Joint Strategic (Commissioning) Plan 2016-19
SUMMARY
Introduction

The Joint Strategic (Commissioning) Plan for 2016-19 is developed jointly in partnership with stakeholders, for adoption by the Integration Joint Board (IJB). It is structured around the client groups / services that are included within the delegated authority of the IJB. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

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

In future the Strategic Commissioning Plan will increasingly describe how people’s lives, health and wellbeing will be improved. This will include decisions about disinvesting in current provision of services in order to reinvest in other services and supports that are required to meet on-going and changing demand.

In addition, we expect future Strategic (Commissioning) Plans to increasingly reflect our engagement with stakeholders and local communities in Shetland, through Locality Planning and links to Community Planning, professional involvement, working with users and carers, and through strategy development on particular themes such as older people and primary care. The IJB’s Communication and Engagement Plan sets out more detail of how this will be done.

The Strategic Plan is informed by work done to analyse the needs of local populations, known as Joint Strategic Needs Assessments (JSNAs). These needs assessments will also inform and guide the commissioning of health, wellbeing and social care services within the area.

In Shetland the specific strategies that have informed the Strategic Plan (on Carers, Mental Health, Older People, Dementia) include strategic needs assessment work, which is also being developed through the Locality Profiling done to inform Locality Planning. This will be an area of development in future iterations of the Strategic Plan, taking into account more detailed information about local populations and their needs.

Similarly, financial analysis of service delivery and change, and to support analytical processes such as programme budgeting / marginal analysis and Locality Planning, will be developed as part of the Joint Finance work in place to support the development of Integration.

This summary highlights the key areas of change and improvement within this Shetland Joint Strategic Commissioning Plan, and provides an easy-read, overarching summary of the strategic commissioning plan with details of the vision for Shetland. The full plan is available at:

http://www.shetland.gov.uk/Health_Social_Care_Integration/StrategicPlan.asp
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:
  - is integrated from the point of view of service-users
  - takes account of the particular needs of different service-users
  - takes account of the particular needs of service-users in different parts of the area in which the service is being provided
  - takes account of the particular characteristics and circumstances of different service-users
  - respects the rights of service-users
  - takes account of the dignity of service-users
  - takes account of the participation by service-users in the community in which service-users live
  - protects and improves the safety of service-users
  - improves the quality of the service
  - 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)
  - best anticipates needs and prevents them arising
  - makes the best use of the available facilities, people and other resources

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 disability including physical disability and learning 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 the Local Authority area over the period of the plan:

- The arrangements for each locality established for locality planning purposes.
- The process of strategic planning, including the Strategic Planning Group set up to prepare future strategic commissioning plans
Further development work:
- Replacing the current CHCP Procurement Strategy with a Joint Commissioning and Procurement Strategy to provide one strategy for health and social care that will be adopted by the Council, NHS Shetland and Shetland’s Integration Joint Board.
- Developing an agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions.
- Considering the need for development of a Market Facilitation Plan in line with national guidance (in the form of expected Advice Notes) and as relevant to the Shetland context in its first year of operation.

Summary of the Plan

The vision for Shetland, as described in the Community Plan and Single Outcome Agreement (SOA), is that we aim to make Shetland the best place to live and work by helping to create communities that are: wealthier and fairer, learning and supportive, healthy and caring, safe, vibrant and sustainable.

For health, NHS Shetland’s 2020 Vision is:
“to deliver sustainable high quality, local health and care services, that are suited to the needs of the population; to make best use of our community strength, community spirit and involvement; for people to make healthy lifestyle choices, and use their knowledge and own capacity to look after themselves and each other.”

