reducing our reliance on expensive inpatient beds and focusing on ambulatory care models
- Increase efficiency and productivity e.g. by delivering more services locally using affordable methods such as tele-health
- Streamlining pathways – reducing the reliance on outpatient services and delivering more complex assessments with practitioners in the community
- Reduce inefficiency and short term spending on locum/supplementary staffing

Our strategic priorities for planned care as set out in the Corporate Action Plan (2015-16 and beyond) and the various strategies referenced above can be summarised as follows:

- Managing patient flow - balancing planned and emergency care and separating flows wherever it is possible to do so
- Developing new models of supported rehabilitation, discharge to enhance recovery and reduce length of stay in hospital
- Repatriating services where it is safe to do so – providing person centred care and maximising the efficiency of local services
- Developing ambulatory care and day care models as a safe alternative to inpatient care and increasing activity through investment in ambulatory care and day surgical facilities
- Using technology and tele-health to avoid unnecessary follow up/review in hospital
- Role development to support planned care service delivery – particularly the positioning of advanced NMAHP practitioners in ambulatory care and outpatient settings
- Reducing the number of people who are delayed in hospital
Some of the specific change management plans/actions/impact and timescales are shown here.

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start/Target</th>
<th>Expected Outcome(s)</th>
<th>National Outcomes</th>
</tr>
</thead>
</table>
| Increasing access to tele-health appointments to avoid unnecessary follow up and travel | Director of Nursing & Acute Services (DNAS) | Ongoing from 2015 – review progress September 2016 and annually thereafter | Increase in use tele-health delivered appointments  
Increase in electronic triage of referrals  
Reduction in the cost of patient travel | Public services contribute to reducing health inequalities  
Resources are used effectively and efficiently |
| Increasing capacity in the renal unit to meet demand | Director of Nursing & Acute Services (DNAS) | Ongoing from 2015 – review progress September 2016 and annually thereafter | Additional renal dialysis stations – to meet growing service demand  
Reduced patient travel through the provision of telehealth | Resources are used effectively and efficiently |
| Identifying appropriate clinical pathways for repatriation to Shetland in collaboration with NHS Grampian – e.g. local surveillance instead of specialist service oversight, shared pathways with specialists in Grampian | Director of Nursing & Acute Services (DNAS) | Ongoing from 2015 – review progress September 2016 and annually thereafter | Reduction in the number of patients travelling to NHS Grampian and other hospitals for follow up  
Reduction in the number of procedures undertaken in NHS Grampian hospitals  
Reduction in the cost of the SLA (at a sub speciality level) | Public services contribute to reducing health inequalities  
Resources are used effectively and efficiently |
| Developing an enhanced Day Surgical Unit (DSU) and ambulatory care facility | Director of Nursing & Acute Services (DNAS) | Ongoing from 2015 – if funding is successful then construction will be complete mid 2017 | Increase in the number of day case surgical procedures (through repatriation of clinical services from Grampian)  
Increase in the number of ambulatory care procedures (as an alternative to admission)  
Reduction in the number of inpatient attendances and outpatient attendances  
Reconfiguration of inpatient services/beds (medium term) | Public services contribute to reducing health inequalities  
Resources are used effectively and efficiently |
### Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)

**Director of Nursing & Acute Services (DNAS)**

- **Scoping exercise 2015-16**
- **Options selection and implementation 2016-17 onwards**

- Increased role development for NMAHPs with advanced practice skills
- Increased number of NMAHPs supporting planned care e.g. in outpatient setting
- Reduced length of stay (LoS) for patients due to increased availability of enhanced recovery models
- Reduced LoS linked to nurse led discharge
- Reduced locum costs (e.g. for junior doctor vacancies)

- Resources are used effectively and efficiently
- H&SC services are centred on helping to maintain or improve quality of life
- People using services are safe from harm

### Put in place a managed service contract for Laboratory Services (joint arrangement with NHS Grampian and NHS Orkney)

**Director of Nursing & Acute Services (DNAS)**

- **Ongoing from 2015 – review implementation in September 2016**

- Fixed costs for revenue requirements for lab reagents
- Reduced capital costs for laboratory equipment replacement and maintenance
- Reduced cost of on call for BMS staff (moving towards point of care testing and sample analysis automation)

- Public services contribute to reducing health inequalities
- Resources are used effectively and efficiently

### Reviewing the management structure for Acute & Specialist Services

**Director of Nursing & Acute Services (DNAS)**

- **Ongoing from 2015 – review implementation in September 2016**

- Improvement management capacity to support service delivery
- Improved skill mix (ratio of professional management to clinical management roles)
- Reduced management costs

- Resources are used effectively and efficiently

### Key Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Planned care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a ‘whole system’ strategic exercise with all partners working to shared objectives
- Pace of change – e.g. developing primary care and locality based alternatives to outpatient assessment, review clinics and early supported discharge will take time. We
need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented
- Viability of alternative models – we will need to work closely with specialist services and NHS partners to ensure that pathway redesign is realistic and deliverable. There are considerable challenges ahead for succession planning generalist clinical roles and we are already starting to see the impact of this on some visiting services
- Increase in demand for acute services due to demographic changes and case complexity
- Rising costs associated with increases in demand and inflation reduce the impact of the redesign plans