The Community Health & Social Care Directorate’s vision is:
“To ensure that everyone in Shetland is able to live and participate in a safe, vibrant and healthy community”

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.
## National health and wellbeing outcomes

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

**Mental Health:**
- Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD
- Establish a person centred Consultation & Engagement Framework (including a Mental Health Website) to facilitate Co-Production

**Substance Misuse:**
- Review of Tier 1 and 2 substance misuse services

**Oral Health:**
- Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
- Encourage independent NHS dental practices to open in Shetland
- Develop referral protocols for use by local dental practices
- Review local oral health care for people with Special/ additional needs
- Review local availability of specialist oral health care
- Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

**Pharmacy:**
- Increase the availability of Pharmacy support to patients in their own homes and in Care homes
- Increase the number of polypharmacy reviews by 20%

**Primary Care:**
- Implement 2016/17 GP Contract and QOF amendments
- 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
- Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
- Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015

**Community Nursing:**
- Continue to support implementation of eKIS Anticipatory Care Planning across the services

**Sexual Health:**
- A range of initiatives to be introduced to help to reduce unplanned pregnancy

**Adult Services:**
- Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.

**Nutrition and Dietetics Service**
- Complete development and implementation of bariatric pathway
- Complete development of and implement general Weight Management plan, and roll out sessions in specific Health Centres
- Complete development of diabetes pathway and roll out as appropriate
Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.
Implement podiatric aspects into falls prevention strategy.

Orthotics Service:
Development of referral criteria and introduction of self referral in line with the Allied Health Professional National Delivery Plan.

Occupational Therapy:
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community

Health Improvement:
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.
‘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.

Public Health:
Team staffing restructure to achieve savings targets

Child & Family Health:
Impact of the Children and Young Person’s Act 2014 and new Health Visitor pathway to be quantified and evaluated – including the workforce needed to deliver the legal requirements of the act
Redesign of the CAHMS team and links to specialist services
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.

**Mental Health:**
- Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
- Implement the 2015-18 Dementia Strategy Action Plan
- Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress

**Oral Health:**
- Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
- Review local oral health care for people with Special/ additional needs
- Review local availability of specialist oral health care

**Pharmacy:**
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**Community Nursing:**
- Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
- Further develop model of case management within Community Nursing services
- Continue to support implementation of eKIS Anticipatory Care Planning across the services

**Adult Services:**
- Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.

**Community Care Resources:**
- Review current models of care in Shetland to ensure sustainability of service.

**Criminal Justice:**
- To contribute to the National outcomes, performance and improvement framework.

**Podiatry Service:**
- Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
- Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.
- Implement podiatric aspects into falls prevention strategy.
- Contribute to savings targets by triaging orthopaedic referrals.
- Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.
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Explore need for specialisation in Dementia services and implement as appropriate  
Increase number of people in receipt of technology enabled care  
Provide rapid response to A&E in order to facilitate discharge straight home  
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community |
| **Health Improvement:** | 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.  
Community capacity building and work in partnership with voluntary sector partners. |
| **Child & Family Health:** | Redesign of the CAHMS team and links to specialist services  
Move to an electronic child’s record to allow the secure sharing of information between services when required under the Children and Young Person’s Act (2014) |
| **Physiological Measurements:** | Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service. |
| **Adult Social Work** | Extend the input and presence of social work in localities. |
| **Intermediate Care** | Extend intermediate care model to all localities using investment opportunities and through redesign of teams. |
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Mental Health:
Extend the availability and responsiveness of Out of Hours support for psychiatric emergencies
Establish a purpose built room in GBH for the management of psychiatric emergencies
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Establish and develop access to Clinical/Counselling Psychology Services
Redesign psychological therapy services and increase local capacity by training a wider range of existing staff
Implement the 2015-18 Dementia Strategy Action Plan
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress
Introduce role appropriate “Equal Partners in Care” (EPiC) training for all staff
Establish a person centred Consultation & Engagement Framework (including a Mental Health Website) to facilitate Co-Production

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
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Primary Care
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Implement agreed actions from both local and national Out of Hours reviews

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Further develop model of case management within Community Nursing services

Adult Services:
Progression of the Day Services need for new premises to replace the current EGRC
Community Care Resources:
Work with locality partnerships to plan / deliver local services.

Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Orthotics Service:
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.
Review service and implement actions to reduce the rate of non-attendees (DNAs) to below 5%, thereby making better use of professional resource.

Occupational Therapy:
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community
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.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

**Mental Health:**
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Establish and develop access to Clinical/Counselling Psychology Services
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**Community Nursing:**
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Further develop model of case management within Community Nursing services
Continue to support implementation of eKIS Anticipatory Care Planning across the services

**Domestic Abuse:**
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17

**Adult Services:**
Progression of the Day Services need for new premises to replace the current EGRC

**Criminal Justice:**
Participate in the transition phase of the redesign of Community Justice at a local and national level.
Work with local partners and partnerships to plan / deliver local services.
Contribute to the National outcomes, performance and improvement framework.
**Podiatry Service:**
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Identify possible opportunities for early intervention in patients with possible signs of dementia.
Contribute to savings when early intervention is possible.
Implement podiatric aspects into falls prevention strategy.
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**Health Improvement:**
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. ‘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. Community capacity building and work in partnership with voluntary sector partners.

**Unscheduled Care:**
Review Nursing, Midwifery & Allied Health Professions (NMAHP) skill mix to support sustainable workforce (incorporating the medical staffing review)

**Staff Development:**
Support the delivery of Service Improvement within the Board.

**Child & Family Health:**
Redesign of the CAHMS team and links to specialist services
Review of available on-island paediatric outpatient care options to sustain input from medical specialist team
Move to an electronic child’s record to allow the secure sharing of information between services when required under the Children and Young Person’s Act (2014)

**Planned Care:**
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)

**Physiological Measurements:**
Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service.

**Audiology:**
Service redesign and improvement including: training one post holder to Associate Audiologist level, therefore increasing the skill mix; secure a permanent second clinical room and associated equipment for Associate Audiologist; triage of ENT referrals to help reduce ENT waits/demand; review clinic for patients fitted with cochlea implants at mainland cochlea implant centre.
5. Health and social care services contribute to reducing health inequalities.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary Community Mental Health Team (e.g. Occupational Therapy, Social Work and GP)
Redesign psychological therapy services and increase local capacity by training a wider range of existing staff
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD
Introduce role appropriate “Equal Partners in Care” (EPiC) training for all staff

Substance Misuse:
Review of Tier 1 and 2 substance misuse services

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
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Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Develop a training and support programme for Remote and Rural pharmacists

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015
Continue to support the growth of the Scalloway practice

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service

Sexual Health:
A range of initiatives to be introduced to help to reduce unplanned pregnancy

Domestic Abuse:
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17
Speech & Language Therapy:
Implement fast track referral to facilitate discharge
Implement designated phone-in advice and information sessions to ensure more efficient use of qualified Speech and Language therapy resources.
Implement monthly drop-in sessions at Independent Living Centre for patients/parents with SLT related concern
Participate in Skype/VC telehealth project as part of a research project aiming to use technology to meet Speech and Language needs more efficiently. Implement recommendations from research project findings if results are positive/effective.

Podiatry Service:
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Orthotics Service:
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.
Implement appropriate appointment booking procedure to ensure equity of access to service.
Ensure access to service operates in line with other services in Scotland by adopting consensus documents under development by Scottish Orthotics Leads (ScOL)

Health Improvement:
Increase 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.
‘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.
Community capacity building and work in partnership with voluntary sector partners.

Public Health:
Team staffing restructure to achieve savings targets

Planned Care:
Increase access to tele-health appointments to avoid unnecessary follow up and travel
Identify 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
Develop an enhanced Day Surgical Unit (DSU) and ambulatory care facility
Put in place a managed service contract for Laboratory Services (joint arrangement with NHS Grampian and NHS Orkney)
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

**Mental Health:**
- Introduce role appropriate “Equal Partners in Care” (EPiC) training for all staff

**Oral Health:**
- Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
- Encourage independent NHS dental practices to open in Shetland
- Review local oral health care for people with special/ additional needs
- Review local availability of specialist oral health care

**Primary Care:**
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**Adult Services:**
- Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.
7. People using health and social care services are safe from harm.