**Targets/Outcomes**

There are a number of HEAT targets that specifically relate to quality or performance markers for effective planned care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E.4.2S</td>
<td>Total Delayed Discharges (count)</td>
<td>Aug</td>
<td>Jul</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>E.9</td>
<td>No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes (count)</td>
<td>Aug</td>
<td>Jul</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A.9aS</td>
<td>Urgent Referral With Suspicion of Cancer to Treatment Under 62 days (percentage)</td>
<td>Jul</td>
<td>Jun</td>
<td>100</td>
<td>R ↓</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>A.9bS</td>
<td>Decision to treat to first treatment for all patients diagnosed with cancer - 31 days (percentage)</td>
<td>Jul</td>
<td>Jun</td>
<td>100</td>
<td>G ↓</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>A.10.2Sa</td>
<td>Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (consultant led services) (count)</td>
<td>Jul</td>
<td>Jun</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A.10.2Sb</td>
<td>Inpatients/Day Cases Waiting Over 9 Weeks (count)</td>
<td>Jul</td>
<td>Jun</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A.10.2Sba</td>
<td>Treatment Time Guarantee - 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Month</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>A.10.2Sc</td>
<td>Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (Orthodontic Service) (count)</td>
<td>2015 Jul</td>
<td>0</td>
<td>R</td>
<td>0</td>
<td>2016-03 0</td>
<td></td>
</tr>
<tr>
<td>A.10S</td>
<td>18 Weeks Referral to Treatment: Combined Performance (percentage)</td>
<td>2015 Jul</td>
<td>94.8</td>
<td>90</td>
<td>2016-12</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Acc1</td>
<td>Number of cases where the Upper GI endoscopy waiting time was greater than 6 weeks (count)</td>
<td>2015 Aug</td>
<td>0</td>
<td>0</td>
<td>2016-03</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Acc2</td>
<td>Number of cases where the Lower endoscopy (excluding colonoscopy) waiting time was greater than 6 weeks (count)</td>
<td>2015 Aug</td>
<td>0</td>
<td>0</td>
<td>2016-03</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Acc3</td>
<td>Number of cases where the colonoscopy waiting time was greater than 6 weeks (count)</td>
<td>2015 Aug</td>
<td>0</td>
<td>0</td>
<td>2016-03</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Acc4</td>
<td>Number of cases where the cystoscopy waiting time was greater than 6 weeks (count)</td>
<td>2015 Aug</td>
<td>0</td>
<td>0</td>
<td>2016-03</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Acc5</td>
<td>Number of cases where the ultrasound scan waiting time was greater than 6 weeks (count)</td>
<td>2015 Aug</td>
<td>0</td>
<td>0</td>
<td>2016-03</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Acc6</td>
<td>Number of cases where the CT scan waiting time was greater than 6 weeks (count)</td>
<td>2015 Aug</td>
<td>0</td>
<td>0</td>
<td>2016-03</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>KPI Code</td>
<td>Description</td>
<td>Week</td>
<td>Week</td>
<td>G</td>
<td>Week</td>
<td>Week</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>-------</td>
<td>-------</td>
<td>-----</td>
<td>-------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Acc7</td>
<td>Number of cases where the Barium enema test waiting time was greater than 6 weeks (count)</td>
<td>2015 Aug</td>
<td>2015 Jul</td>
<td>G</td>
<td>2016-03</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>BSC16</td>
<td>Quarterly Hospital Standardised Mortality Ratios (HSMR) (count)</td>
<td>2015 Jan-Mar</td>
<td>2014 Oct-Dec</td>
<td>1.27</td>
<td>2016-03</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>T.12</td>
<td>Emergency bed days rates for people aged 75+ (rate))</td>
<td>2015 Aug</td>
<td>2015 Jul</td>
<td>G</td>
<td>2016-03</td>
<td>3497</td>
<td></td>
</tr>
<tr>
<td>T.14</td>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%. (percentage)</td>
<td>2014</td>
<td>2013</td>
<td>R</td>
<td>2016-03</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>CCB1</td>
<td>Average length of stay for critical care patients discharged per month (days)</td>
<td>2015 Jul</td>
<td>2015 Jun</td>
<td>G</td>
<td>2014-12</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CE02a</td>
<td>% of people who say they got the outcome (or care support) they expected and needed on Ward 3 (percentage)</td>
<td>2015 Jul</td>
<td>2015 Jun</td>
<td>G</td>
<td>2016-03</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>CE02b</td>
<td>% of people who say they got the outcome (or care support) they expected and needed on Ward 1 (percentage)</td>
<td>2015 Jul</td>
<td>2015 Jun</td>
<td>G</td>
<td>2016-03</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

**Contact Details**

Kathleen Carolan, Director of Nursing & Acute Services, kcarolan@nhs.net

**Further Reading (available at** [http://www.shb.scot.nhs.uk](http://www.shb.scot.nhs.uk))

- Older Peoples Strategy
- Corporate Action Plan
- Unscheduled Care Strategic Plan
Unscheduled Care

Policy Context

Unscheduled care is an umbrella term used to describe services which provide an emergency or unplanned service response. The majority of unscheduled care takes place in the community setting and is managed by community health and social care teams.

The overarching aim of services aligned to unscheduled care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services ‘in an emergency’. Unscheduled care takes place across community, hospital and specialist settings.

The national policy context is very broad and includes: the Public Bodies (Joint Working) (Scotland) Act (2014); 20:20 Vision (2011) and the Patients Rights Act (2011).

Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The importance of planned care services is described in local strategies and plans e.g. the older people’s strategy (2015), dementia strategy (2015), mental health strategy (2013), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of unscheduled care services, which are also aligned to the unscheduled care collaborative essential actions include ensuring that we deliver:

- Clinically Focussed and Empowered Hospital Management
- Hospital Capacity and Patient Flow (Emergency and Elective) Realignment
- Patient Rather Than Bed Management – Operational Performance Management of Patient Flow
- Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway
- Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working
- Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting

Current Services Provided

The majority of healthcare services have an unscheduled care pathway, but the main ones can be defined\(^\text{10}\) as:

- Out of Hospital Services – e.g. community nursing and primary care services ‘out of hours’
- Accident and Emergency Services
- Acute Inpatient Medical Services (including admission of renal patients)
- Acute Inpatient Surgical Services
- Critical Care Services
- Theatre Services
- Obstetric Services
- Emergency Service provision at NHS Grampian for patients requiring specialist interventions

---

\(^{10}\) The services shown in bold are part of the joint service planning arrangements set out in the Integration Scheme – known as part B ‘set aside’ services.
• Diagnostic Services (e.g. Medical Imaging, Laboratory Services)

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of unscheduled care, including the provision of air transfer and critical care retrieval for adults, children accessing tertiary care centres and patients accessing specialist mental health facilities.

The services which are shown in bold are part of the integrated commissioning arrangements.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery. Child and Family Health Services and specialist off island services are also shown in separate plans.

Funding & Resources

Jointly Commissioned Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>14.66</td>
<td></td>
<td></td>
<td>£741,083</td>
<td>£14,822</td>
</tr>
<tr>
<td>Acute Medical Ward (Ward 3)</td>
<td>26.62</td>
<td></td>
<td></td>
<td>£910,654</td>
<td>£27,320</td>
</tr>
<tr>
<td>Rehabilitation Unit (Ronas)</td>
<td>12.89</td>
<td></td>
<td></td>
<td>£524,671</td>
<td>£15,740</td>
</tr>
<tr>
<td>Medical Staffing - Consultant Physicians &amp; Junior Doctors in Training</td>
<td>8</td>
<td></td>
<td></td>
<td>£1,007,037</td>
<td>£30,211</td>
</tr>
<tr>
<td>Renal</td>
<td>3.57</td>
<td></td>
<td></td>
<td>£144,699</td>
<td>£4,341</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65.74</strong></td>
<td></td>
<td></td>
<td><strong>£3,328,144</strong></td>
<td></td>
</tr>
</tbody>
</table>

Other Planned Care Services & Support Functions in the Acute & Specialist Services Directorate

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Services (Surgical Ward, DSU &amp; HDU)</td>
<td>27.38</td>
<td></td>
<td></td>
<td>£1,066,022</td>
<td>£21,320</td>
</tr>
<tr>
<td>Theatre Services</td>
<td>15.19</td>
<td></td>
<td></td>
<td>£929,032</td>
<td>£18,581</td>
</tr>
<tr>
<td>Medical Staffing - Consultant Surgeons &amp; Junior Doctors in Training</td>
<td>7</td>
<td></td>
<td></td>
<td>£883,751</td>
<td>£8,029</td>
</tr>
</tbody>
</table>

11 Establishment is taken from 2015/16 workforce plans
12 Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas
<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staffing - Consultant Anaesthetists</td>
<td>4</td>
<td>£666,556</td>
<td></td>
<td></td>
<td>£3,110</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>16.02</td>
<td>£777,938</td>
<td></td>
<td></td>
<td>£4,538</td>
</tr>
<tr>
<td>Medical Staffing - Consultant Gynaecologist/Obstetrician &amp; GPwSI</td>
<td>1.66</td>
<td>£324,446</td>
<td></td>
<td></td>
<td>£4,155</td>
</tr>
<tr>
<td>Medical Imaging</td>
<td>8.96</td>
<td>£663,449</td>
<td></td>
<td></td>
<td>£26,513</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>9.62</td>
<td>£761,461</td>
<td></td>
<td></td>
<td>£19,997</td>
</tr>
<tr>
<td>Hospital Management</td>
<td>3</td>
<td>£239,559</td>
<td></td>
<td></td>
<td>£22,844</td>
</tr>
<tr>
<td>Total</td>
<td>92.83</td>
<td>£6,312,214</td>
<td></td>
<td></td>
<td>£129,087</td>
</tr>
</tbody>
</table>

**Drivers for Change**

Over recent years, services that provide unscheduled care have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs
- Increasing public expectation of and access to health and social care services
- Delays in accessing up-to-date patient information - impacting on or slowing down clinical decision making
- Need for improved team working and better co-ordination of care between NHS partners (primary care, SAS, NHS 24, secondary care and tertiary care)
- Need for greater collaborative working to reduce delays particularly at the health and social care interface
- Need for closer working between health and social care services to develop integrated models of anticipatory and community based care
- Challenges in training, recruitment and retaining of staff

Another important factor impacting on unscheduled care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways. Our winter planning arrangements as well as a local focus on the strategic development of primary care services and medical staffing models help to support the sustainable delivery of unscheduled care and planned care services.

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies
- Promoting personal and community level resilience and accountability for health and wellbeing
• Developing an integrated approach for older peoples services delivery across health and social care
• Developing robust models for dementia care and community mental health services
• Effective health and care pathway design across primary, secondary and specialist care
• Effective models of planned care delivery e.g. Delivering Outpatient Integration Together (DO IT)
• Strategic plans to support Living and Dying Well

**Plans for Change**

The indicative savings target for unscheduled services in 2016-17 is £221,521. This is equivalent in staffing costs to a reduction of WTE 7 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

• Deliver care closer to home through locality based teams and services (reducing reliance on hospital and care home resources)
• Invest in patient education, self care and self management
• Use technology more to support people at home e.g. telecare, tele-health
• Working collaboratively with the third sector to provide services which help people to access services/support in the community
• Streamlining pathways – reducing the reliance on outpatient services and delivering more complex assessments with practitioners in the community
• Reduce inefficiency and short term spending on locum-supplementary staffing by changing the skill mix in teams

Our strategic priorities for planned care as set out in the Corporate Action Plan (2015-16 and beyond) and the various strategies referenced above can be summarised as follows:

• Managing patient flow - recognising the increase in admissions and demographic changes meaning patients with more complex needs are presenting through emergency care services and discharge planning models need to be revised
• Implementing a joint strategic approach to the delivery of older peoples care across health and social care sectors – particularly our objective to develop a locality based approach to provide more community assessment and support options
• Focus on ensuring that we can provide appropriate care settings/resources/pathways (jointly) to ensure that clinical and care needs are met in the community, whenever it is safe to do so
• Reducing the number of people who are delayed in hospital
• Reviewing the current provision of Out of Hours (OOHs) services to ensure they are sustainable
• Developing ambulatory care and day care models as a safe alternative to inpatient care
• Role development to support unscheduled care service delivery – particularly the positioning of advanced NMAHP practitioners in Acute and Community based care settings
<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s)</th>
<th>National Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)</td>
<td>Director of Nursing &amp; Acute Services (DNAS)/ Director of Community Health &amp; Social Care</td>
<td>Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards</td>
<td>Increased role development for NMAHPs with advanced practice skills Increased number of NMAHPs supporting unscheduled/primary care e.g. OOHs Increased anticipatory care plan development/access Increased access to care to OOHs care packages Reduced locum costs (e.g. for GP vacancies)</td>
<td>Resources are used effectively and efficiently H&amp;SC services are centred on helping to maintain or improve quality of life People using services are safe from harm</td>
</tr>
<tr>
<td>Reviewing out of hours service provision (including medical staffing, primary care configuration and locality based services)</td>
<td>Ralph Roberts (Chief Executive)</td>
<td>Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards</td>
<td></td>
<td>Resources are used effectively and efficiently</td>
</tr>
<tr>
<td>Reviewing the management structure for Acute &amp; Specialist Services</td>
<td>Director of Nursing &amp; Acute Services (DNAS)</td>
<td>Ongoing from 2015</td>
<td>Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs</td>
<td>Resources are used effectively and efficiently</td>
</tr>
<tr>
<td>Reviewing the management structure for Community Care services</td>
<td></td>
<td>Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards</td>
<td>Improvement management capacity to support service delivery at a locality level Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs</td>
<td>Resources are used effectively and efficiently</td>
</tr>
</tbody>
</table>
Key Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Unscheduled care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a ‘whole system’ strategic exercise with all partners working to shared objectives
- Pace of change – developing robust community based models will take time and resources. We need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented
- Increase in demand for acute services due to demographic changes and case complexity