Mental Health:
Extend the availability and responsiveness of Out of Hours support for psychiatric emergencies
Establish a purpose built room in GBH for the management of psychiatric emergencies
Establish and develop access to Clinical/Counselling Psychology Services
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress

Substance Misuse:
Review of Tier 1 and 2 substance misuse services

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Continue to support the growth of the Scalloway practice

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care
Further develop model of case management within Community Nursing services

Domestic Abuse:
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17

Nutrition & Dietetics Service
Complete and evaluate pilot training programme to care homes and roll out across care home estate.
Podiatry Service:
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Physiotherapy Service:
Multi-disciplinary Falls Pilot (within current resources)

Occupational Therapy:
ILC Equipment Store review, and refresh all procedures and protocol that ensure the supply of appropriately maintained equipment.
Integrate district nursing equipment into establish an integrated system.

Unscheduled Care:
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)

Staff Development:
Support the delivery of Service Improvement within the Board.

Public Health:
Team staffing restructure to achieve savings targets

Child & Family Health:
Impact of the Children and Young Person’s Act 2014 and new HV pathway to be quantified and evaluated – including the workforce needed to deliver the legal requirements of the act
Redesign of the CAHMS team and links to specialist services
Review of available on-island paediatric outpatient care options to sustain input from medical specialist team
Move to an electronic child’s record to allow the secure sharing of information between services when required under the Children and Young Person’s Act (2014)

Planned Care:
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)

Medical Imaging:
Diagnostic Imaging Equipment Replace Programme - Replacement of x-ray equipment in 2017-18
Replacement of CT scanner (by 2021)
Replacement of current ultrasound machine (by 2018)

Physiological Measurements:
Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service.
Adult Social Work
Quality assurance framework to be further developed for the service to ensure that rapid changes across the sector can be responded to in a way that minimises risks
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish a person centred Consultation & Engagement Framework (inc a Mental Health Website) to facilitate Co-Production

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
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Continue to support the growth of the Scalloway practice

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care
Conduct review of local District Nursing services in line with national “Transforming Nursing Roles” project
Review of skill set across Nursing and Care staff

Community Care Resources:
Review roles and responsibilities within the care sector.

Podiatry Service:
Implement podiatric aspects into falls prevention strategy.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.
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<td>Support the delivery of Service Improvement within the Board.</td>
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9. Resources are used effectively and efficiently in the provision of health and social care services.

Mental Health:
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan
Establish a person centred Consultation & Engagement Framework (inc a Mental Health Website) to facilitate Co-Production

Substance Misuse:
Review of Tier 1 and 2 substance misuse services

Oral Health:
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan
Encourage independent NHS dental practices to open in Shetland
Develop referral protocols for use by local dental practices
Review local oral health care for people with Special/ additional needs
Review local availability of specialist oral health care
Develop information sharing with local dental practices to maximise effectiveness of Childsmile inputs

Pharmacy:
Increase the availability of Pharmacy support to patients in their own homes and in Care homes
Increase the number of polypharmacy reviews by 20%

Primary Care:
Implement 2016/17 GP Contract and QOF amendments
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
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards.
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015
Continue to support the growth of the Scalloway practice.
Identify permanent arrangements for Practice Management at the Lerwick Health Centre, utilising the capacity across all salaried practices to support primary care management of services
Review the skill mix required in the Lerwick Health Centre following the extension of the ANP model, to ensure efficiency and to identify opportunity for savings

Community Nursing:
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care
Further develop model of case management within Community Nursing services
Continue to support implementation of eKIS Anticipatory Care Planning across the services
Review of skill set across Nursing and Care staff
Domestic Abuse:
Domestic Abuse Strategy for 2016-19 currently in development along with Action Plan for 2016-17

Adult Services:
Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.