Targets/Outcomes

There are a number of HEAT targets that specifically relate to quality or performance markers for effective emergency care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

| E.4.2S | Total Delayed Discharges (count) | M | 2015 Aug | 2 | 2015 Jul | 2 | R | → | 0 | 2016-03 | 0 |
| E.9 | No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes (count) | M | 2015 Aug | 0 | 2015 Jul | 0 | G | → | 0 | 2016-03 | 0 |
| A.7S | A&E 4 Hour waits (percentage) | M | 2015 Aug | 94.1 | 2015 Jul | 96.2 | A | ↓ | 98 | 2016-03 | 98 |
| A.8.1S | 48 hour Access - GP Practice Team (percentage) | A | 2014 | 93.5 | 2013 | 89 | G | ↑ | 90 | 2016-03 | 90 |
| A.8.2S | Advance booking - GP Practice Team (percentage) | A | 2014 | 73.2 | 2013 | 73 | R | ↑ | 90 | 2016-03 | 90 |
| BSC17 | Level of Older People with Complex Care Needs Receiving Care at Home (percentage) | Q | 2015 Apr-Jun | 48 | 2015 Jan-Mar | 40 | G | ↑ | 39 | 2016-03 | 39 |
| T.10 | Rate of attendance at A&E (rate) | M | 2015 Aug | 3094 | 2015 Jul | 3021 | A | ↓ | 3061 | 2015-12 | 3061 |

Contact Details

Kathleen Carolan, Director of Nursing & Acute Services, kcarolan@nhs.net

Further Reading

Older Peoples Strategy, Corporate Action Plan, Unscheduled Care Strategic Plan

http://www.isdscotland.org/Health-Topics/Emergency-Care/
Renal Service

Policy context
To ensure the renal patients receiving renal replacement therapy are meeting the guidelines set by the Renal Association clinical standards.

Current Services
The Renal unit provides renal replacement therapy for the people of Shetland. In addition the service provides pre-dialysis education and monitoring and post transplantation care liaising with Aberdeen Renal Unit and Renal Consultant. The unit provides the opportunity for holiday dialysis whenever possible.
In addition, the renal nursing provide education and support for patients to enable them dialyse at home and provide respite care for these patients as required.
The service cares for patients following peritoneal dialysis and provides home visits if necessary and monitor their adequacy.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RENAL</td>
<td></td>
<td></td>
<td></td>
<td>144699.00</td>
<td>2%</td>
</tr>
</tbody>
</table>

needs/Unmet needs/Drivers for change

There has been an increase in demand over 2015 and moving forward into 2016, the staff have adjusted working times and days to support the increase in demand for the service. This increase in demand for the longer term will require a staffing review and service provision review.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To extend the renal unit by 2 more stations making 6 in all.</td>
<td>Michael Gray</td>
<td>unknown</td>
<td>unknown</td>
</tr>
</tbody>
</table>

Key Risks to Delivery

- **Water quality**- water testing/monitoring and result analysis, testing criteria and plan in place.
- **Water failure**- Estates monitoring, adjustment to service provision, and transportation of patients to NHS Grampian for dialysis if required in major water failure.
- **Dialysis machine failure**- 3 new dialysis machines and reverse osmosis machines have been purchased, a spare machine available which will support service continuity. The other two are for the new dialysis stations once the unit has been extended. Servicing of current machines undertaken by NHS Grampian. Major failure would instigate transfer of patients to ARI.
• **Weather related risks** - due to location of patients, if needs be, patients individual dialysis sessions can be changed to accommodate the patients or patients receive their dialysis in Aberdeen.

• **Specialists staffing resource** - staff work flexibly, hours extended where possible to meet services demand. Continued support is required to sustain the renal service and annual training plans are submitted to ensure staff receive the required updates. There are associated risks with staff sickness / absence and additional resilience is needed within the team to ensure service delivery.

• **Increase in demand for service** - The staff have reviewed their hours and days of work to accommodate the patients and are now full to capacity. This creates an impact on other services in terms of staffing (renal clinics, IV iron etc) which remains a challenge and consideration is required to further expansion of service in terms of staffing. To allow for increased demand for the service it is envisaged the extension to the unit will commence when all plans have been agreed year to allow for additional Shetland patients to receive their dialysis on island.

• **Performance Targets with links to National Outcomes**
  There are a number of standards that specifically relate to adult renal service:
  • Annual audit is carried out using the Quality Improvement Scotland (QIS)
  • Standards for Adult Renal Services.
  • Renal Association clinical standards.
Adequacy takes place with the data submissions to NHS Grampian

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Janice McMahon
Chief Nurse Acute and Specialist Services
Janice.mcmahon@nhs.net

**Further Reading**
National Kidney Foundation: [www.kidney.org.uk](http://www.kidney.org.uk)
UK National kidney foundation: [www.kidney.org.uk](http://www.kidney.org.uk)
The Nephron information centre: [www.nephron.com](http://www.nephron.com)
Royal Infirmary of Edinburgh: [www.edren.org](http://www.edren.org)
Medical Imaging Department

Policy Context

The AHP national plan (2012) and the Healthcare Science National Plan (2015) are key policies which shape the scientific professions aligned to healthcare. Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The contribution of clinical support services is described in local strategies and plans e.g. the older people’s strategy (2015), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of clinical support services, which are also aligned to the AHP and Healthcare Science National Plans include ensuring that we deliver:

- Clinically Focussed and Empowered Diagnostic/Clinical Support practitioners
- Ensure clinical pathways are evidence based and diagnostic tests are evidence based
- Seven day services are appropriately targeted to reduce variation in weekend and Out of Hours working
- Sustainable services and develop our local workforce – including fellowship and development posts to build resilient local teams

Current Services Provided

The team consists of 6 Radiographers, 1 Sonographer, 1 Imaging Assistant and 1 Imaging Services Administrator.

The medical imaging department undertakes approximately 14,000 imaging examinations per year. There is no local Consultant Radiologist and Radiologists at NHS Grampian, Aberdeen Royal Infirmary carry out reporting, where the Clinical Director is also based. Consultant Radiologists visit the department once a month to carry out specialised examinations. Role extension is actively encouraged within the department.

Key modalities available locally include plain film imaging/fluoroscopy/mobile/CT scanning & Ultrasound. There is out of hours emergency cover provided by a single on call radiographer. Modalities therefore available out of hours are dependent on the scope of practice of the radiographer on call.

The department operates highly efficiently by offering plain film imaging on demand; not only for A&E referrals, but for all primary & secondary care referrals where possible. Appointment systems operate for ultrasound and CT scanning due to the nature of the examinations which require preparation.

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13 Medical imaging is a clinical support service and one of the ‘visible other’ services out with the Integration Scheme strategic remit but provides services to practitioners which are part of ‘side aside’ and ‘managed services’.
**Funding & Resources**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Imaging Service</td>
<td>8.9</td>
<td></td>
<td>£522,829</td>
<td>£15,685</td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td>NA</td>
<td></td>
<td>£2,700</td>
<td>£81</td>
<td></td>
</tr>
<tr>
<td>CT Scanning</td>
<td>NA</td>
<td></td>
<td>£137,920</td>
<td>£4,138</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8.9</td>
<td></td>
<td>£663,449</td>
<td>£19,903</td>
<td></td>
</tr>
</tbody>
</table>

**Drivers for Change**

Over recent years, services that clinical support and diagnostics have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs
- Increasing public expectation of and access to health and social care services
- Increasing demand for diagnostic tests and the need to ensure that there is a clear evidence base for test requests
- Challenges in training, recruitment and retaining of staff

**Plans for Change**

The indicative savings target for unscheduled services in 2016-17 is £19,903. This is equivalent in staffing costs to a reduction of WTE 0.5 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Streamlining pathways – reducing the number of diagnostic tests by creating a more consistent approach and evidence based pathways for diagnostic testing
- Increasing the number of diagnostic tests available locally – reducing off island service level agreement costs (e.g. looking at the potential to bring MRI to Shetland)
- Reduce inefficiency and short term spending on locum-supplementary staffing by changing the skill mix in teams

Our strategic priorities for medical imaging services as set out in the Corporate Action Plan (2015-16 and beyond) and the Capital Plan (2015 and beyond) as well as the various strategies referenced above can be summarised as follows:

---

14 Establishment is taken from 2015/16 workforce plans
15 Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas
• Role development to diagnostic/clinical support service delivery – particularly the positioning of advanced NMAHP practitioners to support local and regional shared services as well as looking at the development of the Assistant Practitioner role
• Ensuring that there is appropriate investment in medical imaging technology to support the repatriation of diagnostic tests from specialist services and ensure that we can sustain the delivery of local services

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s)</th>
<th>National Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing the medical imaging staffing skill mix and team structure</td>
<td>Head of Medical Imaging/ Director of Nursing &amp; Acute Services (DNAS)</td>
<td>Ongoing from 2015</td>
<td>Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs</td>
<td>Resources are used effectively and efficiently</td>
</tr>
<tr>
<td>Diagnostic Imaging Equipment Replace Programme - Replacement of x-ray equipment (2017-18) Replacement of CT scanner (by 2021) Replacement of current ultrasound machine (by 2018)</td>
<td>Head of Medical Imaging</td>
<td>Ongoing from 2015</td>
<td>Increased opportunity for new technologies/modalities of diagnostic testing which might be less invasive or potent (e.g. radiation levels) Increased opportunity to provide local diagnostics to support clinical pathways in Shetland (including repatriation of services)</td>
<td>Resources are used effectively and efficiently People using services are safe from harm</td>
</tr>
</tbody>
</table>

**Key Risks to Delivery**

Key issues (as set out in various local strategies/corporate action plan etc) include:

• Impact of local HB plans to repatriate services locally and increases in diagnostic testing generally have put pressure on all clinical support services and diagnostic modalities such as ultrasound have seen significant increases in demand

• A recent needs assessment for ultrasound services depicted a requirement to increase sonographer staffing to meet current demand and we have trained additional staff to help match this demand. However, we will need to keep a watching brief on increasing demand in terms of workforce planning and development and expansion of the service. A
A business case has been put together proposing expansion of the existing ultrasound facilities which will be progressed if no other solution to meet service needs is identified.

- Expectations towards delivery of 7 day working in remote and rural services – we have reviewed the models of clinical support service delivery and an oncall model is the most sustainable way of providing 24/7 access to diagnostic tests. However, this may not align with national standards for the delivery of 7 day services, but alternative models for remote and rural service provision might not be available (e.g. reporting can be part of a shared service model with remote decision making, but a Radiographer is still required to undertake the diagnostic test and where services have diseconomies of scale, moving to 7 day service delivery for ultrasound would be challenging).