Community Care Resources:
Review current models of care in Shetland to ensure sustainability of service.
Sector review of procedures and processes

Criminal Justice:
Review of processes and procedures to ensure they remain fit for purpose.
Continue to promote increased use of fiscal and police direct measures.

Speech & Language Therapy
Implementation of designated phone-in advice and information sessions to ensure more efficient use of qualified Speech and Language therapy resources.
Implementation of monthly drop-in sessions at Independent Living Centre for patients/parents with SLT related concern.
Participate in Skype/VC telehealth project as part of a research project aiming to use technology to meet Speech and Language needs more efficiently. Implement recommendations from research project findings if results are positive/effective.

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

Podiatry Service:
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.
Identify possible opportunities for early intervention in patients with possible signs of dementia.
Contribute to savings when early intervention is possible.
Implement podiatric aspects into falls prevention strategy.
Contribute to savings targets by triaging orthopaedic referrals.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.

Orthotics Service:
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.
Continue to review and revise technician’s activity to release time to service community equipment, thereby reducing spend on community equipment.
Development of referral criteria and introduction of self referral in line with the Allied Health Professional National Delivery Plan.
Ensure access to service operates in line with other services in Scotland by adopting consensus documents under development by ScOL

Physiotherapy Service:
Review of neurophysiotherapy service
Review of physiotherapy musculoskeletal outpatients service
**Occupational Therapy:**
Explore need for dedicated Mental Health aspect of OT service and implement as appropriate
Explore need for specialisation in Dementia services and implement as appropriate
Increase number of people in receipt of technology enabled care
Provide rapid response to A&E in order to facilitate discharge straight home
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community
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.

**Health Improvement:**
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.
‘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.
Community capacity building and work in partnership with voluntary sector partners.

**Unscheduled Care:**
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)
Reviewing out of hours service provision (including medical staffing, primary care configuration and locality based services)
Reviewing the management structure for Acute & Specialist Services
Reviewing the management structure for Community Care services

**Occupational Health:**
Introduction of Fit for Work Service

**Staff Development:**
Support the delivery of Service Improvement within the Board.

**Public Health:**
Team staffing restructure to achieve savings targets

**Child & Family Health:**
Impact of the Children and Young Person’s Act 2014 and new HV pathway to be quantified and evaluated – including the workforce needed to deliver the legal requirements of the act
Redesign of the CAHMS team and links to specialist services
Review of available on-island paediatric outpatient care options to sustain input from medical specialist team
Development of Joint commissioning and joint budgeting for Integrated Children’s Services
Move to an electronic child’s record to allow the secure sharing of information between services when required under the Children and Young Person’s Act (2014)
Planned Care:
Increase access to tele-health appointments to avoid unnecessary follow up and travel
Increase capacity in the renal unit to meet demand
Identify 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
Develop an enhanced Day Surgical Unit (DSU) and ambulatory care facility
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)
Put in place a managed service contract for Laboratory Services (joint arrangement with NHS Grampian and NHS Orkney)
Review the management structure for Acute & Specialist Services

Medical Imaging:
Reviewing the medical imaging staffing skill mix and team structure
Diagnostic Imaging Equipment Replace Programme - Replacement of x-ray equipment in 2017-18
Replacement of CT scanner (by 2021)
Replacement of current ultrasound machine (by 2018)

Physiological Measurements:
Service redesign including: Grampian to provide implanted cardiac device follow-up service, employment of a BSE accredited echocardiographer, move community services done in the hospital to the community eg Spirometry & ABP and investigate arrhythmia service.

Audiology:
Service redesign and improvement including: training one post holder to Associate Audiologist level, therefore increasing the skill mix; secure a permanent second clinical room and associated equipment for Associate Audiologist; triage of ENT referrals to help reduce ENT waits/demand; review clinic for patients fitted with cochlea implants at mainland cochlea implant centre.