**Targets/Outcomes**

There are a number of HEAT targets that specifically relate to quality or performance markers for effective medical imaging services and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

<table>
<thead>
<tr>
<th>Acc5</th>
<th>Number of cases where the ultrasound scan waiting time was greater than 6 weeks (count)</th>
<th>M 2015 Aug</th>
<th>0</th>
<th>2015 Jul</th>
<th>0</th>
<th>G → 0</th>
<th>2016-03</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acc6</td>
<td>Number of cases where the CT scan waiting time was greater than 6 weeks (count)</td>
<td>M 2015 Aug</td>
<td>0</td>
<td>2015 Jul</td>
<td>0</td>
<td>G → 0</td>
<td>2016-03</td>
<td>0</td>
</tr>
<tr>
<td>Acc7</td>
<td>Number of cases where the Barium enema test waiting time was greater than 6 weeks (count)</td>
<td>M 2015 Aug</td>
<td>0</td>
<td>2015 Jul</td>
<td>0</td>
<td>G → 0</td>
<td>2016-03</td>
<td>0</td>
</tr>
</tbody>
</table>

**Contact Details**

ANN SMITH, 01595 743000 EXT. 3158, ANNSMITH5@NHS.NET

**Further Reading**

Medical imaging Department intranet page.

Royal College of Radiologists [https://www.rcr.ac.uk/](https://www.rcr.ac.uk/)

Society of Radiographers [https://www.sor.org/](https://www.sor.org/)


Physiological Measurements

Policy context

Following the Healthcare Sciences Delivery Plan it is hoped that resource will become available to help streamline the current demand led service.

Current Services

Physiological Measurements provides mainly cardiac physiological measurement services to NHS Shetland and the local community. The service is multifunctional with diagnostic services in the main along with treatment services for patients with implanted cardiac devices. The service aims is to provide physicians with data to guide treatment as well as treating patients with implanted cardiac devices to maximise their function.

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSIOLOGICAL MEASUREMENTS SERVICE</td>
<td>1</td>
<td>69,725</td>
<td>0</td>
<td>69,725</td>
<td>0</td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

National changes in the patient demographic not only result in an increase of patients surviving to an older age but also result in an increase of patients with conditions of older age along with technology that can treat these patients. For example Aortic Stenosis – in the past a simple echocardiogram to determine the condition and measure a single number to guide treatment took about 20 minutes. Today that test requires more parameters such that 60 minutes is not unusual. That and in the future, more information will be required as there are now surgical treatments for those older patients who were just treated palliatively. While numbers may not increase dramatically in Shetland, the time per patient will.

Reducing employment cost is a massive driver for change. The nominal retirement of the present incumbent is the end of 2016/17. And while this is an opportunity to redesign the service it is against a background of shortages of appropriately qualified and sufficiently skilled cardiac physiologists in the UK.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE REDESIGN AS PART OF RETIREMENT OF PRESENT INCUMBENT</td>
<td>KATHLEEN CAROLAN</td>
<td>JAN 2015 ONWARDS</td>
<td>CONTINUED SAFE AND APPROPRAITE CARDIAC PHYSIOLOGY SERVICE FOR SHETLAND</td>
</tr>
</tbody>
</table>
## Current draft model:

- Grampian to provide implanted cardiac device follow-up service
- Employ a BSE accredited echocardiographer
- Move community services dome in the hospital to the community eg Spirometry and ABP
- Investigate arrhythmia service

To be in place end 2016

Seamless service provided by appropriately qualified and experienced cardiac physiologists

Community testing closer to the patient

### Key Risks to Delivery

Financial risks are involved with requiring increased investigations for an aging population. Eventually capacity will overwhelm supply and further practitioners may be needed. Already bank staff are being used to supply chaperoning services to avoid females having a longer wait time than males for echocardiography.

The shortage of appropriately qualified and experienced echocardiographers.: A package to recruit and retain will most likely be higher financially than for the present incumbent.

Weather and travel costs for the visiting implanted cardiac devices service.

Still a single-handed practitioner.

The present incumbent is paediatric trained and it may not be possible to source a future clinical physiologist with a broad skill base.

### Contact Details

Physiological Measurements is situated in the GBH.
Contact Chris Brown 01595743053.
Email chrisbrown3@nhs.net
Laboratory

Policy context

Current Services

Funding and Resources

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical diagnostic laboratory services comprising Biochemistry, Haematology, Transfusion Medicine and Microbiology. Provided 24/7 by a combination of rostered shifts and OOH on-call service to NHS Shetland acute services (GBH) and primary care providers (GPs)</td>
<td>9.62</td>
<td></td>
<td>770654</td>
<td></td>
<td>(-3%)</td>
</tr>
</tbody>
</table>

Needs/Unmet needs/Drivers for change

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Severe difficulties in recruitment of specialist BMS staff</td>
<td>Director Acute Services &amp; laboratory manager</td>
<td>1. Ongoing</td>
<td>1. Ongoing</td>
</tr>
</tbody>
</table>
Key Risks to Delivery

Performance Targets with links to National Outcomes

Contact Details

Further Reading
Audiology Service

Policy context

SENSORY IMPAIRMENT STRATEGY (SEE HEAR) -

Scottish Audiology Quality standards -

Locally a 2014 patient survey shows that lack of deaf awareness amongst staff is an issue for patients. (Kathleen Carolan – holds an action plan for this survey). Through 2015 additional funding from SIC to increase support hours from WTE0.6 to WTE 0.4 has allowed for deaf awareness and hearing aid care training to be supplied to SIC and NHS staff. A hearing aid care box has been supplied to each GHB Ward and SIC care home facilities along with other care facilities. Funding for this will stop at the end of December 2015 and impact greatly on the service plans going forward.


1. Streamlining health technology management – implement by end of 2020
2. Point-of-care testing – implement by end of 2020
3. Demand optimisation – implement by end of 2019
4. Developing sustainable services – implement by end of 2019
5. A new integrated model for clinical physiology services – implement by end of 2020

The key deliverables for Audiology are 3, 4 and 5.

Current Services

The Audiology service provides Audiological support to NHS Shetland, visiting ENT clinics and the local community.

Hearing assessment, hearing aid provision, hearing aid follow up, hearing aid maintenance and other hearing aid related services. Hearing aid repairs by appointment or by post or drop box at main reception.

Paediatric hearing assessment clinic, hearing aid fitting when required generally for school age children. Babies and pre-school children requiring hearing aid fitting would be seen in Aberdeen with specialist paediatric Audiologists.

Support to the visiting ENT service with the Audiologist working at advanced practitioner level to triage and pre-assess ENT referrals.

Deaf Awareness training to staff of all levels both NHS and SIC

Work with SIC to implement the Sensory Impairment Strategy which has come from the SEE HEAR consultation.

Maintain and improve the services for hearing impaired people both adults and children with a growing elderly population with increasingly complex needs.

Aim to routinely re-design the service to meet changing clinical and financial demands whilst maintain quality of service to patients.
Funding and Resources

Table of budget and savings targets, including workforce details

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings target 2% of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>1.6</td>
<td>161,001</td>
<td>137,001</td>
<td>2,740.02</td>
<td></td>
</tr>
</tbody>
</table>

As of month 6 (2015) budget statement the non pay part of the budget (61,900) is over spent by £12,815. Due to being a demand led service although efforts are being made to reduce costs it is likely that the service will have an over spend of around £24,000. This will mean not being able to meet the 2% savings target.

**Savings plans**
- **5% saving on hearing aid** costs from Oticon as main supplier
- **Recurrent saving** of WTE 0.4 Band 4 support post
- **Redesign of reassessment criteria** to reduce the number of self referrals of current hearing aid users. But this may turn out to be futile as time goes on a patients genuinely need re-test and hearing aid upgrade due deterioration in hearing.

**Needs/Unmet needs/Drivers for change**

There is a growing elderly population with the number of people in the UK rising from 1 in 7 around 20 years ago to 1 in 6 currently. This compares to 1 in 30 who have sight impairment. So, there are a significant number of people in the local population with some degree of hearing impairment. Not all will seek help and some will access hearing aids privately but the majority of those suitable for hearing aid provision will be referred for NHS hearing aid provision. We keep a register of active NHS hearing aid users and currently (29th Oct 15) it is 1,108 people. In 2005 there was a list of around 200 Shetland patients supplied from the Aberdeen Audiology service. But this quickly proved to be an underestimate of the those using NHS hearing aids at the time. As with all NHS services in recent years who deal with older people the demand has begun to increase sharply.

As permanent hearing impairment is a progressive condition the “Scottish Audiology Standards” recommend that this group require review every 3yrs. The Audiology service has not been able to provide this for several years due to lack of capacity within the service. This group of patients has begun to self refer for review as they notice hearing deterioration which puts them in to the 18wks pathway. Further demand comes from the general increase in the older population and increased demand from the ENT service for both Adults and Children. The demand for Paediatric hearing assessment has been steadily increasing for several years. There is increasing difficulty in supporting elderly hearing aid users who are more likely to have additional complex needs such as dementia and sight loss.

**Unmet need**

Many hearing aid users do not represent for testing as described above as they may not be aware of the slow deterioration of hearing. Studies have shown that hearing loss can increase problems with dementia and some people have been misdiagnosed with dementia due to hearing loss. Untreated hearing impairment can cause an already elderly person to become more vulnerable and require more support.
Lack of a second soundproof room to meet demands is becoming more of an issue going forward. This reduces the services ability to re-design and meet the HCS deliverables, 18wks RTT and local targets.

We do not offer an unscheduled service but patients do still turn up without prior arrangement or a scheduled appointment. This can impact on other nearby services such as Physiotherapy and GBH reception staff if patients are no able to access a member staff from Audiology.

**Plans for change**

Headline actions including service redesign, lead officer, target dates and links to national outcomes.

Please reference any Action Plans already in existence.

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead Officer</th>
<th>Start date/target</th>
<th>Expected Outcome(s) (link to National Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Staffing/Training</strong></td>
<td>Jackie Haywood</td>
<td>Sep 14 – Jun 16</td>
<td>Diploma in Hearing Aid Audiology (2yrs) online and blocks of study at QMU, Edinburgh. HCS Deliverable 4 Developing sustainable services</td>
</tr>
<tr>
<td>Assistant Audiological Practitioner post</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From Sep 2014 funding secured from NES to support all or most of the costs of training this post holder to Associate Audiologist level. Therefore increasing the skill mix</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Accommodation/Equipment</strong></td>
<td>Jackie Haywood</td>
<td>ongoing</td>
<td>But measures are in place to use the OH dept room with soundproof booth at most once a week. Along with room availability in outpatients 1 day a week over 2 1/2 day sessions. The OH room use is currently on hold due to a new round of direct supervision and log book completion for the 2nd year of diploma. We should be able to utilise the OH room again from May/Jul 2016 but this will be of limited use if the newly qualified Associate Audiologist is still on WTE 0.6 rather than WTE1.0 HCS Deliverable 4 Developing sustainable services</td>
</tr>
<tr>
<td>It has not been possible to secure a permanent second clinical room and associated equipment for the Associate Audiologist to work from when qualified. As per previous plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Changes to Directorate management structure</strong></td>
<td>Kathleen Carolan</td>
<td>2015-16</td>
<td>Creating a diagnostics lead and therefore a diagnostic group within the directorate. This groups <strong>Audiology, Cardiology, Labs and Medical Imaging.</strong> This is a step towards HCS Deliverable 5 “…develop a</td>
</tr>
</tbody>
</table>
4. Advanced practitioner
The Audiologist works as an advanced practitioner with support to ENT clinics. From Jan 2014 an extended triage of ENT referrals was piloted to help reduce ENT waits/demand. Jackie Haywood Pilot from Jan – Jun 14 and now ongoing. Suspended from January 2016 Due to the TAA dropping back to WTE 0.6 there will not be the capacity within Audiology to continue these clinics. This will impact on the ENT service. Outcomes Jan – Apr 14 Discharged 2% (no ENT apt needed) ENT apt needed 65% Hearing aid/Audiology apt needed 33% There is some overlap of patients who need to see ENT after extended triage and also need Audiology input.

HCS Deliverable 4
“...explore new and developing healthcare science roles that support areas of service pressure and have the potential to free-up medical capacity....”

5. Cochlea implant reviews
We have a small number of Shetland patients who have been fitted with cochlea implants at the mainland cochlea implant centre, Lanakshire. Jackie Haywood /Diane Coleman (outpts) From early 2016 These patients have previously travelled to the mainland for assessment/fitting/review. After a pilot in Orkney to offer a review clinic there, we are to set this up for Shetland in early 2016. This will reduce the cost of patients travelling to the mainland. The cochlea implant team will pick up the costs of their travel/accommodation and plan to set this up as a yearly VC type review clinic from 2017 (using the VC facilities in outpatients.) Linked to local aims of reducing travel costs off island for treatment which can be provided via telemedicine.

As the Trainee Associate Audiologist (TAA) is still in training and will from January 2016 be going back to WTE 0.6 after a temporary period of WTE 1.0 Jan-Dec 15 as noted in “policy contex”. The plans for change are limited as the Audiologist will have to pick up routine clinical tasks formally supported by the TAA from January 2016 at a time of high demand.

Key Risks to Delivery
As per “Drivers for change” the NHS as whole is dealing with an increasing elderly population who are living longer and requiring assistance with more complex needs. As most of the
Audiology service users are older/elderly people this is and will continue to be a risk to delivery of Audiology services. The service has 1.0WTE Audiologist who works at advanced practitioner level and so this can make the service fragile when this person is not available. Currently demand is regularly outstripping capacity and although the TAA is training to take on more of the clinical work we only have one permanent clinical room. The new TAA role is increasing the clinical role but the consequence of this is reduced clerical support for the service. We do not have a proper point of contact for patients trying to access the service for unscheduled care. This impacts on other services such as Physiotherapy and main reception. Costs will rise with increasing numbers of patients seen and hearing aids fitted.

Performance Targets with links to National Outcomes

National outcomes/targets
18wks RTT
Scottish Audiology quality standards
Sensory impairment strategy (SEE HEAR)
The Scottish Healthcare science national delivery plan 2015-2020

Service indicators of quality locally – Patient satisfaction survey (usually annually) part of Scottish Audiology quality standards

Contact Details

There is no reception or clerical staff so sometimes people need to leave a message on the answer phone. This can be very difficult for hearing impaired people to be able to use but we also have an email contact.
Audiology Department, Gilbert Bain Hospital, Lerwick, Shetland, ZE1 0TB.
Telephone: 01595 743231 (Audiology office)
Fax: 01595 692184
Email: shet-hb.audiology@nhs.net

We are piloting a link with outpatients to transfer the Audiology phone to them when Audiology staff are seeing patients and not able to answer the phone. (From October 2015)

Further Reading

SENSORY IMPAIRMENT STRATEGY -

Scottish Audiology Quality standards -

http://www.gov.scot/Resource/0047/00476785.pdf the programme has 5 deliverables

http://www.hearingreview.com/2014/01/update-on-dementia-and-hearing-loss/
http://hub.jhu.edu/2014/01/24/hearing-loss-brain-size
Central Decontamination Unit

Policy Context

CDU provides sterilization and decontamination services from a Unit based at the Gilbert Bain Hospital. The Unit was built in 1996 and has been completely refurbished to meet the current statutory requirements. It is supported by a robust Quality Management System which helps meet ever changing customer requirements in what is a very specialist field. The Unit provides sterilization and decontamination services for Primary and Secondary Care covering a number of specialities that include Orthopaedics, General Surgery, ENT, Obstetrics, Gynaecology, Ophthalmology, Dental, Maxilla-facial and podiatry.

Staff in CDU provide expert advice on all aspects of sterilization and disinfection, taking great pride in the quality and reliability of the service provided.

Funding and Resources

<table>
<thead>
<tr>
<th>Service CDU</th>
<th>Number of staff (WTE)</th>
<th>Expenditure</th>
<th>Income</th>
<th>Net Budget</th>
<th>Savings Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing funded by NHS Shetland</td>
<td>B4 1.6 B3 3.04</td>
<td>£127,638</td>
<td>NA</td>
<td>£127,638</td>
<td>2% across pay/ non pay budget = £3161</td>
</tr>
<tr>
<td>Staffing funded by Dental, NHS Shetland</td>
<td>B3 1.36 Available from Dental services/ Finance</td>
<td>NA</td>
<td>Available from Dental services/ Finance</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Non pay</td>
<td>NA</td>
<td>£30,440</td>
<td>NA</td>
<td>£30,440</td>
<td>As above</td>
</tr>
</tbody>
</table>

Needs/ Unmet needs/ Drivers for change

£5000 removed from non pay budget for year 2015/2016 as recurrent savings. Savings targets of 2% for 2016/2017 from April = £3161 across pay/ non pay budget to be achieved.

Plans for change

<table>
<thead>
<tr>
<th>Description</th>
<th>Lead officer</th>
<th>Start date/ target date</th>
<th>Expected outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in non pay budget by £5000</td>
<td>Carol Barclay</td>
<td>April 2015</td>
<td>To be taken as recurrent savings</td>
</tr>
<tr>
<td>Reduction in B4</td>
<td>Carol Barclay</td>
<td>April 2016</td>
<td>To meet target</td>
</tr>
</tbody>
</table>
Quality Supervisor post by 0.1 WTE to release £2961

| Reduction in non pay budget by £200 | Carol Barclay | April 2016 | To meet target savings of 2% |

These saving targets have already been submitted to Finance as part of projected savings for NHS Shetland for the year 2016/2017.

Key Risks to Delivery

There is one washer disinfector in the unit that is now eleven years old and spare parts can no longer be obtained for this. This machine needs to be replaced and a request for replacement has been submitted as part of the Capital Management Programme.

The duplex reverse osmosis steam generator for the two sterilizers has had numerous operational issues since installation and commissioning. A bid to link the existing reverse osmosis plant which already supplies the washer disinfectors to the sterilizers to overcome these issues has also been made to the Capital Management Programme.

Both these issues mean that the reliability of decontamination/sterilization services provided can be interrupted due to breakdowns. Business continuity plans are in place with NHS Grampian for any prolonged breakdowns in service provision.

Performance Targets

NHS Shetland submits data as part of HFS national benchmarking project. This project is still in the early stages of development.

Contact Details
Carol Barclay, Decontamination Lead – GBH Ext 3190
Ruth Black, Production Supervisor – GBH Ext 3191
Angela Hall, Quality Supervisor - GBH Ext 3191

Further Reading
CDU is audited by an external notified body, SGS on an annual basis to ensure conformity to the Medical Devices Directive 93/42/EEC and to the requirements of 2007/47/EC as well as EN ISO 13485:2012.
Appendix 1: Localities Map